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Katrina Jacinto

Yale-NUS College, katrina.jacinto@u.yale-nus.edu.sg

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Skin Stories and Family Feelings: The Contradictions of Skin Picking in Mother and Daughter

Katrina Jacinto

Yale-NUS College

Introduction

Sitting together in the quaint counseling center of my junior college, a friend’s offhand comment made a curious breakthrough in my therapeutic journey. Troubled by persistent anxiety and low mood, I had been trying for several weeks to seek out psychiatric treatment. I felt that an official diagnosis might give me more clarity about what I was experiencing and how to handle it. My counselor, however, was reluctant to give me a diagnostic test, unconvinced that I needed help beyond our regular sessions. My friend, who had accompanied me for emotional support that day, changed her mind in a matter of seconds.

“Oh, Kat *always* scratches her head until it bleeds!”

My counselor turned towards me sharply, and coincidentally caught me in the act.

“Is that true, Kat?”

“Um... yes?” I answered sheepishly, lowering my hand to my side.

“Why didn’t you say so sooner? I’ll get you that test then.”

That this *physical* habit was apparently a smoking gun in the diagnosis of my *mental* illnesses was confounding to me. However, upon further research, I have realized that my compulsive picking is apparently a psychiatric problem. I started picking my scalp when I was 11 years old, and continue to do so now despite repeated attempts to stop. I mostly pick when I am bored or stressed, which is often. Almost unwittingly, I find my fingers reaching into my hair, roaming around my scalp and finding bumps, dry skin, or scabs to scratch off. During especially intense periods of stress, I sometimes collect these “bits” of organic debris and keep them in a pile next to me. I remember forming such piles during my secondary school debate sessions, in the middle of my GCE A-Level exams and even now, on the corner of my laptop while I write essays. It is difficult to explain why I do this, but I do remember how I picked up the habit: from watching my mother, Pinky, do the same. I conducted an ethnographic interview with her to learn about her experience of skin picking.

At 54 years old, Pinky is undeniably beautiful. In public, we are regularly mistaken as sisters, because she easily appears 20 years younger than her real age.

Pinky's "arrival story" with regards to scalp picking is different from mine. For her, this behavior only started well into adulthood, in 2008. Rather than a generalized phenomenon like mine, her picking was localized to a single spot: a "picker's nodule" on the top of her head that "wouldn't go away," as the damage from her picking would cause the skin to grow back thicker and more itchy. After a few years, she went to a dermatologist to address the issue, who treated the nodule using cryotherapy, and her picking ceased. However, while she claimed to have kicked the habit, it seemed to me that it may simply manifest in different forms: we spent a portion of our interview discussing a pimple on her thigh which had been irritating her, precisely because she would pick at it, and it would come back. Albeit to a less distressing degree, skin picking remains an issue that Pinky is preoccupied with.

It is perhaps helpful to give a brief medical overview of this behavior. Skin picking disorder, otherwise known as dermatillomania, is marked by "recurrent and excessive picking, scratching or rubbing of normal skin" that leads to significant emotional and social distress.²⁶⁶ Alternatively, as in my case, compulsive skin picking may be a symptom of other conditions such as ADHD, rather than a disorder in and of itself. Nonetheless, given the recent inclusion of dermatillomania in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), compulsive skin-picking is defined as a psychiatric condition.²⁶⁷ These simplistic definitions, however, do not cohere with Pinky's experience. She has never felt that her picking is a disorder: rather, she described it simply as a "bad habit" that has little bearing on her mental wellbeing. The question of whether either of us "actually" have dermatillomania is irrelevant to my analysis. What is more interesting is this: How could our picking be understood, and addressed, through such different terms? How does skin picking simultaneously link and separate my body from my mother's?

