



Do it yourself! Evaluation of self-help habit reversal training versus decoupling in pathological skin picking: A pilot study

Steffen Moritz^{a,*}, Susanne Fricke^{a,1}, András Treszl^b, Charlotte E. Wittekind^a

^a University Medical Center in Hamburg-Eppendorf, Department of Psychiatry and Psychotherapy, Martinistr. 52, D-20246 Hamburg, Germany

^b University Medical Center in Hamburg-Eppendorf, Department of Medical Biometry and Epidemiology, Martinistr. 52, D-20246 Hamburg, Germany

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ABSTRACT

Pathological skin picking (PSP) is a rather frequent but yet underrecognized impulse control disorder at the crossroads of dermatology, psychology, and psychiatry. The present pilot study assessed the feasibility and efficacy of self-help interventions in the disorder. Habit reversal training (HRT), the current treatment-of-choice intervention, was tested against a newly developed technique entitled decoupling (DC). Both techniques were conveyed by bibliotherapy. A total of 70 subjects with PSP were recruited via self-help forums and were randomly allocated either to HRT or DC. Manuals were sent via email attachment. Four weeks after the dispatch of the manual, each participant was recontacted and underwent the same questionnaires as before, which included the Modified Skin Picking Scale (M-SPS). Pre-post comparisons indicated a strong symptom decline under HRT but not DC. Every second patient reported a symptom decline due to HRT relative to every third patient in the DC condition (50% versus 33%). The study affirms the efficacy of self-help HRT but discourages the usage of DC in PSP. Possible reasons why DC has exerted positive effects in prior trials on trichotillomania and pathological nail-biting but not PSP are put forward.

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1. Introduction

Pathological skin picking (PSP) is a body-focused behavior characterized by the repetitive scratching and picking of the skin. PSP is sometimes also described as stereotypic movement disorder (Stein et al., 2007). Whereas the majority of patients pick their skin with their fingernails and fingers, some patients (52%) also employ instruments such as pins or tweezers (Arnold et al., 1998; Tucker, Woods, Flessner, Franklin, & Franklin, 2010; Wilhelm et al., 1999). Skin picking may involve all body parts. Notwithstanding that the phenomenology was first described more than 130 years ago (see Fruensgaard, Hjortshøj, & Nielsen, 1978) and carries many (virtually) synonymous terms (e.g., *Acne Excoriée*, neurotic excoriation, psychogenic excoriation, dermatotillomania, body focused repetitive behavior), as of yet it is both underrecognized and underdiagnosed by many clinicians (Neziroglu, Rabinowitz, Breytman, & Jacofsky, 2008). Many patients regard PSP as a bad habit and are neither aware that it is considered a disorder nor that treatment is available (Neziroglu et al., 2008).

Diagnostic screening instruments usually do not assess PSP and most clinicians accordingly fail to ask about it. While solid

prevalence rates are therefore lacking, the available literature suggests that PSP is not a rare disorder supporting current efforts to add and explicitly name PSP in the DSM-V. In a community sample (Hayes, Storch, & Berlanga, 2009), 62.7% of the participants endorsed some form of skin picking and 5.4% had clinical levels of skin picking. In a study conducted by Bohne, Wilhelm, Keuthen, Baer, and Jenike (2002), more than 90% of students reported occasional skin picking. Based on a telephone survey on 2513 adult Americans, 16.6% ($n=416$) disclosed having suffered from marked skin injuries due to skin picking (Keuthen, Koran, Aboujaoude, Large, & Serpe, 2010). This proportion dropped to 1.4% ($n=34$) when additional criteria had to be met such as significant psychosocial impairments.

The clinical underrecognition of PSP is concerning in view of its occasional severe somatic consequences. PSP can result in various somatic complications including infections, tissue damage, bleeding, injuries, and bruises (Neziroglu et al., 2008). PSP may even culminate in life-threatening incidences. O'Sullivan, Phillips, Keuthen, and Wilhelm (1999) reported a case where a patient with PSP secondary to body dysmorphic disorder nearly lacerated her carotid artery as a result of using tweezers in an attempt to remove a perceived defect from her skin. Moreover, a considerable subgroup of patients suffers from suicidal ideation due to skin picking (Arnold et al., 1998).

Like other impulse control disorders, pathological picking is usually preceded by negative emotions such as anxiety, tension,

* Corresponding author. Tel.: +49 40 7410 56565; fax: +49 40 7410 57566.

E-mail address: moritz@uke.de (S. Moritz).

¹ The first two authors split authorship.

and boredom (e.g., Keuthen et al., 2010; Wilhelm et al., 1999). During picking, many patients report a (mesmerized) trance-like mental state, satisfaction, and relief (Arnold et al., 1998; Snorrason, Smari, & Olafsson, 2010; Wilhelm et al., 1999). In stark contrast, these short-term positive feelings later fade and are overshadowed by shame, pain, and guilt (Snorrason et al., 2010; Wilhelm et al., 1999). Further, a subgroup of patients adopt skin picking as an emotion regulation strategy (Deckersbach, Wilhelm, Keuthen, Baer, & Jenike, 2002; Wilhelm et al., 1999) and the disorder has been associated with difficulties in emotion regulation (Snorrason et al., 2010).

