

Body-Focused Repetitive Behaviors: The Specifics of the Psychological Testing and Tactics of Cognitive Behavioral Therapy

Melehin AI*

PhD, Associate Professor, clinical psychologist of the highest qualification category, Moscow, Russian Federation

*Corresponding author: Melehin AI, PhD, Associate Professor, clinical psychologist of the highest qualification category, Moscow, Russian Federation.

Submitted: 16 October 2023 Accepted: 24 October 2023 Published: 24 November 2023

doi <https://doi.org/10.63620/MKJPNR.2023.1021>

Citation: Melehin, A. I. (2023). *Body-Focused Repetitive Behaviors: The Specifics of the Psychological Testing and Tactics of Cognitive Behavioral Therapy*. *J of Psych and Neuroche Res*. 1(3), 01-05.

Abstract

The article describes clinical manifestations of repetitive traumatic behavior directed (focused) on the body or skin picking disorder. The spectrum of forms of repetitive traumatic behavior directed at the body is detailed. A diagnostic algorithm and a psychological approach to the assessment and initial treatment of psychosocial stressors in this group of patients are proposed. The general tactics of treatment are presented, and emphasis is placed on the specifics of cognitive behavioral therapy (CBT) for repetitive traumatic behavior directed at one's own body, as well as its effectiveness and limitations. It is shown that the "classical" CBT protocol (for example, habit change training, habituation, attention management, stimulus control) is an insufficient tactic of psychotherapeutic treatment, because it is unable to help the patient cope with internal experiences and emotional dysregulation. In this regard, it is recommended to use a multimodal protocol with an emphasis on metacognitive features of perception of the situation, regulation of impulsivity, maladaptive perfectionism and minimization of empirical avoidance of one's own experiences.

Keywords: Psychodermatology, Cognitive Behavioral Therapy, Psychotherapy, Repetitive Traumatic Behavior Directed at the Body, Trichophagy, Onychophagy, Trichotillomania, Itching, Combing, Skin, Skin Picking Disorder, Excoriation

Introduction

Over the past few years, there has been an increase in the number of complaints from patients complaining of a specific itching sensation, repeated pulling (trichotillomania) and/or eating hair (trichophagia) from different parts of the body, picking, combing the skin (psychogenic excoriation) in various parts of the body, biting cheeks, lips, nails, eating cuticles, skin on the fingers (onychophagia, dermatodaxia or "wolf bite"). These patients may complain of itching, burning, pain, discharge and bleeding. For example, "I press the skin in front of the mirror", "I squeeze out a ball with secretions and it becomes emotionally easier for me", "when I comb myself until I bleed, it becomes calmer, and I get some strange pleasure." They may complain that the symptoms do not allow them to sleep at night, and that is why they become so "tired" and "deprived" of sleep. The condition of itching, specific discomfort often increases in patients in the evening before going to bed, when the feeling of "insufficient day", "inefficiency", "dissatisfaction" worsens. Some patients indicate that their symptoms are constantly present in

their thoughts and that it is very difficult to ignore the symptoms and the desire to pick at the skin, there is shame. Other patients (quite often) it is said that they discover that they are picking at their skin unconsciously, and that when they realize that they have been picking (or a friend or relative points it out to them), they have already damaged their skin quite badly. This then leads to feelings of shame and loss of a sense of control [1].

The size of the lesions can vary from a few millimeters to several centimeters. They can affect any part of the body, but are more common on the face and visible areas of the skin (arms, thighs, abdomen, chest). Sometimes the affected part of the body can make a difference (for example, breasts and genitals in sexually abused patients). And sometimes the dominant hand of the patient may matter (for example, the left side of the body may be more actively involved in right-handed people, and the middle of the back may be overlooked due to its relative inaccessibility) [2]. Morphology varies from superficial erosions to deep ulceration and even changes in facial and other skin structures

You can see scars, post-inflammatory or hyperpigmentation and all stages of the healing process. A characteristic feature may be damage to the skin appendages with baldness and loss of sweating. The scars can be extensive, and patients may find that their skin has changed a lot and there are very clear visible differences. This behavior leads to a patient-specific pleasure that is difficult for them to compare with something, complacency, composure ("being attentive", minimizing "boredom", "returning to reality from thoughts", is also an indicator of increased hyper-vigilance [1].

