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Measuring the role of psychological inflexibility in Trichotillomania

David C. Houghton^a, Scott N. Compton^b, Michael P. Twohig^c, Stephen M. Saunders^d,
 Martin E. Franklin^e, Angela M. Neal-Barnett^f, Laura Ely^g, Matthew R. Capriotti^h,
 Douglas W. Woods^{a,*}

^a Department of Psychology, Texas A&M University, 4235 TAMU, College Station, TX 77843, USA

^b Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, NC, USA

^c Department of Psychology, Utah State University, Logan, UT, USA

^d Department of Psychology, Marquette University, Milwaukee, WI, USA

^e Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA

^f Department of Psychology, Kent State University, Kent, OH, USA

^g Psychological Health Roanoke, Roanoke, VA, USA

^h Department of Psychology, University of Wisconsin-Milwaukee, Milwaukee, WI, USA

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ABSTRACT

Psychological Inflexibility (PI) is a construct that has gained recent attention as a critical theoretical component of Acceptance and Commitment Therapy (ACT). PI is typically measured by the Acceptance and Action Questionnaire-II (AAQ-II). However, the AAQ-II has shown questionable reliability in clinical populations with specific diagnoses, leading to the creation of content-specific versions of the AAQ-II that show stronger psychometric properties in their target populations. A growing body of the literature suggests that PI processes may contribute to hair pulling, and the current study sought to examine the psychometric properties and utility of a Trichotillomania-specific version of the AAQ-II, the AAQ-TTM. A referred sample of 90 individuals completed a battery of assessments as part of a randomized clinical trial of Acceptance-Enhanced Behavior Therapy for Trichotillomania. Results showed that the AAQ-TTM has two intercorrelated factors, adequate reliability, concurrent validity, and incremental validity over the AAQ-II. Furthermore, mediational analysis between emotional variables and hair pulling outcomes provides support for using the AAQ-TTM to measure the therapeutic process. Implications for the use of this measure will be discussed, including the need to further investigate the role of PI processes in Trichotillomania.

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1. Introduction

Trichotillomania (TTM), or hair pulling disorder, is an obsessive-compulsive spectrum disorder characterized by the repeated pulling of one's own hair, resulting in significant hair loss (American Psychiatric Association [APA], 2013). Research has revealed two styles of pulling: "automatic" and "focused" (Christenson et al., 1991). "Automatic" pulling is performed with little control or awareness, whereas "focused" pulling appears to be a more purposeful process. Some have suggested that "focused" pulling may function to regulate affect and/or aversive cognitions (Begotka et al., 2004; Woods et al., 2006). Supporting this idea, Diefenbach et al. (2002) found that people with TTM report reductions in anxiety, tension, and boredom following pulling episodes.

The most empirically supported behavioral intervention for TTM is Habit Reversal Training (HRT; Azrin et al., 1980; Rosenbaum and Ayllon, 1981; Tarnowski et al., 1987; Mouton and Stanley, 1996; Stoylen, 1996; Rapp et al., 1998), which consists of awareness training, competing response training, and social support. Unfortunately, evidence suggests that while effective at reducing pulling, HRT does not address the aversive cognitions and emotional states that often trigger pulling episodes (Woods et al., 2006). One factor that links emotions to pulling may be Psychological Inflexibility (PI), which is a generalized, maladaptive strategy used to regulate affect and unwanted cognitions resulting in reductions in meaningful life activities. Not to be confused with problems with cognitive flexibility (which involves the ability to shift attentional focus and does not appear to be dysfunctional in TTM; see Chamberlain et al. (2006)), PI involves problems in resisting maladaptive behaviors that are triggered by aversive cognitions and emotions (Hayes et al., 2006). PI has been associated with increased hair pulling severity and pulling urges

* Corresponding author. Tel.: +1 979 845 2540.

E-mail address: dowoods@tamu.edu (D.W. Woods).

(Begotka et al., 2004). Therefore, interventions that include techniques that target PI may be effective in reducing TTM symptoms.

Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) is an empirically supported form of behavior therapy that attempts to reduce PI and increase individuals' engagement in valued behavior while also experiencing negative private events (e.g., not responding to the urge to pull hair because doing so takes one away from doing things more consistent with one's values). ACT has been found generally effective for a variety of mental health issues (Hayes et al., 2006), and components have been successfully incorporated into HRT for TTM (Twohig and Woods, 2004; Woods et al., 2006; Flessner et al., 2008a).

Psychological flexibility is thought to mediate successful outcomes in ACT (Ciarrochi et al., 2010) and is typically measured by the Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011). Because the AAQ-II is a general measure of PI, the measure's utility in clinical populations with specific psychopathologies can sometimes be limited. Thus, specific versions based on the AAQ-II have been created for diabetes (Gregg et al., 2007), epilepsy (Lundgren et al., 2008), substance abuse (Luoma et al., 2011), weight (Lillis and Hayes, 2008), cigarette smoking (Gifford et al., 2004), body image (Sandoz et al., 2013), chronic pain (McCraken et al., 2004), social anxiety (MacKenzie and Kocovski, 2010), tinnitus (Westin et al., 2008), and auditory hallucinations (Shawyer et al., 2007). These disorder-specific versions have shown increased precision for measuring PI in specific clinical and research contexts. For instance, when compared to the original measure, the AAQ for tinnitus more successfully predicted treatment outcomes (Westin et al., 2008), and the AAQ for substance abuse showed considerably stronger psychometric properties in its targeted population (Luoma et al., 2011).