In this essay, I seek to disrupt the notion of compulsive skin picking as a straightforward medical fact. Instead, I suggest that skin picking is a "[technique] of the body" that has been transmitted intergenerationally from my mother to me.²⁶⁸ Yet, simultaneously, it is a "stigma symbol" which "[discredits]" the individual in some way.²⁶⁹ As a result of this stigma, skin picking becomes pathologized and rendered as a site of medical intervention. Yet, even the notion of "medical intervention" is more pluralistic than one might assume. I was fascinated by how differently my mother and I treated our skin picking: Pinky went to a dermatologist, and I went to a psychiatrist. This difference, I argue, reveals that skin picking is *polyvalent*. Borrowing from literary theory, I use the notion of

²⁶⁶ Matthew J. Paylo and Allison A. Zins, "Excoriation disorder: A new diagnosis in the DSM-5," *ACA Center for Counseling, Policy and Research Practice Briefs* (June 2015): 18.

²⁶⁷ Paylo and Zins, "Excoriation disorder," 18.

²⁶⁸ Marcel Mauss, "Techniques of the Body," *Economy and Society* 2, no. 1 (1973): 75.

²⁶⁹ Erving Goffman, *Stigma Notes on the Management of Spoiled Identity* (New Jersey: Prentice-Hall, Inc., 1963): 3.

polyvalence to demonstrate that the same technique can hold *different meanings* in *different bodies*, as a result of the unique “physio-psycho-social assemblages” that the action manifests from in each individual.²⁷⁰ These meanings invite different *kinds* of medical intervention, influenced by our individual beliefs about the body in general and about our own bodies. Our bodies as medical objects thus come to be managed and produced through situated knowledge, practices, and socialities.

I theorize our skin picking this way to resist the dominant belief in medicine, and in psychiatry in particular, that all disorders are rooted in individual biology.²⁷¹ Many critiques of this ideology have already been launched in academia, for it erases the “social systemic causation” behind these widespread experiences of illness, distress, and dysfunction.²⁷² While these critiques are often theoretical, pointing to the role of broader social systems such as capitalism, my intervention attends specifically to the *body*.²⁷³ Writing against the neat binary between mind and body, I seek to understand mental illness as *a fundamentally embodied experience*, and thus mediated by the ideologies and socialities entailed in the body. The individual experience of health and illness always exists in relation to others, and other bodies. My family is no different.

While my focus lies in the embodiments of mental illness, the social context in which my family is situated is nonetheless noteworthy. Pinky is a single mother and the primary caregiver for myself and my younger, 18 year old sibling. Both myself and my sibling identify as disabled, as we both have ADHD and my sibling is also Autistic. We are also an upper middle class immigrant family, having moved from the Philippines (where we are originally from) to Hong Kong in 2000 and finally to Singapore in 2005 as a result of my mother’s corporate job. As a single, immigrant mother of two mentally ill children, Pinky has had to navigate unfamiliar healthcare and education systems for most of our time in Singapore. I, too, have played my own part in this: being 7 years older than my sibling, I was often advocating for their diagnoses and treatment when Pinky was either resistant to or simply clueless about the Singaporean mental healthcare system. Our family’s experience of illness and care is thus intertwined with our particular social position and resources. I am interested, primarily, in how these systems and identities are enacted in, on, and through our bodies. Based on my interview with my mother, as well as reflections on my own experience, it became startlingly clear: the stories of our skin are far from simple.

²⁷⁰ Mauss, “Techniques,” 85.

²⁷¹ Jill A. Fisher, “Coming Soon to a Physician Near You: Medical Neoliberalism and Pharmaceutical Clinical Trials,” *Harvard Health Policy Rev.* 8, no. 1 (2007): 65.

²⁷² Mark Fisher, *Capitalist Realism: Is There No Alternative?* (United Kingdom: Zero Books, 2009): 21.

²⁷³ Fisher, *Capitalist Realism*, 19.