Apart from psychopharmacotherapy (mainly antidepressant medication; see Arnold, Auchenbach, & McElroy, 2001), cognitive-behavioral techniques, especially habit reversal training (HRT), currently represent the treatment-of-choice. HRT (Azrin & Nunn, 1973) involves different behavioral techniques, whereby awareness training and competing response training (CRT) are considered its most essential elements (Woods & Miltenberger, 1995). CRT teaches patients to substitute the misbehavior with a (freezing) alternative behavior (e.g., clenching one's fist for some time or holding tight to a stone). The new behavior should be contingent upon the occurrence of the target behavior (Miltenberger & Fuqua, 1985). Various (small) studies assert the efficacy of HRT in the disorder. Twohig and Woods (2001) employed HRT in two adults with chronic skin-picking problems. Decreases in self-reported skin picking were confirmed by independent ratings. However, the behavior was not eliminated and treatment gains were maintained for only one participant after three months. In another trial conducted by the same group (Teng, Woods, & Twohig, 2006), 25 subjects were allocated to either HRT or a wait-list control group. Despite few treatment sessions HRT exerted large effects, which were maintained at follow-up. In a small study on five patients, acceptance-enhanced behavior therapy (AEBT) involving HRT greatly reduced both picking and trichotillomania (TTM) in all participants (Flessner, Busch, Heideman, & Woods, 2008). Other successful case reports were published by Kent and Drummond (1989) on a single patient who maintained treatment gains after 4 months and Deckersbach et al. (2002) on three patients. Deckersbach et al. (2002, p. 374) speculate that HRT may be less effective in patients who – reminiscent of borderline personality disorder – engage in skin picking as a form of emotion regulation. In contrast, those who pick habitually may experience greater therapeutic benefit. Whereas HRT emerged as effective across all prior studies, these investigations are limited by several factors, most notably small sample sizes and uncontrolled designs. A recent randomized controlled study on 34 college students with PSP demonstrated that brief cognitive-behavioral therapy (non-HRT) produced large effect sizes relative to a wait-list control, which were maintained at follow-up (Schuck, Keijsers, & Rinck, 2011).

A variant of HRT entitled decoupling (DC) has been recently developed by our group (Moritz & Rufer, 2010). Both HRT and DC interfere at the motor level. The core difference concerns the terminal movement. Whereas HRT teaches the subject to perform

an antagonistic behavior (e.g., clenching one's fist) for some time instead of the malbehavior, DC requests that the subject performs a motor sequence that mimics the usual behavioral pattern (e.g., PSP) but alters its behavioral goal: the original movement is deviated rather than frozen. Close to the former behavioral goal, a new terminal movement with a different (benign) behavioral target (e.g., nose, ear, point in room) is executed, preferably with an accelerated movement (see Fig. 1). The accelerated movement is aimed to override the previous motor sequence and create motor irritation when impulses for the misbehavior – which is often not available to consciousness – surface. The presumed irritation may then reach awareness allowing initiation of active self-control strategies. The technique has been successfully tested in TTM and pathological nail-biting (PNB) as a self-help strategy. The on-line administration of this technique over a period of 4 weeks led to a significant decline of TTM (Moritz & Rufer, 2010) and PNB (Moritz, Treszl, & Rufer, 2011) relative to an active control intervention. Despite tentative evidence for the efficacy of DC, its theoretical rationale needs further empirical testing.

1.1. How to reach the untreated?

Patients with PSP rarely seek dermatologic or psychiatric treatment (Grant & Odlag, 2009). In the population investigated by Neziroglu et al. (2008) only 30% sought specific help for PSP. In view of the apparent large treatment gap in PSP reflecting poor treatment motivation, shame, stigma, but also poor dissemination of knowledge and treatment options among clinicians, many patients attempt to cope with the symptoms themselves or turn to other patients via internet help forums. There is preliminary evidence that information conveyed via the internet may well ameliorate symptoms. Flessner, Mouton-Odum, Stocker, and Keuthen (2007) assessed the feasibility of a commercial web page devoted to PSP called www.StopPicking.com. The web site includes both diagnostic and intervention tools. The program first assesses and then increases awareness of variables subserving SP and then conveys coping skills and techniques to reduce the frequency and severity of PSP symptoms and to maintain treatment gains. The program offers education about SP and provides links to various resources and relevant upcoming events and publications. Uncontrolled pre-post assessments indicate that while the majority of patients discontinue usage of the program after some time and very few complete all of its modules, it brings substantial symptom relief to many of its users. A total of 63% percent of the sample showed a reduction of at least 25% on the Skin Picking Scale (SPS; Keuthen et al., 2001).

1.2. The present study

The present study tested HRT versus DC. To reach the majority of untreated patients with PSP an internet trial was set up. It is an advantage of self-help interventions that they can be carried out by patients in the privacy of their homes without fear of



Fig. 1. Competing response training (CRT) as a part of HRT. Options for competitive responses: clenching fists (A), sitting on hands (B) or folding hands (C).

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