



Short communication

Body focused repetitive behaviors among Salvadorian youth: Incidence and clinical correlates



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ABSTRACT

Body-focused repetitive behaviors (BFRBs; e.g., hair pulling, skin picking, and nail biting) can cause significant physical and psychological distress. However, data examining BFRBs in non-clinical youth is limited. This study examined parent-reports of the incidence and clinical correlates of BFRBs in 315 Salvadorian children (4–17 years). Forty-six percent had at least one BFRB; nail biting was commonly reported (34.6%), followed by skin picking (24.8%), and hair pulling (10.5%). Of those endorsing BFRBs, 13.7% reported elevated distress and/or interference due to these behaviors, including approximately one-third of skin pickers and hair pullers (8.3% and 2.9% of the total sample) and one-fifth of nail biters (7.3% of the total sample). Skin pickers and hair pullers, but not nail biters, had higher levels of internalizing and externalizing behaviors, poorer adaptive functioning, and more difficulties with inattention, compared to those who reported no BFRBs. Skin picking symptom severity was positively correlated with externalizing and internalizing behaviors. Nail biting symptom severity was associated with increased internalizing symptoms, while severity of hair pulling was not significantly associated with behavioral and emotional functioning. These data suggest that BFRBs are commonplace and may be associated with behavioral and emotional functioning.

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1. Introduction

Body focused repetitive behaviors (BFRB), including skin picking, nail biting, and hair pulling, involve repetitive behaviors targeting one or more body regions. Historically, these behaviors were considered relatively benign and not worthy of clinical or academic attention. With growing recognition that BFRBs can confer significant impairment and distress in a proportion of individuals, there has been increasing investigation on the classification, assessment, and treatment of these behaviors (e.g., McGuire et al., 2012; Roberts, O'Connor, & Belanger, 2013; Teng, Woods, Twohig, & Marcks, 2002). To date, most

information on BFRBs has been derived from adults or clinical samples of the respective BFRB. There has been limited research examining the incidence and correlates of BFRBs in non-clinical youth despite evidence for their frequent occurrence. The purpose of this study is to investigate the incidence, severity, and clinical correlates of skin picking, nail biting, and hair pulling in a large sample of Salvadorian youth.

Information regarding skin picking among youth is limited. Between 5% and 13% of adults compulsively skin pick (Hayes, Storch, & Berlanga, 2009; Teng et al., 2002), with estimates suggesting that as many as 10–40% of children pick their skin and/or nose when assessed by the Child Behavior Checklist (Achenbach & Rescorla, 2001). Among those with clinical levels of symptoms, onset often occurs during childhood (Wilhelm et al., 1999), and affect more females than males (Hayes et al., 2009). Compulsive skin picking among adults has been linked with increased anxiety, depressive symptoms,

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and impulsivity (Flessner & Woods, 2006; Hayes et al., 2009; Wilhelm et al., 1999). Few data exist regarding correlates of skin picking among youth.

Hair pulling behaviors occur with frequency among adults, with approximately 15.3% engaging in non-grooming hair pulling (Duke, Bodzin, Tavares, Geffken, & Storch, 2009; Stanley, Borden, Bell, & Wagner, 1994) and 1–6.5% affected by clinical levels of hair pulling (i.e., trichotillomania; Christenson, Pyle, & Mitchell, 1991; Lochner, Simeon, Niehaus, & Stein, 2002); prevalence rates in youth are unknown. Among those with trichotillomania, age of onset tends to occur during childhood, with peaks during early childhood and early adolescence (Duke, Keeley, Geffken, & Storch, 2010; Lochner et al., 2002; Swedo & Rapoport, 1991). Hair pulling seems to affect females with increased incidence compared to males in non-clinical adult samples (Woods et al., 2006). Those who pull their hair are at risk for heightened social impairment, increased comorbidities, and functional disability (Duke et al., 2009; Lochner, Seedat, & Stein, 2010; Tolin et al., 2008). Childhood trichotillomania is associated with the presence of clinically significant anxiety (Reeve, Bernstein, & Christenson, 1992; Santhanam, Fairley, & Rogers, 2008; Tolin, Franklin, Diefenbach, Anderson, & Meunier, 2007), disruptive behavior, attentional problems (King, Scahill, Vitulano, & Schwab-Stone, 1995; Tolin et al., 2007), and other body focused repetitive behaviors (e.g., thumb sucking, nail biting, lip biting, and cheek chewing; Flessner, Woods, Franklin, Keuthen, & Piacentini, 2009; Orange, Peereboom-Wynia, & DeRaeymaecker, 1986; Reeve et al., 1992; Santhanam et al., 2008; Simeon et al., 1997). Information about rates of hair pulling in non-clinical samples of children is unknown, and knowledge regarding associated psychosocial correlates is limited.

