



Short communication

Functional assessment and treatment of trichotillomania and skin-picking: A case study



Zachary LaBrot, Brad A. Dufrene*, Emily Ness, Rachel Mitchell

The University of Southern Mississippi, 118 College Drive #5025, Hattiesburg, MS 39406, United States

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ABSTRACT

This case study included functional assessment and treatment of trichotillomania and skin picking by a 6-year old female kindergarten student of typical development. The school's behavior specialist provided assessment and treatment services in the school setting. Functional assessment included indirect assessment (i.e., teacher completed functional assessment rating scale and follow-up interview) followed by a brief functional analysis. The behavior specialist used functional assessment data to individually tailor a simplified habit reversal intervention, which effectively treated trichotillomania and skin picking. Treatment gains maintained at 3-month follow-up. Results from this case study may be used to inform assessment and treatment of trichotillomania and skin picking across school and clinical settings.

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1. Theoretical and research basis for treatment

Body-focused repetitive behaviors (BFRB) include behaviors such as hair pulling, skin picking, and nail biting. For some individuals, BFRB significantly impair functioning and warrant clinical attention. Trichotillomania includes chronic hair pulling not attributable to any specific medical condition despite attempts to stop that results in noticeable hair loss, negative health outcomes (e.g., stomach/intestine obstruction due to a trichobezoar), and causes clinically significant impairment in social, school, or occupational functioning (American Psychiatric Association, 2013). Annual prevalence of trichotillomania in adults and adolescents is approximately 1–2%, but less is known regarding annual prevalence in children; however, it is clear that females are much more frequently affected than males. Lifetime prevalence of trichotillomania in adults is estimated to be between .6% and 15.3% (American Psychiatric Association, 2013; Duke, Keeley, Geffken, & Storch, 2010; McGuire et al., 2012).

Excoriation disorder includes chronic skin picking not attributable to substance use or a medical condition despite attempts to stop and results in tissue damage and clinically significant impairment in social, school, or occupational functioning. The prevalence of chronic skin picking in adults is between 1.4% and 13% (American Psychiatric Association, 2013; McGuire et al., 2012; Stein et al., 2010); however, less is known regarding prevalence in children, but females are clearly more likely to engage in skin picking than males (McGuire et al., 2012).

Chronic hair-pulling and skin picking may result in avoidance of common social activities and diminished self-evaluation. Additionally, chronic skin picking is often associated with comorbid mental health concerns such as alcohol misuse, Obsessive Compulsive Disorder, depression, and anxiety (Flessner et al., 2006). Odlaug, Kim, and Grant (2010) found that individuals engaging in chronic hair-pulling or skin picking report having a lower quality of life.

Hair pulling and skin picking may be accompanied by a variety of emotional states and contextual variables. For example, hair pulling and skin picking may be triggered by negative emotional states (e.g., anxiety), tension, boredom, or an uncomfortable body sensation (e.g., itching). Additionally, individuals may engage in hair pulling or skin picking to reduce unpleasant emotional states, tension, or uncomfortable body sensations (i.e., negative physiological reinforcement; Tucker, Woods, Flessner, Franklin, & Franklin, 2011). Alternatively, individuals might engage in skin picking or hair pulling to produce stimulation after a period of sensory deprivation (i.e., positive physiological reinforcement; McGuire et al., 2012; Woods & Miltenberger, 2001). In fact, research including behavioral assessment of hair pulling and skin picking has identified contextual variables and physiological reinforcement processes that trigger and maintain hair pulling and skin picking (Duke et al., 2010; McGuire et al., 2012; Walther, Ricketts, Conelea, & Woods, 2010). Moreover, behavioral assessment of hair pulling and skin picking may facilitate development and implementation of empirically supported treatment for BFRB such as habit reversal.

The original habit reversal treatment package, first described by Azrin and Nunn (1973), included 13 treatment components, and

* Corresponding author.

E-mail address: brad.dufrene@usm.edu (B.A. Dufrene).

was used to effectively treat a variety of BFRB (e.g., tics, hair pulling, nail biting). More recently, researchers have identified streamlined habit reversal packages that include two to four components (i.e., awareness training, competing response training, social support, relaxation training). With regard to habit reversal for the treatment of tics, Woods, Miltenberger and Lumley (1996) found that awareness training alone reduced motor tics for one participant, while awareness training and self-monitoring was required to reduce motor tics for one other participant. However, the combined use of awareness training, competing response training, and social support were required for motor tic reduction in the remaining participants. In another study, Flessner, Busch, Heideman, and Woods (2005) evaluated the relative efficacy of habit reversal (i.e., awareness training and competing response) with and without social support for treating nail biting in college-aged individuals. Results indicated that habit reversal with and without social support resulted in statistically significant decreases in nail biting with increases in nail length, and that there were not significant differences between the two treatment groups. However, it is important to note that Flessner et al. included only college-aged participants that sought treatment for nail biting, and those results may not generalize to children engaging in other BFRB. Social support, therefore, may be critical for children who do not have the motivation or developmental capacity to engage in competing responses without prompts or social reinforcement (e.g., praise for use of competing response). Furthermore, if operating under the hypothesis that some BFRB may result in negative physiological reinforcement (i.e., reduction of anxiety, tension reduction), then relaxation training may be a critical habit reversal component (Miltenberger, Fuqua, & Woods, 1998).

