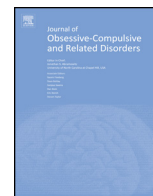




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Clinical report

Personality characteristics and experiential avoidance in Trichotillomania: Results from an age and gender matched sample

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ABSTRACT

Despite its prevalence and a growing body of research, significant gaps remain in the knowledge of trichotillomania (TTM). The current study sought to address this issue by examining personality characteristics, impulsivity, and experiential avoidance of those with TTM compared to an age and gender matched sample. 56 Female participants (28 with TTM and 28 non-clinical age-matched controls) completed the Personality Assessment Inventory (PAI), Barratt's Impulsivity Scale (BIS), and the Acceptance and Action Questionnaire (AAQ). Paired-sample *t*-tests compared each of the 28 individuals who met criteria for TTM to an age and gender matched individual who did not meet criteria for TTM or any Axis I condition. Significant differences were found between many of the PAI scales and subscales, impulsivity, and experiential avoidance. The TTM group displayed higher levels of pathology than the control group. The findings provide evidence that individuals with TTM demonstrate differing levels of personality characteristics compared to individuals without TTM and that treatment may benefit from acknowledging and targeting these areas.

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1. Introduction

Trichotillomania (TTM) is characterized by repetitive hair pulling, resulting in noticeable hair loss and significant distress or impairment (American Psychiatric Association *American Psychiatric Association* (2013)). TTM is a noteworthy disorder, affecting approximately 1–3% of the population (Duke, Bodzin, Tavares, Geffken, & Storch, 2009; Duke, Keeley, Ricketts, Geffken, & Storch, 2010).

Woods, Wetterneck, and Flessner (2006) argue that despite a growing body of research, significant gaps remain in the knowledge of TTM and that much empirical work is needed to develop a better understanding of TTM and its treatment. The current study is an attempt to improve knowledge of TTM by examining personality and psychopathological characteristics in individuals with this disorder.

There has been limited research examining comorbid symptoms, personality variables, and psychological constructs (e.g.,

experiential avoidance (EA)) among individuals with TTM. Among this limited literature, three studies are of particular interest because they examine potential personality differences in those with TTM. The first study (Christenson, Chernoff-Clementz, & Clementz, 1992) compared individuals with TTM to an age and gender-matched psychiatric control group and did not identify significant differences between the two groups in levels of personality disorders or traits. The second study (Hagh-Shenas, Moradi, Dehbozorgi, Farashbandi, & Alishahian, 2004) compared 43 individuals with TTM to an age- and gender matched non-psychiatric control group on personality and psychological variables assessed by the Persian version of the NEO Personality Inventory-Revised (NEO-PI-R). Results demonstrated that TTM participants scored higher on the anxiety, angry-hostility, depression, self-consciousness, impulsivity, and vulnerability to stress subscales and lower on the compliance subscale compared to the control group. The researchers noted that these personality characteristics resemble the results of individuals with borderline personality disorder. The third study (Keuthen et al., in press) compared 54 participants with TTM and 25 non-psychiatric controls using the NEO-Five Factor Inventory (NEO-FFI). Results indicated that higher neuroticism scores predicted a greater chance of TTM diagnosis. The researchers then utilized data from 164 participants with TTM to

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determine if NEO-FFI personality domains predicted TTM behavior, and found that lower levels of agreeableness and higher levels of neuroticism and openness were associated with greater pulling severity. Higher neuroticism was also associated with less control over hair pulling.

Taken together, these studies identified specific comorbid symptoms and traits as potentially playing an important role in TTM, including anxiety, depression, agreeableness, neuroticism, openness, angry-hostility, self-consciousness, impulsivity, vulnerability to stress, and compliance. Two of the studies (Hagh-Shenas et al., 2004; Keuthen et al., in press), however, utilized the NEO-PI-R and NEO-FFI, which were not developed for use with individuals with psychopathology. Additionally, the NEO-PI-R and NEO-FFI lack validity scales, which are important in determining positive or negative response bias as well as general comprehension and consistency in responding. It is important, therefore, to conduct research on potential characteristics associated with TTM using measures normed with clinical populations and that include validity scales.

Of the aforementioned traits, impulsivity has long been thought to be associated with TTM and could potentially inform and enhance future treatment modalities (Chamberlain, & Sahakian, 2007; Flessner, Knopik, & McGeary, 2012). Despite the earlier classification of TTM as an impulse control disorder, there is a paucity of research on impulsivity and TTM, and extant research has notable limitations and disparate results. The Hagh-Shenas et al.'s finding of higher levels of impulsivity in TTM than control participants is interesting in light of ongoing speculation of the role of impulsivity in TTM. Some previous research has also identified higher impulsivity among individuals with TTM (Stein et al., 1995); however, others have not identified higher levels of impulsivity among individuals with TTM compared to non-clinical controls and individuals with OCD (Chamberlain, Fineberg, Blackwell, Robbins & Sahakian, 2007).