Nail biting is a fairly common childhood problem with 5–29% of children engaging in the behavior (Feteih, 2006; Garde et al., 2014). Incidence seems to be similar across genders (Ghanizadeh, 2011), with most individuals reporting a childhood onset of nail biting that peaks during adolescence and often declines in adulthood (Peterson, Campise, & Azrin, 1994). Nail biting severity is negatively linked to quality of life among university students (Pacan, Reich, Grzesiak, & Szepietowski, 2014). Although few data on clinical correlates of nail biting in children exist, nail biting has been associated with higher levels of anxiety (Joubert, 1993; Klatte & Deardorff, 1981) and obsessive–compulsive symptoms (Joubert, 1993) among adults. In children, nail biting has been linked to increased emotional and conduct problems, and decreased prosocial behavior (Ghanizadeh, 2011). Among clinical samples, nail biting commonly co-occurs with Tourette Syndrome (Ghanizadeh & Mosallaei, 2009), attentional problems (Ghanizadeh, 2010), and separation anxiety (Ghanizadeh, 2008).

As previously noted, investigations of BFRBs in youth are largely limited, as are investigations utilizing ethnically diverse samples. Hispanic populations are particularly underrepresented in clinical research involving BFRBs with virtually no data having been reported. Given this and the link between BFRBs and obsessive–compulsive symptoms (e.g., Joubert, 1993; Lovato et al., 2012), a more broad review of obsessive–compulsive symptoms in Hispanic populations was conducted. Indeed, extant literature on obsessive compulsive disorder in Hispanic populations is sparse and yields relatively inconsistent results; one study reported elevated levels of contamination symptoms among Hispanic subjects compared to Caucasians (Williams, Turkheimer, Schmidt, & Oltmanns, 2005) while other studies found no significant differences in contamination symptoms (or other core obsessive–compulsive symptom dimensions) between Hispanics and other racial groups (Chavira et al., 2008; Wheaton, Berman, Fabricant, & Abramowitz, 2013). There is some evidence to suggest that incidence of obsessive–compulsive disorder may be slightly lower in Hispanic populations, as lifetime prevalence rates in Puerto Rico and Chile have been documented at 1.1% and 1.2% (Canino et al., 1987; Vicente et al., 2006), compared to 1.6% in the United States

Table 1
Demographic characteristics.

	M (SD)/N (%)
Parent	
Age	35.26 (7.62)
Gender	
Mother	195 (61.9)
Father	98 (31.1)
Not Reported	22 (7.0)
Education	
Primary School	22 (7.0)
Secondary School	19 (6.0)
Bachillerato	120 (38.1)
University Degree	129 (41.0)
Graduate Degree	17 (5.4)
Not Reported	8 (2.5)
Religion	
Catholic	157 (49.8)
Evangelical	125 (39.7)
Non-Religious	12 (3.8)
Other	17 (5.4)
Not Reported	3 (1.0)
Monthly income	
< 250	47 (14.9)
250–499	68 (21.6)
500–749	63 (20.0)
750–999	30 (9.5)
1000–1999	50 (15.9)
2000–4999	35 (11.1)
5000–10000	7 (2.2)
Not Reported	15 (4.8)
Child	
Age	8.39 (3.10)
Gender	
Male	149 (47.3)
Female	163 (51.7)
Not Reported	3 (1.0)

(Kessler et al., 2005); this difference may be accounted for by cultural differences and/or differences in symptom expression (Chavira et al., 2008). Ultimately, continued investigation into obsessive–compulsive spectrum disorders in Hispanic populations is needed. The purposes of this study were threefold. First, we sought to investigate parental reports on the incidence and severity of BFRBs in a non-clinical pediatric sample of youth from El Salvador. We expected skin picking and nail biting but not hair pulling to be relatively common, but only a small percentage of parents to endorse elevated symptom distress and interference in their child. Second, we examined the relationship of varied BFRBs with internalizing and externalizing symptoms, as well as adaptive functioning. We expected youth with BFRBs to demonstrate higher levels of internalizing and externalizing symptoms, as well as poorer adaptive functioning when compared to youth without BFRBs. Finally, we will evaluate the relationship between the severity of BFRBs and emotional functioning. We predicted positive correlations between the severity of BFRBs and internalizing and externalizing symptoms, and adaptive functioning.

2. Method

2.1. Participants and procedures

Participants were 315 parents of children visiting the Tin Marin Children's Museum located in San Salvador, El Salvador (see Table 1 for full demographics). Both mothers (61.9%) and fathers (31.1%) participated (7% did not report their relationship), with the children's ages ranging from 4 to 17 years of age ($M=8.39$, $SD=3.10$). Gender was evenly split, as 47.3% percent of children were female. Monthly

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