In foreign psychiatry and clinical psychology, these manifestations have received the general name of repetitive traumatic behavior directed (focused) on the body (body-focused repetitive behaviors, BFR) or skin Picking Disorders as a heterogeneous disease accompanied by a large spectrum of frequently recurrent, destructive, non-functional behaviors, which can be single or mixed (multiple BFR), are often designed to "remove something" and/or "get rid of ...", they are an indicator of a failure in the emotional regulation of the patient ("intense emotions", "passion", "made a mistake), as well as the presence of a regime of high self-criticism ("you need to be good", "like", "responsible", "normal"), punitivity ("what the fuck didn't you work today"), self-sacrifice (I don't say, I don't express), finding a foothold ("gives me a connection with reality"). Acts as a marker of "emotional flooding" or "combustion" [1, 3-7].

Repetitive forms of traumatic behavior focused on the body are often characterized by:

- A feeling of tension, anxiety or boredom before committing behavior. For example, the sight or feeling of a preferred hair type or imperfection ("unevenness") causes episodes of this behavior
- The presence of a specific sensory-tactile sensitivity in the patient (a tendency to high tactile stimulation), in which torn or torn pieces of hair, skin and nails are manipulated (for example, rolled between fingers, stroked on the lips) or swallowed (sniffed). It is worth noting that some patients have experience of surfactants, a constant search for impressions
- There is a tendency to search for intense sensory impressions, for example, watching perversions, movies with intense passions
- Patients often protect, protect, hide this behavior, try to mask it with clothes and cosmetics
- High manifestations of strict standards towards oneself and other people, shame, perfectionism and alexithymia (lack of emotional clarity). They often focus on certain types of skin defects (irregularities, bulges, etc.)
- Satisfaction or relief during the behavior and 3) subsequent feelings of remorse or guilt. It leads to harmful consequences, such as bald spots, ulcers, wounds, infections in the affected areas, feelings of shame and psychosocial disorders (the spectrum of avoidant, reinsurance cosmetic behavior)
- There is insensitivity to pain.

Repetitive traumatic behavior directed at the body is considered as part of the continuum of the obsessive-compulsive spectrum of disorders (according to DSM-V), and is also similar to tic and may be part of the spectrum of tic disorders [7]. Both actions are partially arbitrary, demonstrate similar trigger behavioral

profiles in the patient, bring relief from sensations and include sensory stimulation. In both disorders, sensorimotor activation and similar profiles of metacognitive triggers for assessing the situation are observed [4].

However, with repetitive traumatic behavior directed (focused) on the body, there is a problem of the multilayered trigger and the identification of the "root" trigger. The thing is that what starts as a trigger can turn into a symptom and vice versa.

It should be taken into account:

- Triggers can manifest very slowly
- There are dangerous and unpredictable triggers (for example, provoking people, "unfamiliar people")
- Triggers can be immediate and predictable
- Triggers change
- Serious triggers are stress related to work, study, death or illness of a significant person, obligations that need to be fulfilled in a short time, tense personal relationships, moving, getting married, promotion, having a child, social life

Any attempts to curb the desire not to pick, comb can lead the patient to an increase in psychological tension, provoking a compulsive act. Compulsive skinning syndrome is a repetitive, sometimes "ritualistic" behavior that occurs at regular intervals throughout the day for an extended period of time. Patients feel the urge to act and find relief in this activity. Attempts to control this desire lead to an increase in discomfort [1].

Impulsive behavior (in psychodermatology) consists of isolated or repeated acts of uncontrolled desire to manipulate (the phenomenon of "doing something", "correcting something") skin, sometimes without an intrusive component, and quick, but short-term relief [6]. Controlled awareness of their behavior may vary, but patients may engage in this type of traumatization in dissociative states, when subsequently they may not have full awareness or memories of their behavior [5]. Other factors such as substance abuse, risky behavior, and eating disorders may also be detected. Impulsive forms of the disorder with skin damage can be called "non-suicidal self-harm" when there is no conscious suicidal intention. This can include bites, cuts, scratches, bumps and burns. However, "moderate" and "severe" forms may be associated with suicidal thoughts and suicidal attempts. The impulsive form of this condition may not fall under the category of obsessive-compulsive disorder (OCD) and may occur in the context of personality disorders, for example, emotionally unstable personality disorder. The DSM-5 classification classifies self-induced dermatoses into a diagnostic group called: "Obsessive-compulsive and related disorders." Within this classification system, the impulsive form of peel picking disorder is separated from the compulsive form.