Skin Picking as a Technique of the Body

The way that I pick my scalp is not random; it follows unarticulated rules and strategies that I have developed over the years. For example, I use a circular, rubbing motion when I am scouting for something to pick at, and then move to picking with a single fingernail when I have found my target. I can tell which angle I need to pick from in order to remove the feature, and whether I need to switch hands to facilitate this. It brings me satisfaction to use these methods to uproot particularly stubborn “bits,” as though I were solving a puzzle. Noticing this unintentional yet methodical approach has led me to understand my scalp picking as a bodily technique, as opposed to an exclusively psychiatric phenomenon.

According to Mauss, techniques of the body are actions which are “*effective and traditional*.”²⁷⁴ In the case of me and my mother, skin picking is a behavior which meets these criteria. Mauss suggests that “tradition” is what allows for the “transmission” of techniques, thus distinguishing the inherently social bodily technique from an idiosyncratic action.²⁷⁵ Essential to this transmission is that it is a “prestigious imitation:” techniques are learned by individuals from those who have “authority” over them, which legitimizes the given action.²⁷⁶ While Mauss appears to rely on a cultural definition of tradition, drawing on examples from different ethnicities and nationalities, I suggest that tradition *also* manifests within the smaller scale unit of the family. Skin picking, then, is traditional in that it has been *intergenerationally* transmitted from Pinky to me. When I reflect on the origins of my scalp picking, it is directly tied to witnessing Pinky adopt the same habit. Rather than being an “oral transmission,” this constituted a *visual* transmission.²⁷⁷ Seeing my mother, who had authority over me as my sole parental figure, engage in this behavior gave me the bodily vocabulary to do the same. Combing my memory for moments of transmission, I realized that I “borrow the series of movements” I witnessed in my mother: the picking methods that I described are ones that I saw her perform when I was a child, though we never explicitly acknowledged them.²⁷⁸ I continue to practice them because they are *effective* in creating the relief and satisfaction that I crave when I pick.

The question of transmission led me to wonder how Pinky started picking, which I had never known before I asked her in our interview. I was surprised to learn that Pinky also understood her behavior as “multigenerational.” Though my grandmother never picked her skin, she did transmit certain beliefs about the body which primed Pinky to pick up the habit later on in life. Pinky described her mother as “fastidious” and “vain,” often nitpicking both her own appearance and her

²⁷⁴ Mauss, “Techniques,” 75.

²⁷⁵ *Ibid.*

²⁷⁶ *Ibid.*: 73.

²⁷⁷ *Ibid.*: 75.

²⁷⁸ *Ibid.*: 73.

children’s. When Pinky was a child, these comments were usually made about her skin or her weight, and accompanied with interventions such as dermatological appointments or dieting. This normalized an approach to her own body as a “technical object” which had to rid *itself* of perceived flaws.²⁷⁹ In her own words, Pinky learned that “there was always something wrong with one’s appearance.” Echoes of this belief were evident when Pinky described her picking as an attempt to rid of physical features which she felt were not “perfect.” This reveals how one’s self-perception, and the ways they act on it, is entangled in “a social context that gives meaning to the senses beyond the individual.”²⁸⁰ Pinky’s bodily technique is inextricable from the context of her upbringing. In this way, it is possible to take an expansive approach to Mauss’ notion of transmission. From her mother, Pinky internalized beliefs about her body which formed the necessary “physio-psycho-social assemblage” that made this bodily technique possible.²⁸¹ Her skin picking, through visual transmission, was then passed to me.

Pinky’s, and her mother’s, preoccupation with physical appearance further reveals the *gendered* quality of this transmission in our family. I noticed, for example, that Pinky’s brothers do not display the same kind of bodily techniques that Pinky does. Pinky’s compulsion to pick can, in some ways, be understood as a compulsion *to beautify*, a compulsion that is demanded of women in particular. Given that beauty is a “sign that circulates among women and assigns value to female bodies as an effect of that circulation,” the techniques and practices associated with beautification likewise come into circulation.²⁸² The prerogative to perfect one’s body, passed on from Pinky’s mother to her, both arises from and perpetuates this circuit. Jarrín suggests that beauty thus produces a “contagious form of gender difference,” in which women and those raised as women become more susceptible.²⁸³ This contagiousness is part of what has made the transmission of certain techniques possible in my family, particularly along gendered lines. I do not want to suggest that skin picking is *always* a gendered phenomenon, as people of all genders engage with this behavior. However, for Pinky, the gendered logics of beauty are bound to the beliefs and the practices she holds. Thus, in our family, skin picking can be understood as a technique of the body, rendering it a distinctly social, rather than purely medical, phenomenon.

