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The role body-esteem plays in impairment associated with hair-pulling and skin picking in adolescents

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ABSTRACT

Trichotillomania (hair pulling disorder, HPD) and pathological skin picking (PSP) are associated with significant rates of psychosocial impairment and distress. Little research has addressed the physical consequences and associated impairment in youth (e.g., poor body-esteem). The present study explores the relationship between body-esteem, skin picking (SP), and pulling-related impairment in a sample of adolescents with primary HPD. Ninety four adolescents who pull their hair, 40 of whom also pick their skin, were recruited via internet-sampling as part of the Child and Adolescent Trichotillomania Impact Study (CA-TIP). All youth and a parent completed anonymous questionnaires online assessing psychiatric symptoms, repetitive behaviors, and psychosocial impairment, among other variables. Appearance-based body-esteem was not found to be predictive of more severe psychosocial impairment in these youth. However, SP, in combination with HPD, contributed to worse appearance-based body-esteem above and beyond symptoms of HPD alone. The current study suggests that psychosocial functioning in youth with HPD is less impacted by body-esteem or pulling than other factors (e.g., depression and anxiety), and that SP contributes to lowered body-esteem. These findings suggest the importance of addressing body-esteem in case conceptualization for youth with both HPD and SP. Further research is required to confirm these suggestions.

1. Introduction

Trichotillomania (hair pulling disorder, HPD) has been conceptualized as part of a class of body-focused repetitive behaviors (BFRBs; Mansueto, Thomas, & Brice, 2007; Stein et al., 2008) along with excoriation disorder (also known as pathological skin picking; PSP). HPD, which occurs in approximately 1–3% of adults (Christenson, Pyle, & Mitchell, 1991), is characterized by chronic and excessive pulling out of one's hair that results in hair loss and clinically significant distress (American Psychiatric Association, 2013). Prevalence rates in children have not been firmly established, but HPD may be even more common in youth (Tolin et al., 2008) with the typical onset during childhood (11–13 years; Christenson, 1995; Keuthen et al., 2001). PSP is characterized by recurrent picking of the skin, resulting in skin lesions and clinically significant distress, despite repeated attempts to decrease or stop the behavior. While occasional picking of the skin is normal in the general population (Bohne, Wilhelm, Keuthen, Baer, & Jenike, 2002; Hayes, Storch, & Berlanga, 2009) and rates of PSP in youth are again unknown, estimated rates of clinical symptomatology in adults are significant (1.4–5.4%; Hayes et al., 2009; Keuthen, Koran, Aboujaoude, Large, & Serpe, 2010). To qualify as HPD and PSP, pulling and picking symptoms, respectively, cannot be due to another psychiatric or medical condition (APA, 2013).

Youth with HPD also exhibit greater levels of comorbid internalizing symptoms (e.g., depression, anxiety) than the general public, contributing significantly to impairment in their functioning (Lewin et al., 2009). What is more, HPD and PSP frequently co-occur (Lovato et al., 2012; Snorrason, Belleau, & Woods, 2012) – suggesting the potential for compounding levels of impairment and a shared underlying pathology (e.g., Brennan & Flessner, 2015; Odlaug & Grant, 2008). Available evidence for both disorders suggests impairment across several domains of functioning, including medical, emotional, occupational/academic, and psychosocial (e.g., Flessner, Conelea,

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et al., 2008; Harrison & Franklin, 2012; Neziroglu, Rabinowitz, Breytman, & Jacofsky, 2008; Odlaug & Grant, 2008), with impairment increasing as a function of clinical severity (Begotka, Woods, & Wetterneck, 2004; Franklin et al., 2008; Odlaug, Kim, & Grant, 2010). For example, youth and young adults with HPD or PSP have been found to avoid common activities (e.g., social activities, engagement with close friendships) and experience interference with academic functioning (e.g., ability to study; Franklin et al., 2008; Keuthen et al., 2000).

Psychosocial functioning is influenced by one's sense of confidence, self-efficacy, and global self-esteem. Appearance-based body-esteem, which refers to self-evaluations of one's own appearance, has been linked with global self-esteem (Mendelson, Mendelson, & White, 2001), and thus likely also influences psychosocial functioning. Though body dissatisfaction generally emerges during childhood (McCabe & Ricciardelli, 2003), adolescence is highlighted as a "peak" developmental period for critical evaluations of one's physical attributes (e.g., Ata, Ludden, & Lally, 2007). In adults with HPD, low self-esteem, negative self-image, feelings of unattractiveness, and body dissatisfaction are common (Penzel, 2003; Soriano et al., 1996). Furthermore, high levels of self-criticism regarding one's appearance are related to frequency of pulling, anxiety, and depression in females with HPD (Soriano et al., 1996). Similar relationships may exist for PSP, though no such research among youths has been reported.