It should be noted that repetitive traumatic behavior directed at the body is slightly different from OCD in that the cognitive (mental) component rarely precedes them, but instead may precede sensory experiences (feeling of discomfort, itching, tightness). Episodes are often idiosyncratic in nature and follow a certain behavioral sequence. For example, one of our patients pulled out her hair when she was waiting for someone or "felt like she was wasting time on weekends." She was able to identi-

fy frustration and impatience as the dominant emotions present during this traumatic behavior, and to identify trigger dysfunctional thoughts such as "I'm not doing fast enough" and "I'm not coping well." These thoughts increased her stress level and provoked traumatic behavior directed at the body [4].

Specifics of Psychological Examination of Patients

We offer three questions that help a specialist correctly classify dysfunctional behavior that leads to skin damage:

- Does the patient deny the behavior responsible for the somatic damage, or is it kept "secret", "hidden", hidden?
- If the answer to the first question is "Yes", are there any external consciously provoking stimuli?
- If the answer to the first question is "No", then is the behavior? compulsive or impulsive?

The assessment of psychosocial factors, such as stressful life events and psychological trauma, is important because it has been proven that these factors have a direct effect on the barrier function of the skin and immune responses. Simple treatment of skin lesions does not eliminate psychological suffering.

There are many scales that can be specific for assessing this disorder (the specifics of stress, skin effects), for example, Generic BFRB Scale-8 and Skin Picking Scale, we suggest using the following diagnostic algorithm. Speaking about the peculiarities of communication with this group of patients, the ignorance of patients about the psychological causes responsible for their symptoms can become a problem in the management of patients [8]. A simplified discussion of stress reactions of the skin and activation of cutaneous nerves would be a good starting point to get the patient to consider a systematic, clinical and psychological approach to treatment. A clear statement about the complexity is recommended, not about the difficulties the patient is facing. It may also be helpful to explain that although the actual cause of their symptoms is not completely clear, there are cognitive behavioral strategies that can be used and that can change the way the skin and brain process incoming signals. As with all psychodermatological conditions, patients should be treated non-confrontationally. It is unlikely to be helpful if patients are told to simply stop skin-damaging behavior, since they have often already tried to resist this behavior. Family members should be advised not to simply try to stop this behavior if the patient and the family have not come to an agreement on this.

Treatment Tactics

It should be taken into account:

- Treat skin and psychological diseases, concomitant psychological problems at the same time
- Treat the psychiatric and psychological component of this disorder with non-pharmacological and pharmacological approaches simultaneously, where appropriate and acceptable to the patient, since the combination can lead to more effective treatment

Treatment is based on the severity of the symptoms. For example, if itching occurs, medications containing menthol, emollients or a 5% doxepin cream may be useful. Cool compresses can be useful to remove the crust and soothe the skin. Emollients may also be offered (patient preferences should be taken into account) with or without antiseptics to improve hydration and thus

reduce the itching sensation. It should be noted here that taking a "positive approach" to solving skin problems is extremely helpful, since patients invariably get upset if the skin component of their condition is overlooked. Local/intraoperative steroids / tape to eliminate the inflammatory component of existing lesions can be used as a supplement for chronic or non-healing lesions. Combinations of antibiotics and glucocorticoids can also be used in a decreasing dose for several days or weeks [1].

Obsessive-compulsive symptoms observed in skin-combing disorders were associated with serotonin-mediated neural pathways. Antidepressants that selectively block the absorption of serotonin (SSRIs) may be useful for patients with this problem. Commonly used SSRIs include Citalopram, Sertraline, and fluoxetine. Mirtazapine, a noradrenergic and specific serotonergic antidepressant, is used mainly in the treatment of depression and has anxiolytic and sedative effects. Mirtazapine occupies such a place on the therapeutic ladder, where either the patient does not tolerate SSRIs, or insomnia is a key sign. Antidepressants can be used, for example, doxepin, a tricyclic drug commonly used in this disease, which has powerful antihistamine activity [6, 7].