²⁷⁹ *Ibid.*: 75.

²⁸⁰ Alvaro E. Jarrín, *The Biopolitics of Beauty: Cosmetic Citizenship and Affective Capital in Brazil* (Berkeley: University of California Press, 2017): 12.

²⁸¹ Mauss, “Techniques,” 85.

²⁸² Jarrín, *Biopolitics of Beauty*, 89.

²⁸³ *Ibid.*

The Socialities of Stigma

The story of my scalp picking would not be complete without acknowledging that it quickly became a source of tension in my relationship with Pinky, despite being a habit that we shared. What distinguishes skin picking from other bodily techniques is that it carries profound “stigma,” and with it complex feelings of shame.²⁸⁴ An individual’s attributes acquire stigma when they are “incongruous with our stereotype of what [they] should be,” thus becoming a “deeply discrediting” part of them.²⁸⁵ The stigma attached to skin picking was clear in the ways that Pinky described both mine and her own behavior. On multiple occasions, she described it as a “bad habit” that was “not normal,” using language that echoed Goffman’s own writing.

Yet the question of what exactly was *discrediting* about our skin picking was not so straightforward. In some senses, skin picking can be seen as a purely physical stigma, a certain “[abomination] of the body.”²⁸⁶ Pinky reflected the concern that my scalp picking would cause me to lose hair and develop a bald spot, which would be especially unsightly in a young woman. Beyond its effects, the mere act of picking, to her, simply “doesn’t look nice.” Her preoccupation with appearance reveals the force of perception “as a social interface.”²⁸⁷ Through this interface, it is possible to “imagine the body as emerging from the world it interacts with.”²⁸⁸ In this way, *looking* abnormal not only marks but *produces* an individual as abnormal. In other senses, however, skin picking can also be seen as a “[blemish] of individual character,” in that it *visibilizes* an otherwise ‘invisible’ mental condition.²⁸⁹ After all, to the trained eye of my counselor, it was my scalp picking which signalled my need for a clinical diagnosis, and thus my identity as a mentally ill person. Thus, in several ways, our skin picking marks both me and Pinky as somehow “not normal.”

With stigma, “shame becomes a central possibility.”²⁹⁰ Shame, however, is not simply an effect of stigma but rather a reinforcement mechanism of stigma as well—upon feeling shame, the belief that a certain attribute is stigmatized becomes stronger. In my family, this shame was not only experienced individually but interpersonally through the “regulation and surveillance” of each other’s bodies.²⁹¹ Pinky went to great lengths throughout my childhood to get me to stop picking,

²⁸⁴ Goffman, *Stigma*, 3.

²⁸⁵ *Ibid.*

²⁸⁶ *Ibid.*: 4.

²⁸⁷ Jarrín, *Biopolitics of Beauty*, 11.

²⁸⁸ *Ibid.*

²⁸⁹ Goffman, *Stigma*, 4.

²⁹⁰ *Ibid.*: 7.

²⁹¹ Karen K. Kroeger, “AIDS Rumors, Imaginary Enemies, and the Body Politic in Indonesia,” *American Ethnologist* 30, no. 2 (May 2003): 244.

albeit unsuccessfully. Whenever she saw me picking, she always told me to stop regardless of where we were or what we were doing—this type of interruption even happened during our interview, as I was asking Pinky a question. Beyond verbal reminders, she also devised physical means to disincentivize me from the habit. I have a vivid memory of Pinky giving me a beanie as a child, telling me to wear it so that I would not be tempted to scratch. I donned this hat dutifully for many days but to no avail. My grandmother reflected similar sentiments: she very recently interrupted my picking with the admonition that it made me “look like a monkey.” These disciplinary measures reinforced the fact that my scalp picking was undesirable and shameful. This belief, in turn, reinforced my feelings of anxiety and embarrassment around my picking, which were heightened by the fact that I found it impossible to simply stop.