Such psychosocial difficulties may be exacerbated by feelings of isolation, shame, and embarrassment (Tolin et al., 2008). Accordingly, recent research has suggested that body-esteem associated with symptoms of HPD may play a role in psychosocial impairment in adolescents (Altenburger, Tung, & Keuthen, 2014). Altenburger and colleagues (2014) found that, in comparison to same age peers, HPD contributed to lower appearance-based body-esteem independently of comorbid anxiety and/or depression diagnoses. The authors also noted that increased HPD severity correlated with worse appearance-based body-esteem – supporting a hypothesis that the deleterious physical aspects of HPD impact body-esteem in youth. No such investigations have addressed the potential contribution of PSP, however. Moreover, some evidence suggests that adults with PSP may experience even greater psychosocial dysfunction than those with HPD due to the consequences of picking (Odlaug et al., 2010). Likewise, adults with PSP who pick on their face have been found to report greater dissatisfaction with their appearance than responders who do not pick on their face (Snorrason et al., 2013). Unfortunately, no comparisons of HPD and PSP currently exist in the youth literature and little is known about the impact these disorders have in combination in affected youth. The present study thus seeks to address this latter gap by examining the relationship between body-esteem and pulling-related psychosocial impairment in adolescents with HPD, or both HPD and skin picking (SP) symptoms.

When considering the literature and the conspicuous physical consequences of disorders such as HPD and PSP, it becomes apparent that youth who engage in behaviors symptomatic of these disorders are at risk for decreased self-esteem, psychosocial functioning, and overall quality of life. Following this literature, the primary aim of this paper is to explore the relationships between HPD severity, body-esteem, and pulling-related psychosocial impairment in a youth sample. Specifically, we hypothesized that appearance-based body-esteem in youths will predict greater psychosocial impairment above and beyond the influence of HPD symptom severity and self-reported depressive and anxiety symptoms. Furthermore, little is yet understood regarding the impact on body-esteem in youth with multiple repetitive pathological behaviors (i.e., hair pulling and skin picking). As such, a secondary aim is to quantify the additional impact of co-occurring SP on appearance-based body-esteem in youth who pull their hair. To this, we hypothesized that, while controlling for additional self-reported psychiatric symptomatology, the additive combination of SP with symptoms of hair pulling (HPD+SP) will be associated with poorer appearance-based body-esteem than symptoms of hair pulling alone (HPD only).

2. Materials and methods

2.1. Participants

For the present study, a subset of adolescent participants was selected from the 336 youth recruited as part of the larger Child and Adolescent Trichotillomania Impact Project (CA-TIP; e.g., Flessner, Woods, et al., 2008; Franklin et al., 2008). The CA-TIP investigated the measureable impact of HPD symptoms on youth ages 10–17 years. Details on the distribution of the CA-TIP survey can be found in Section 2.8. Briefly, 869 individuals opened the survey, and 336 completed the majority of the survey. Cases were included in the current study if (1) both a parent and child completed all measures of interest (e.g., BESAA, described below), (2) the child was 13–17 years of age (M =15.27 ± 1.38) and (3) the child's parents reported that their child met modified HPD diagnostic criteria (below), resulting in a final sample of 94 adolescents. For the purposes of this study (and based upon prior HPD research among youths utilizing internet-sampling procedures (e.g., Flessner et al., 2007; Franklin et al., 2008)), modified diagnostic criteria included: the child currently pulls his/her hair resulting in noticeable loss (e.g., bald patches; parent and/or child report) *not* due to the direction of internal voices (e.g., an imaginary friend; child report), the belief that bugs are crawling on the skin (child report), the use of illicit substances (parent and/or child report), or as the result of physical causes (e.g., skin conditions; parent report). Parental-report was the sole determinant of whether adolescents were additionally categorized as currently engaging in broadly-defined SP ("Does your child currently engage in [...] recurrent picking at the skin or scabs resulting in physical damage..."). Of note, though SP is a focal behavior for this paper, it was not an inclusion criterion during the original recruitment of participants for the CA-TIP. Ninety-four youth met modified criteria for HPD, 40 of whom also picked their skin. The sample was predominantly female (n=85, n_{male}=9) and Caucasian (n=79), with 2.1% (n=2) identifying as African American and 4.3% (n=5) as Multi-racial. Additionally, 5.3% (n=5) identified as Hispanic/Latino, and 4.3% (n=4) declined to report their ethnicity. Additional detailed demographic characteristics can be seen in Table 1.

2.2. Measures

Notably, good reliability has been published for child self-report of HPD symptoms (e.g., Franklin et al., 2008; Tolin et al., 2008) and children have more broadly been recognized as adequate reporters of internalizing symptoms (Welner, Reich, Herjanic, Jung, & Amado, 1987; Yule, 1993). This is particularly true of adolescents with disorders such as HPD (Keuthen et al., 2008). As such, though group inclusion was based on parent and/or child report of pulling and only parent-report of picking, this study utilized child report of HPD symptom severity and functional impairment, as well as body-esteem, in order to maintain greater consistency in measurement.

2.2.1. Trichotillomania Impact Survey – Child (TIS-C)

TIS-C (Franklin et al., 2008) utilizes parent and/or child self-report to assess demographic characteristics, HPD symptoms, related behaviors (i.e., nail biting, SP, etc.), family psychiatric history, phenomenology- and treatment-related data relevant to a child's symptoms of HPD, the impact of pulling on psychosocial impairment, and several self-/parent-report measures (incorporated within the TIS-C) designed to assess pulling severity (i.e., "On most days in the last week, how many hairs did you pull out? "), body-esteem ("My looks upset me."), and other psychiatric symptoms ("I have trouble sleeping many nights.") in greater detail. What follows is a brief description of individual items and/or measures utilized from the TIS-C for the