Neuroleptics of the "second" and "third" generations, such as risperidone, olanzapine and aripiprazole, are sometimes used in severe obsessive-compulsive disorder associated with self-inflicted skin damage, under the supervision of a psychiatrist. Anticonvulsant drugs such as lithium, carbamazepine, valproate and others are commonly used in bipolar disorder in psychiatry. They can be useful in certain conditions associated with self-inflicted skin injuries, when the behavior is caused by a rapid change of mood, but the participation of a psychiatrist will also be required. Naltrexone, commonly used for opioid toxicity, may be useful for skin diseases associated with severe itching. Benzodiazepines can be very rarely used in patients with anxiety, but side effects and addiction mean that these drugs are often used only as a "last resort" or last resort or in special circumstances (usually with addiction problems). Topiramate was used with occasional success [7]. While some reviews recommend selective serotonin reuptake inhibitors (SSRIs) or N-acetylcysteine for the treatment of this disorder, however, to date, no medication has been approved by the Food and Drug Administration (FDA) [1]. In this regard, over the past few years, the "gold standard" of psychotherapeutic treatment of repetitive traumatic behavior directed at the body is cognitive behavioral therapy (CBT), which is based on a comprehensive behavioral model (A Comprehensive Model for Behavioral Treatment, Comb, Mansueto, Stemberger, 1997), a model of dysregulation of emotions (Shusterman et al., 2009) and models of changes in the regulation of perception of stimuli (Stimulus regulation model, Penzel, 2002) [9].

The goal of CBT in this disorder is to reduce increased sensorimotor activity, increase flexibility in perfectionist beliefs about oneself, other people and the underlying style of excessive planning of actions.

The protocol includes from 8 to 10 sessions, once a week, for 60 minutes., before and at the end of psychotherapy, a psychological examination of the patient is carried out.

The "classical" tactics of CBT initially focuses on the change

(extinction) of behavioral habits (Habit Reversal Training) [10]. It includes several stages – awareness (awareness raising), behavioral reduction of hypermobility, training in flexible behavioral responses to unforeseen circumstances (control of stimuli with the metaphor of a "speed bump") and positive reinforcement — and is a key element of practicing a competitive antagonistic reaction (training in replacing undesirable behavior with an incompatible reaction, such as clenching hands into fists, spread the cream on your hands). There is also an emphasis on accepting without negative assessments (labels) the urge to pull out, bite. This tactic is effective in the initial stages of trichotillomania, skin picking and nail biting. This approach is based on the ABC model of changing habits when combing the skin (A-B-C Model of Habit Reversal for Skin Picking) [11].

- A – regulation of affect and emotions
- B – behavioral addiction
- C – cognitive flexibility and control

On the basis of a complex behavioral model (ComM, Mansueto, Stemberger, 1997), multimodal triggers and facilitators-inhibitors that precede the implementation of habits that enhance the effects on daily functioning are investigated. Patients report that the desire to pick, pull or bite occurs more often under certain conditions and that various external or internal signals cause this behavior:

- External triggers for episodes include tools (e.g. comb, tweezers) and furnishings (e.g. bedroom).
- Sensory triggers include physical sensations, such as the sensation of coarse hair between the fingers, the texture of a hard scab, or the rough edge of a burr.
- Motor triggers refer to behaviors such as driving a car or talking on the phone.
- Cognitive and metacognitive triggers are thoughts or beliefs that provoke the desire to pull, bite or pick (for example, "Why do I have such thick eyebrows?" and "I will never be able to stop biting my nails, so why try")
- Affective triggers - frustration, depression, boredom, anxiety or tension
- Emotions can directly provoke an episode of injury to the body. Alternatively, the urge to engage in behavior can be triggered by an external signal or an environmental signal, and the effort to control the urge (i.e. not to pick, bite or pull) can provoke further complex emotions, creating a vicious circle of emotions and traumatic behavior.
- Facilitators and inhibitors are objects, places, people, thoughts and emotions that respectively encourage or hinder an episode of body trauma. For example, the presence of a mirror, a phone screen

As soon as a patient has an episode of body trauma, positive and negative reinforcement increase the likelihood of continuing pulling, biting or picking. Pleasure or relief immediately after this behavior provides sensory positive reinforcement, and satisfaction and a sense of achievement obtained from the removal of a certain type of hair (for example, curly, split ends, wrong color), skin (for example, rough or covered with scabs) or nails (for example, broken, rough, too long) provide affective and cognitive reinforcement. The pleasure or satisfaction that follows pulling out a hair, or picking out a scab or nail, can also cause relief from negative emotions. Relief is a powerful negative reinforcement, and injury to the body can be constantly used to restrain negative

emotions in the patient.

In the course of psychotherapy, situations with a "high" risk of traumatic behavior directed at the body are highlighted, including actions and contexts in which the patient feels judged, embarrassed, disappointed or dissatisfied, while situations with a "low" risk identify existing strengths to move into situations with a "high" risk in order to prevent the occurrence of behavior. Emphasis should be placed on understanding the differences in how the patient himself assesses situations of "high" and "low" risk and approaches them flexibly in terms of reactions.

