

Excoriation (skin-picking) disorder in adults: a cross-cultural survey of Israeli Jewish and Arab samples

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Abstract

Objective: We sought to estimate the lifetime prevalence of Excoriation (Skin-Picking) Disorder (SPD) in the Israeli adult population as a whole and compare SPD prevalence in the Jewish and Arab communities. We also explored demographic, medical and psychological correlates of SPD diagnosis.

Methods: Questionnaires and scales screening for SPD, and assessing the severity of perceived stress, depression, obsessive–compulsive disorder (OCD), body dysmorphic disorder (BDD), alcohol use, illicit drug use, and medical disorders were completed in a sample of 2145 adults attending medical settings.

Results: The lifetime prevalence of SPD was 5.4% in the total sample; it did not differ between genders or within Jewish and Arab subsamples. Severity of depression ($p < 0.001$), OCD ($p < 0.001$) and perceived stress ($p = < 0.001$) were greater in the SPD positive sample. Similarly, diagnoses of BDD ($p = 0.02$) and generalized anxiety ($p = 0.03$) were significantly more common in the SPD-positive respondents. Alcohol use and illicit substance use were significantly more common among SPD positive respondents in the total sample (both p 's = 0.01) and the Jewish subsample ($p = 0.03$ and $p = 0.02$, respectively). Hypothyroidism was more prevalent in the SPD-positive Jewish subsample ($p = 0.02$). In the total sample, diabetes mellitus was more common in women than in men ($p = 0.04$).

Conclusion: Lifetime SPD appears to be relatively common in Israeli adults and associated with other mental disorders. Differences in the self-reported medical and psychiatric comorbidities between the Jewish and Arab subsamples suggest the possibility of cross-cultural variation in the correlates of this disorder.

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1. Introduction

Excoriation (skin-picking) disorder (SPD), also variously described as pathological skin picking, dermatillomania or neurotic excoriation, has been introduced into the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) in the diagnostic category, obsessive–compulsive and related disorders [1].

DSM-5 defines SPD as repetitive skin picking resulting in skin damage. The affected individual must have attempted to decrease or stop the skin picking, and it must cause significant clinical distress or impairment in functioning. The excoriation cannot be attributable to substance intake or to any other medical or mental disorder.

The prevalence of SPD ranges from 1.25% to 5.4% in adult samples [2], and 2% to 9% in university students [3–5]. Three large-scale investigations have been conducted in community samples of adults in the United States [6–8]. Hayes et al. examined a community sample of 354 adults and found a lifetime prevalence of SPD of 5.4% [6]. Keuthen et al. reported a lifetime prevalence of 1.4% in a random sample of 2513 adults surveyed by telephone [7]. Most recently, Monzani et al.

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studied a sample of 2518 twin women and found a lifetime SPD prevalence of 1.2% [8].

Psychiatric comorbidity often occurs in SPD. Tucker et al. described the frequent co-occurrence of depression, anxiety and stress in SPD [9]. In a survey of 1916 American university students, SPD was associated with significantly higher prevalence of anxiety, depression, substance use, and impulse control disorders [5]. A large literature describes associations between SPD and other obsessive–compulsive-related disorders. A significant relationship between SPD and body dysmorphic disorder (BDD) has been documented. Phillips et al. reported that 26% of 123 subjects with BDD picked their skin [10]. Grant et al. investigated 176 individuals with BDD and found that 44.9% reported lifetime SPD and 36.9% reported current SPD secondary to BDD [11]. Hoarding, another obsessive–compulsive related disorder, has also been found to be associated with SPD [12]. The association between SPD and trichotillomania has been investigated extensively, since these two disorders present many similarities [13–16]. Monzani et al. reported that the two disorders share a latent genetic factor [15]. In contrast, in a family study of trichotillomania, Keuthen et al. found no familial relationship between SPD and trichotillomania [16].

To date, no studies have examined the prevalence of SPD in the Israeli adult population. Moreover, there is scant literature addressing cross-cultural comparisons of SPD prevalence and associated psychiatric comorbidities. Only one study addressed the question, comparing the prevalence of BDD and its correlates (including skin picking) in 101 American and 133 German students [17]. In Israel, the population is comprised of many ethnic groups, the largest subpopulations being Jews and Arabs. Given the different socio-economic characteristics and cultural backgrounds of these groups, we explored whether differences may exist in their SPD prevalence rates and associated comorbidities.

The aims of this study were three-fold. First, we sought to estimate the prevalence of SPD in the general Israeli adult population. Second, we compared the prevalence of SPD in the Jewish and Arab study participants to determine whether cultural and religious differences might influence SPD prevalence. This is an exploratory study, since no existing data suggest specific group differences in skin picking or its correlates. Third, we investigated the demographic, medical and psychological correlates of SPD.

2. Material and methods

2.1. Sample description

The authors distributed questionnaires to 2745 adults including 2590 adult patients presenting to three Kupat Cholim (Health Maintenance Organization) family physicians (one Jewish, two Arab) and 155 consecutive parents and grandparents of children attending the outpatient clinic of the Department of Dermatology of Hadassah Hebrew University Medical Center from January 2012 to March 2014. Children

aged 17 or younger coming for medical consultation were not approached with questionnaires. Potential participants aware of having, or being treated for, any dermatological or mental disorder were excluded. The survey was anonymous and the participants voluntarily consented after reading the introductory page, which explained that participation was voluntary, anonymous, would not be monetarily compensated, and could be discontinued at any time without effect on care. The study was approved by the Helsinki Committee for clinical trials of the Hadassah-Hebrew University Medical Center.

2.2. Assessments

The socio-demographic data collected included age, gender, marital status, income and level of education.

SPD was assessed using the skin picking questionnaire and diagnostic criteria developed for a randomized telephonic study in the United States [7,18]. Thirteen questions addressed SPD phenomenology using yes/no/don't know/refuse responses. Among these were items assessing the presence of noticeable skin damage, whether picking was attributable to an inflammation or itch from a medical condition, the presence of distress due to skin picking, and whether work or school or important events or social time were cancelled or avoided due to skin picking. The questionnaire also asked about tension or nervousness before or while attempting to resist picking the skin. Participants were considered to have SPD if they met the following criteria: repetitive skin picking resulting in skin damage, attempts to decrease or stop the skin picking, significant clinical distress or impairment in functioning, and no substance intake or any other medical or mental disorder that could explain the excoriations.

Obsessive–compulsive disorder (OCD) symptoms were assessed using the Obsessive Compulsive Inventory (OCI) [19] (total scale score 0–72). The Beck Depression Inventory (BDI) (total scale score 0–63) was used to assess depressive symptoms [20]. Symptoms of BDD were assessed using the questionnaire described by Koran et al. [21]. This slightly modified version of the Phillips et al. severity rating scale for BDD [22] included five questions. The first two deal with preoccupation with perceived defects in physical appearance that is not observable to others. Two questions examine clinical distress and impairment in work, or other areas of functioning. Lastly, preoccupation with weight or body fat, better explained by eating disorder, was also assessed. Participants were considered to have BDD if they met the following criteria: excessive appearance preoccupation regarding defects that are not observable or appear slight to others: the preoccupation causes clinical distress; and, absence of eating disorders. Perceived stress was assessed using the Perceived Stress Scale-10 Item (PSS-10) [23,24] (total score 0–40). The first PSS factor includes questions reflecting negative feelings (being upset, angry or nervous) and inability to handle stress, while the second factor included questions expressing positive emotions and ability to act in stressful situations. One question assessed whether the respondent

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