The habit reversal literature is in need of additional guidance to assist clinicians in identifying streamlined habit reversal packages that include the essential components given a particular client's BFRB and the contextual variables that may evoke and maintain the BFRB. Preliminary research has evaluated the utility of functional assessment for informing individually tailored habit reversal packages. Briefly, functional assessment is the range of assessment procedures that identify target behaviors, as well as the contextual variables that evoke and maintain target behaviors. The term functional analysis is reserved for a specific functional assessment procedure that includes experimentally manipulating specific contextual variables (e.g., task demand, contingent attention) to experimentally determine the variable or variables that evoke or maintain the target behavior. In one case study, Dufrene, Watson, and Kazmerski (2008) conducted a functional assessment of a client's nail biting behavior and used the functional assessment data to identify a streamlined habit reversal package that included only awareness training, competing response training, and social support as assessment data did not indicate any concern regarding anxiety. Results indicated that the assessment derived habit reversal package resulted in reductions in nail biting as evidenced by consistent finger nail growth and decreased self-recorded nail biting. In a follow-up study, Dufrene et al. (2013) conducted functional assessments of tics for two children with Tourette Syndrome. Similar to Dufrene et al., assessment data were used to identify streamlined habit reversal packages, and those assessment data indicated habit reversal packages effectively reduced tic rate for both children.

It is important to note that Dufrene et al. (2008) and Dufrene et al. (2013) conducted functional analyses in outpatient clinics, and there is a paucity of research including school-based functional analysis and treatment of BFRB. Clinic-based functional analysis treatments of BFRB have provided guidance for school-based functional analysis and treatment of BFRB, but there are important differences between clinic and school settings that

impact school-based functional analysis procedures. First, the contextual variables manipulated in clinic-based functional analyses are typically designed to mimic contextual variables that may be related to home behavior (e.g., parent delivered command). Therefore, specific guidelines are needed for conducting school-based functional analyses of BFRB that include manipulation of contextual variables common in school settings (e.g., academic task demand). Second, treatments for BFRB such as habit reversal have typically been tested in outpatient clinic settings. Therefore, there is a need for empirical demonstrations of the feasibility of evidence-based treatments for BFRB in school-based settings when implemented by existing school staff (e.g., interventionists). Finally, in addition to demonstrating feasibility of evidence-based treatments of BFRB in school settings, there is a need for demonstrating the effectiveness of evidence-based treatments for BFRB when implemented in school settings.

Given the results of Dufrene et al. (2008) and Dufrene et al. (2013) and the limited research employing functional analyses and treatment for BFRB in school settings, empirical tests are needed that demonstrate the usefulness of school-based functional assessment data for identifying streamlined habit reversal packages that are tailored to an individual student's BFRB and the classroom variables that surround their BFRB. The following case study was conducted in order to provide a demonstration of the feasibility and effectiveness of school-based functional assessment informed habit reversal for treatment of BFRB.

2. Case introduction

At the time of referral, Jenna (pseudonym) was a six-year old female who attended a regular education kindergarten class in the southeastern United States. She had previously been diagnosed with Attention Deficit/Hyperactivity Disorder (subtype unspecified). Jenna's teacher referred her to the district's behavior specialist, a doctoral student in school psychology, for supplemental intervention due to concerns regarding social skills deficits. However, during the consultation process, Jenna's teacher identified hair pulling and skin picking as substantial referral concerns and indicated that hair pulling and skin-picking interfered with social and academic functioning. Moreover, Jenna's teacher identified skin picking as the primary referral concern due to skin picking resulting in open sores. At the time of the referral, Jenna had several small bald spots and open sores on her scalp, with additional open sores on her forehead and the back of her neck. Jenna's teacher reported observing frequent skin picking and moderate hair pulling and twirling. Consistent with the school district's standard protocol for obtaining parent consent for intervention services, Jenna's mother provided consent for assessment and intervention services.

A review of Jenna's school records indicated that there were no underlying medical conditions that could account for hair pulling and skin picking (e.g., psoriasis, scabies). Jenna's teacher reported that Jenna experienced substantial difficulties in the classroom such as inattention, spelling problems, and receiving failing school grades. Furthermore, her teacher suggested that part of Jenna's inability to concentrate in class was at least partly related to frequent hair manipulation and skin picking. Jenna's teacher reported that Jenna received psycho-stimulant medication for the treatment of ADHD, although, we were not able to independently verify the specific medication or dosage.

3. Data collection

Graduate students in school psychology with advanced training in behavioral assessment, and who had previously met a 90%

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