We have shown that the tactics of psychotherapeutic treatment are multimodal in nature. The "classic" CBT protocol is an insufficient method of treatment, because it is not able to help the patient cope with internal experiences, such as emotions and emotional dysregulation. Taking into account the cognitive-psychophysiological model of treatment of traumatic behavior directed at the body (cognitive psychophysiological treatment model, CoPs, Roberts, O'Connor, 2015 [9]), emphasis is placed on metacognitive features of perception of the situation, regulation of impulsivity, maladaptive perfectionism, which often cause tension and negative emotions, which the patient is difficult to cope with.

It should be borne in mind that maladaptive body-oriented behavior can be used to prevent or change unpleasant psychological experiences, such as painful thoughts, emotions or urges. The use of maladaptive behavior to avoid complex personal events is the main target, known as empirical avoidance (see survey tactics above), which should be minimized during psychotherapy, with an emphasis on the revision of cognitive patterns (rigid internal standard, seeking approval, abandonment, shyness, defectiveness) and personal values.

Available studies show that CBT has the greatest effect on traumatic body-directed behavior compared to clomipramine and selective serotonin reuptake inhibitors. A number of patients show significant improvement after treatment, but only 35-40% retain results with long-term follow-up (on average, 3.9 years later). Thus, CBT has the potential for effective treatment of this disorder, but in order to improve the maintenance of the effect, additions or changes in protocols are required with a greater emphasis on the specifics of improving emotional regulation skills and personification for each form of this disorder.

Forecast

Depends on several factors. It may be necessary to pay attention to predisposing factors, such as anxiety, depression, dependence on surfactants and other concomitant mental illnesses. It may be necessary to eliminate other provoking factors, such as stressful life events. It is reported that the average duration of the disease is about 5-8 years with relapses and remissions that occur in parallel with stressful situations.

References

1. Gieler, U., Consoli, S. G., Tomás-Aragones, L., Linder, D. M., Jemec, G. B. E., et al. (2013). Self-inflicted lesions in dermatology: terminology and classification—a position paper from the European Society for Dermatology and Psychiatry (ESDaP). *Acta Dermato-Venereologica*, 93, 4-12.

2. Gupta, M. A., & Gupta, A. K. (2019). Self-induced dermatoses: a great imitator. *Clinics in Dermatology*, 37, 268-277.
3. Grant, J. E., Redden, S. A., Leppink, E. W., Odlaug, B. L., & Chamberlain, S. R. (2016). Psychosocial dysfunction associated with skin picking disorder and trichotillomania. *Psychiatry Research*, 23, 68-71.
4. Alexander, J. R., Houghton, D. C., Bauer, C. C., Lench, H. C., & Woods, D. W. (2018). Emotion regulation deficits in persons with body-focused repetitive behavior disorders. *Journal of Affective Disorders*, 227, 463-470.
5. Gupta, M. A., Vujcic, B., & Gupta, A. K. (2017). Dissociation and conversion symptoms in dermatology. *Clinics in Dermatology*, 35, 267-272.
6. Madan, S. K., Davidson, J., & Gong, H. (2023). Addressing body-focused repetitive behaviors in the dermatology practice. *Clinics in Dermatology*, 41, 49-55.
7. Najera, D. B. (2022). Body-focused repetitive behaviors: Beyond bad habits. *JAAPA*, 35, 28-33.
8. Kalin, N. H. (2023). Treatment Issues Related to the Use of Psychedelics, Trichotillomania, Social Anxiety Disorder, Schizophrenia, and Opioid Use Disorder. *American Journal of Psychiatry*, 180, 21-39.
9. O'Connor, K., Lavoie, M., Desaulniers, B., & Audet, J.-S. (2018). Cognitive psychophysiological treatment of bodily-focused repetitive behaviors in adults: An open trial. *Journal of Clinical Psychology*, 74, 273-285.
10. Skurya, J., Jafferany, M., & Everett, G. J. (2020). Habit reversal therapy in the management of body focused repetitive behavior disorders. *Dermatologic Therapy*, 33, e13325.
11. Okumuş, H. G., & Akdemir, D. (2023). Body Focused Repetitive Behavior Disorders: Behavioral Models and Neurobiological Mechanisms. *Türk Psikiyatri Dergisi*, 34, 50-59.