Another trait-like construct emerging as an important factor in TTM is EA. EA is a behavioral repertoire defined by a tendency to minimize, avoid, or eliminate contact with unwanted private experiences and hypothesized as an underlying process in many disorders (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). In TTM, EA may be attempts to produce short-term reductions in undesired feelings of anxiety, stress, or an "urge" through hair-pulling.

Researchers suggest EA is an important target in the treatment and maintenance of TTM, calling for further investigation (Begotka, Woods, & Wetterneck, 2004; Houghton et al., 2014; Twohig & Woods, 2004; Woods et al., 2006). Twohig and Woods (2004) found a moderate effect size in the reduction of EA in six adults with TTM treated with Acceptance and Commitment Therapy enhanced Habit Reversal (ACT/HR). Similarly, Woods et al. (2006) found a significant reduction of EA in 12 individuals treated with ACT/HR compared to a waitlist control group. EA has also been shown to mediate relationships between hair pulling severity and shame related cognitions, fear of negative evaluation, and dysfunctional beliefs about appearance (Norberg, Wetterneck, Woods, & Conelea, 2007). Finally, another study found a significant relationship between EA and TTM severity in a large non-referred sample (Begotka et al., 2004). Thus, EA appears to play an important role in TTM. Further research into how EA impacts the development and maintenance of TTM symptoms, as well as how EA relates to other relevant constructs (i.e., anxiety, depression, emotion regulation, impulsivity) is needed.

The current study aims to examine personality characteristics and EA among individuals with TTM compared to an age and gender matched paired sample. To address limitations of previous research, the current study will measure personality characteristics using the Personality Assessment Inventory (PAI; Morey,

1991), which provides a comprehensive, clinically-normed assessment of personality and psychopathology. We hypothesize that those with TTM will have elevated levels of anxiety, depression and borderline features as measured by PAI clinical scales compared to the control group. Moreover, we hypothesize that the treatment consideration scales of the PAI related to aggression and stress will be elevated compared to the control group. Furthermore, we posit that those with TTM will have greater levels of impulsivity and EA than the control group.

2. Method

2.1. Participants and procedure

Data from participants with TTM were collected in Woods et al. treatment study (2006). Of the 34 females who participated in that study, we found sex- and age-matched non clinical controls for 28 of them (20 were same-age matches; 8 were within 2 years) from two universities in the Midwest ($n=12$) and Southwest ($n=16$) United States. Data from the matched controls was gathered at the same time as the participants with TTM. All participants completed measures assessing TTM severity, impulsivity, personality characteristics, and EA. Demographic information is displayed in Table 1. Mean age was 33.04 ($SD=9.04$; range 18–50); ethnorracial background was 85.7% White, 7.1% Hispanic, and 7.2% other. The TTM group's mean age was 33.32 ($SD=9.21$; range 18–49). Ethnicity was 89.3% Caucasian/White, 7.1% Hispanic, and 3.6% other. The control group's mean age was 32.75 ($SD=9.03$; range 18–50). Ethnicity was 82.1% Caucasian/White, 7.1% Hispanic, and 10.8% other. All participants received a diagnostic interview using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) to assess for comorbid Axis I conditions. Individuals were excluded from the control group if they endorsed any conditions. The TTM group consisted of 11 participants who did not meet criteria for comorbid conditions. Of the remaining 17 TTM group participants, 13 met criteria for one, three met criteria for two, and one met criteria for four comorbid conditions. Comorbid diagnoses included major depressive disorder ($n=7$), substance use disorder ($n=6$), OCD ($n=4$), mood disorder NOS ($n=3$), specific phobia ($n=2$), panic disorder ($n=1$), and social phobia ($n=1$). Independent sample *t*-tests comparing age, and scores on each of the measures (including all PAI scales) of participants without

Table 1
Participant age, ethnicity, and rates of comorbidity.

	TTM ($n=28$)	Non-TTM ($n=28$)	Total ($n=56$)
Mean age	33.32 (9.21)	32.75 (9.03)	33.04 (9.04)
Ethnicity			
White	89.3% (25)	82.1% (23)	85.7% (48)
Hispanic	7.1% (2)	7.1% (2)	7.1% (4)
Other	3.6% (1)	10.8% (3)	7.2% (4)
Secondary diagnoses			
Substance use disorder	21.4% (6)	–	–
Major depressive disorder	25.0% (7)	–	–
Obsessive–compulsive disorder	14.3% (4)	–	–
Mood disorder NOS	10.7% (3)	–	–
Specific phobia	7.1% (2)	–	–
Panic disorder	3.6% (1)	–	–
Social phobia	3.6% (1)	–	–
No comorbid condition	39.3% (11)	100% (28)	–
One comorbid condition	46.4% (13)	–	–
Two comorbid conditions	10.7% (3)	–	–
Four comorbid conditions	3.6% (1)	–	–

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