Cognitive-affective variables, such as anxiety and mood, are linked to TTM (Diefenbach et al., 2002). According to ACT theory, it is the struggle to control inner experiences (i.e., avoidance) rather than the content of the experience itself (i.e., valence) that fuels psychological distress (Hayes et al., 1999). Individuals who are more psychologically inflexible would then be at risk for developing psychopathology in response to aversive inner experiences. Therefore, individuals with TTM might show a link between emotional variables and hair pulling that is mediated by PI, as has been reported in a previous study (Norberg et al., 2007). By extension, improving psychological flexibility through ACT or similar treatments could decrease pulling by making the behavior less susceptible to aversive inner experiences.

The current study examines the psychometric properties and mediational effects of a novel disorder-specific version of the AAQ for TTM. Specifically, it was hypothesized that the AAQ-TTM would demonstrate acceptable reliability and concurrent validity, adequate incremental validity over the AAQ-II on relevant indices, and potential utility as a process of change measure.

2. Methods

2.1. Participants

From March 2009 until January 2013, 274 adults were screened for possible participation in a randomized clinical trial of Acceptance-Enhanced Behavior Therapy (AEBT) for Trichotillomania through newspaper ads, the Trichotillomania Learning Center, and clinic referrals at a Trichotillomania Specialty Clinic. Ninety participants (83 females; Mean Age=35.16) completed the baseline assessment battery and constituted the cross-sectional data for this study.

2.2. Measures

2.2.1. Psychological Inflexibility

The Acceptance and Action Questionnaire-Trichotillomania (AAQ-TTM) is a 10-item self-report measure of PI within the context of TTM. The third author (Dr. Twohig), a TTM and ACT expert, created the items based off the AAQ-II (Woods and Twohig, 2008). Individuals are provided a list of statements describing how they interact with their urges to pull hair, and they rate each statement on a seven-point Likert scale (1="never true", 7="always true"). Scale scores are created by summing the items, and higher scores are intended to indicate greater psychological flexibility in the presence of hair pulling-related cognitions and affect. See Table 1 for a list of items.

The Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011) is a 10-item self-report measure of overall PI. Analysis of the AAQ-II showed that the scale demonstrates adequate psychometric properties, as evidenced by an alpha coefficient of 0.87 and acceptable convergent and divergent validity (Bond et al., 2011). The structure is similar to the AAQ-TTM, with statements about one's experiential avoidance/acceptance being scored on a seven-point Likert scale, and higher scores indicate higher global psychological flexibility.

2.2.2. Hair pulling

The Massachusetts General Hospital Hairpulling Scale (MGH-HPS; Keuthen et al., 1995; O'Sullivan et al., 1995) is the most widely used self-report outcome measure of TTM, and demonstrates satisfactory psychometric properties (Keuthen et al., 1995, 2007; O'Sullivan et al., 1995; Diefenbach et al., 2005). The MGH-HPS has seven items that are scored on a five-point Likert scale for a total ranging from 0 to 28, with higher scores reflecting greater hair pulling severity.

The Milwaukee Inventory of Subtypes of Trichotillomania-Adult Version (MIST-A; Flessner et al., 2008b) is a 24-item self-report measure designed to assess different pulling styles in adults with TTM. It consists of two subscales corresponding to "automatic" and "focused" pulling, and has demonstrated adequate internal consistency and good construct and discriminant validity (Flessner et al., 2008b).

The NIMH Trichotillomania Scale (Swedo et al., 1989) is a semi-structured clinical interview consisting of two clinical indices: the NIMH Trichotillomania Severity Scale (NIMH-TSS) and the NIMH Trichotillomania Impairment Scale (NIMH-TIS). The scales ask questions about time spent pulling, resistance to pulling urges, distress, and impairment. The scales have shown adequate psychometric properties in both adults and children (Diefenbach et al., 2005; Franklin et al., 2011; Stanley et al., 1999; Swedo et al., 1989).

2.2.3. Impairment

The Clinical Global Impression-Severity Scale (CGI-S; Guy, 1976) consists of a single seven-point Likert scale with which the clinician rates the overall severity of a person's illness at the time of assessment. The CGI-S has good reliability (Dahlke et al., 1992), strong convergent validity (Leon et al., 1993), and has been used as a treatment outcome measure for adults with TTM (Ninan et al., 2000; Diefenbach et al., 2006).

Table 1
Pattern matrix of AAQ-TTM.

Item number	Factor 1	Factor 2
Item 2: my urges to hair pull make it difficult for me to live a life I would value. (R)	0.90	
Item 5: my urges to hair pull prevent me from having a fulfilling life. (R)	0.87	
Item 9: urges to pull get in the way of my success. (R)	0.86	
Item 8: it seems like most people are handling their lives better than I am. (R)	0.69	
Item 7: urges to pull cause problems in my life. (R)	0.64	
Item 4: I worry about not being able to control my urges to hair pull. (R)		0.71
Item 6: I am in control of my pulling.		0.53
Item 3: I am afraid of my urges to hair pull. (R)		0.52
Item 1: It is OK if I experience the urge to pull my hair.		0.43

Note: R=Item reversed for scoring purposes.

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