However, I also noticed that Pinky’s interventions were bound up with her feelings about her own picking. Of my scalp picking, Pinky insightfully said “I notice because I know.” This observation highlights that the surveillance of my body is made possible by her surveillance of her own body and the familiarity of the feelings that skin picking causes. Pinky admitted that she feels somewhat “frustrated” when she sees me pick and “surprised” that I have not yet stopped. This frustration was mirrored in the way she spoke about her own body, whether it was the picker’s nodule from years before or the pimple on her thigh that had just appeared. The ways she saw my body are thus just as much a reflection of how she saw her own body. The fluidity of these feelings and how they linked our distinct bodies reveal our family as having our own, microcosmic “body politic,” forged through kinship.²⁹² The stigma, and shame, associated with our skin picking became a “[threat]” to not only our own but also *our family’s* appearance as normal.²⁹³ Under such duress, the boundaries between our individual bodies “become blurred,” allowing shame about one’s own body to become refracted in other bodies as well.²⁹⁴ Through the logics of the body politic, shame moves interpersonally between myself and Pinky, reinforcing the stigma attached to our skin picking.

It is this stigma which is central to the construction of skin picking as a problem which requires medical intervention. According to the DSM-5, “feelings of guilt, embarrassment and shame” are in fact a diagnostic requirement in determining whether or not an individual has dermatillomania.²⁹⁵ The very perception of skin picking as a stigmatized behavior, and the feelings associated with this stigma, is thus an essential component in rendering skin picking *as a mental disorder* to begin with. In other words, the stigma attached to the behavior

²⁹² *Ibid.*

²⁹³ *Ibid.*

²⁹⁴ *Ibid.*

²⁹⁵ Paylo and Zins, “Excoriation disorder,” 18.

and the attributes which make this behavior stigmatizing are mutually reinforcing. This complicates the aloof clinicism with which medicine treats the phenomenon of diagnosis. The presence, and circulation, of stigma reveals that diagnosis is *not only* a mere description or pronouncement of medical fact. Diagnosis often profoundly influences the individual's experience of illness, sometimes even on a visceral, and physiological, level.

Another component in the diagnosis of dermatillomania is the element of compulsion. This speaks to the unique troubles of skin picking as a stigmatized *bodily technique*. Individuals often “cannot get rid of” their techniques, as they are actions which are learned and deeply ingrained.²⁹⁶ The force of the technique persists in spite of stigma, which further entrenches feelings of helplessness and embarrassment. Pinky similarly noted that she believes skin picking “becomes a problem when you can't stop” doing it yourself. In this emotional and bodily landscape, medical intervention thus emerges as a necessity to “correct” the stigma, as the individual cannot correct it themselves.²⁹⁷ This is why both Pinky and I eventually sought out treatment for our skin picking. Thus, through stigma and shame, skin picking is pathologized and becomes a site of medical intervention.

A Derma or A Psych? The Polyvalence of Picking

Over the course of our interview, however, I began to notice that the language Pinky and I used to describe and understand our skin picking—even as a medical phenomenon—was markedly different. What I thought would be a straightforward discussion of mental illness and its symptomatic presentations quickly became complicated, because Pinky does not think of herself as afflicted with any kind of mental disorder. Rather, in her own words, skin picking is a “bad habit.” These differences, and the material implications that they had in the ways Pinky and I sought out medical intervention, speak to the *polyvalence* of skin picking as a bodily technique. I use this term to illustrate how the same action, and the same bodily features, hold different meanings in different bodies. Skin picking clearly *means* something different to Pinky than it does to me, and this mediates how we invite and negotiate medical interventions. Through polyvalence, “what we think of as a single object may appear to be more than one” because our perceptions of our bodies are fundamentally colored by our own practices, beliefs, and histories.²⁹⁸ Furthermore, I use this observation to write against the idea of medicine “as if it were a whole,” and the phenomenon of medical intervention as a uniform or monolithic process.²⁹⁹ Rather, different strands of medicine construct our bodies as medical objects in different ways, offering different solutions to “the

²⁹⁶ Mauss, “Techniques,” 71.

²⁹⁷ Goffman, *Stigma*, 10.

²⁹⁸ Annemarie Mol *The Body Multiple: Ontology in Practice* (Durham and London: Duke University Press, 2002): vii.

²⁹⁹ Mol, *The Body Multiple*, viii.

same” problem and producing different forms of bodily knowledge and social identities as a result. The choices to engage with specific types of medical treatments over others are likewise informed by bodily context. In my family, these interpretive tensions and nuances can be summed up neatly in a single question: who should treat my skin picking, a dermatologist or a psychiatrist?

For Pinky, dermatology was the answer. Her skin picking is motivated not by the sensation of picking but rather the urge to rid her body of a feature that she considers “not correct or perfect.” To her, it was *the feature* that was the root cause of her skin picking, because it gave her the “nagging desire to pick [at] it.” Without the feature, the behavior would, in her mind, simply go away. From this perspective, Pinky’s skin picking can be understood as a kind of grooming technique, intended to rectify the body’s imperfections. The appropriate response, then, was to seek out a dermatologist, who could remove the offending feature. This also conveniently avoided the stigma associated with mental illness and psychiatry: Pinky reflected that mental health was “not even a thing” that people talked about when she was growing up. On the other hand, the perfection and beautification made possible through medical intervention, such as dermatological procedures, is “naturalized” in women, hence rendering dermatology a more sensible and intuitive choice for Pinky.³⁰⁰

Pinky’s choice, to turn to dermatology, is rooted in her body’s personal history. Jarrín notes that “perceptions of beauty latch on to bodily features laden with sensory memories,” which was true of Pinky’s experience.³⁰¹ She told me that her skin picking reminded her of the acne that she attempted to manage as a teen, which she also saw a dermatologist for. The sensations of grooming and treating her body created an affective association between past and present, orienting her to engage in the same medical interventions that she did as a child. These *feel* familiar to her body. Furthermore, her choices and experiences arise from a specific and socially constructed belief about what constitutes the “normal” body. Pinky was raised to imagine the normal body as one that “should be close to perfection.” Perceived imperfections, then, are afflictions to the body that must be corrected because they are “not naturally there,” and are thus not normal. In Pinky, skin picking is rendered as a cosmetic problem, rather than a psychological problem. Dermatology then allows her to restore her body to a state of perceived normalcy, and in turn correct her skin picking.

For me, however, psychiatry has been the path forward. Hearing Pinky’s appraisal was shocking to me because it could not depart further from how I understand *my* scalp picking. Unlike Pinky, I am not preoccupied with correcting bodily features that I perceive as flaws: I tend to pick regardless of whether there is *something obvious* to pick, and often create features to pick through the scarring that my picking causes. It is the sensation of picking, and the relief and satisfaction

³⁰⁰ Jarrín, *Biopolitics of Beauty*, 88.

³⁰¹ *Ibid*: 82.

it brings me, that matters much more to me than how my body looks. In this way, I understand my scalp picking as a self-soothing technique which helps me manage boredom and stress. The prominence of these emotional aspects of my picking has led me, and those around me, to understand this as a psychological phenomenon. Solutions which were purely physical, like when a General Practitioner dismissively told me to “just cut [my] nails shorter,” seemed ineffective to me. Psychiatry, thus, became the appropriate kind of medical intervention in my body. While I have not completely stopped, therapy and psychoactive medication have made my picking more manageable and less distressing.

My inclination towards psychiatry, likewise, is informed by my own unique context. Pinky specifically “tried not to” raise me with the same beliefs that her mother imparted to her. I tend not to obsess over and correct my apparent flaws, choosing instead to see them as a natural part of my body. Instead, my sensory memories are dominated by the struggle to make sense of my mind and mood. My body is inscribed with sensations from my teenage years, of lying in bed for days at a time or chewing through the sleeve of my cardigan during a panic attack. Feelings, after all, are a profoundly embodied experience. Coupled with the language and politics of an era more accepting of mental illness than Pinky’s, I am more equipped and more willing to engage with skin picking as a psychological problem. This engagement with psychiatry thus renders me as an individual with mental illness, in a way that Pinky is not.

Skin picking is therefore not a stable or straightforward medical fact, despite the definitions of the DSM-5. In my family, it is a polyvalent phenomenon, mediated through different ideologies, different medical practices, and different bodies. This not only positions but also produces the body in different ways. The “single object” that is a bump on the scalp takes on so many different meanings.³⁰² To Pinky, it is an unnatural imperfection that must be eradicated. To the dermatologist that she consults, it is a “picker’s nodule.” To me, it is a “bit” to be collected and a means to self-soothe. To my psychiatrist, it is a physical and emotional trigger for my compulsive tendencies. These discrepancies are no longer as contradictory to me as I had initially felt. Instead, I have come to appreciate that they are a consequence of the fact that our bodies, and bodily practices, are always situated.

Conclusion

When I first sat Pinky down for an interview, I did not fully appreciate how different our shared habits could be. In fact, the phenomenon of skin picking in my family is paradoxical in its complexity. How does a “technique of the body” remain transmissible when its performance is stigmatized and not unequivocally successful?³⁰³ How is stigma reinforced and resignified by the very measures we take to evade it? In what ways do we simultaneously resist and invite different

³⁰² Mol, *The Body Multiple*, vii.

³⁰³ Mauss, “Techniques,” 75.

kinds of intervention for a problem that is sometimes medical and sometimes not? These are the questions that come to my mind as I remember the many times that Pinky and I would sit at the dining table and argue about our picking, both with our fingers firmly scratching away at our heads. Sometimes, the sheer irony of this scene would occur to us, and the frustrated criticisms would give way to shared laughter.

The stakes of these paradoxes become more pressing when we recognize how medicine, and medical interventions, *erases* them. Despite their very best intentions, it never once seemed to me that Pinky’s dermatologist or my counselor were interested in seeing our skin picking as anything more than a medical condition. It is their job, after all, to reduce our skin picking to a conceivable and diagnosable problem that medicine can solve. Recognizing the polyvalence of the body, and the plurality of illness as an embodied experience, pushes back against this prevailing logic. The body—*our bodies*—cannot be reduced to medical facts alone. To do so perpetuates simplistic and often dangerous beliefs about the individual patient as a bounded, biological entity. Medicine, both as a dominant ideology and as a collection of varied practices, must seek to understand the body in context and in connection with other bodies.

Rather than attempting to resolve them, the tensions that I address serve as a reminder that the body is often so much messier in practice than in theory. Frameworks such as technique, stigma and polyvalence explain how skin picking has been simultaneously circulated *and* corrected within my family, but only approximately. In many ways, that Pinky and I continue to pick simply does not make sense. Our bodies, however, *make sense* in other ways, brimming as they are with different memories, ideologies, and practices. They are simultaneously individual and social, medical subjects and medical objects, and, most crucially, healthy and sick. These seeming contradictions are part and parcel of what it is like to live in and as our bodies, and Pinky and I have developed our own unique ways of navigating them. We attempt to care for ourselves and for each other, without ever truly knowing the line between “bad habit” and “medical disorder.” In some ways, this line simply does not matter. The stories of our skin picking are not coherent, and they have never needed to be.

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