Dance/Movement Therapy as a Therapeutic Approach for Excoriation (Skin Picking) Disorder: Movement Treating Movement

Karissa Martens  
*Columbia College Chicago*

Follow this and additional works at: [https://digitalcommons.colum.edu/theses_dmt](https://digitalcommons.colum.edu/theses_dmt)

Part of the Dance Movement Therapy Commons

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License.

Recommended Citation
Martens, Karissa, "Dance/Movement Therapy as a Therapeutic Approach for Excoriation (Skin Picking) Disorder: Movement Treating Movement" (2014). Creative Arts Therapies Theses. 52.
[https://digitalcommons.colum.edu/theses_dmt/52](https://digitalcommons.colum.edu/theses_dmt/52)

This Thesis is brought to you for free and open access by the Thesis & Capstone Collection at Digital Commons @ Columbia College Chicago. It has been accepted for inclusion in Creative Arts Therapies Theses by an authorized administrator of Digital Commons @ Columbia College Chicago. For more information, please contact drossetti@colum.edu.
DANCE/MOVEMENT THERAPY AS A THERAPEUTIC APPROACH FOR EXCORIATION (SKIN PICKING) DISORDER: MOVEMENT TREATING MOVEMENT

Karissa Martens

Thesis submitted to the faculty of Columbia College Chicago
in partial fulfillment of the requirements for
Master of Arts
in
Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies
December 13, 2014

Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA
Chair, Creative Arts Therapies

Laura Downey, MA, BC-DMT, LPC, GL-CMA
Research Coordinator

Laura Allen, MA, BC-DMT, LCPC, GL-CMA
Thesis Advisor

Andrea Brown, MA, BC-DMT, LCPC, NCC
Reader
Abstract

Through a collective case study, the principal researcher examined how a positive psychology based dance/movement therapy (DMT) approach could be a viable treatment method for individuals with Excoriation (Skin Picking) Disorder (SPD). The intention of this research was to find additional therapeutic modalities for individuals with SPD, as well as inquire how DMT and SFT would be viable in treating SPD. As a new disorder in the publication of the DSM-5, individuals with SPD currently have limited treatment options available. Solution Focused Therapy (SFT) was integrated with DMT to create a more comprehensive treatment.

Participants consisted of board-certified dance/movement therapists with experience in a private practice setting, and professional members of Trichotillomania Learning Center (TLC) who were familiar with treating SPD and related Body-Focused Repetitive Behaviors (BFRB). Semi-structured interviews were conducted with the participants, and the principal researcher maintained a researcher journal. Data was analyzed through Sequential Analysis. Results indicated that this therapeutic approach was seen as a potentially viable treatment method for individuals with SPD because of the compatibilities that exist between the treatment and disorder. These compatibilities were; DMT and SFT compliment each other, there is a shared body based component in both the treatment and disorder, individuals with SPD may have an innate somatic component that responds well to this treatment, and individuals with SPD may be able to reshape their relationship with this disorder through DMT and SFT. The principal investigator also recognized the importance of conducting future research that would utilize this specific therapeutic approach for participants with SPD. Further research would help with understanding more precisely how DMT and SFT could be a viable treatment for individuals with SPD.
Acknowledgements

There were many individuals that have been integral throughout my thesis journey. I would like to thank the faculty, and the 2011-2013 cohort in the Department of Creative Arts Therapies at Columbia College Chicago. Thank you for believing in me, seeing my potential, and fostering my growth as a professional.

Thank you to all the participants who took part within this study. Your time and professional views were integral to my research, and I am grateful for your generosity in sharing these with me.

I would like to thank my thesis advisor Laura Allen. Thank you for your patience and dedicated involvement in this process. Throughout your many roles in my education at Columbia College Chicago, you have been a role model and mentor. You have helped shape me as a professional, and as a person. Your work ethic and worldview has taught me more than you will ever know. The sky is truly the limit!

I would like to thank my reader Andrea Brown. Your feedback transformed my final product into a more clear, and meaningful piece of work.

I would like to thank my family and close friends. Thank you for your love and support throughout this journey. I felt your love and prayers while living in Chicago, and during the writing process. Thank you for all the phone calls, emails, writing breaks, coffees, hugs, encouraging words, and for your undying belief in me. I love you all.

Finally, I would like to thank my amazing husband Aaron. What an adventure this has been! Words cannot express the gratitude I have for your incredible support, patience, and love. This was my dream, and you walked, ran, and trudged through this journey with me. I love you to the moon and back.
Table of Contents

Chapter One: Introduction 1
Chapter Two: Literature Review 6
Chapter Three: Methods 21
Chapter Four: Results 29
Chapter Five: Discussion 39
References 55

Appendices

Appendix A: Definition of Terms 64
Appendix B: Informed Consent Form 65
Appendix C: Theoretical Synthesis 70
Appendix D: Initial Interest Email for Dance/Movement Therapists 80
Appendix E: Recruitment Email Script for Dance/Movement Therapists 81
Appendix F: First Follow-up Email Script for Dance/Movement Therapists 82
Appendix G: Second Follow-up Email Script for All Participants 83
Appendix H: ADTA: What is Dance/Movement Therapy Document 84
Appendix I: Recruitment Email Script for SPD Experts 86
Appendix J: First Follow-up Email Script for SPD Experts 87
Appendix K: Semi-structured Interview Questions 88
Appendix L: Personal Reflection Journal Entry Template 89
Appendix M: Table of Clusters and Frequencies 90
Appendix N: List of Mini-Theories 91
Appendix O: Electronic Thesis Agreement 92
Chapter One: Introduction

I have lived with SPD for the past 18 years. For the majority of this time I was confused about what I was doing, and why. The resulting physical and emotional distress from this disorder caused me to miss school, stay home from social functions, and live in deep isolation. During this time I was misdiagnosed, misunderstood, and did not get the help and support I needed. It took 13 years to find criteria that fit, and the help I needed. I strongly believe that help for this disorder needs to be more readily available.

Research Problem

My purpose for researching the SPD disorder has shifted from myself to others. Although I continue to deal with aspects of SPD in my own life, I am motivated to advocate for treatment of the disorder. There is a need for more awareness and available treatment methods for individuals with SPD. In response to this need, when solidifying what would be included in the DSM-5, feedback from individuals with SPD as well as SPD advocates was requested. Stein and Phillips (2013) stated, “the input of patients and patient advocates usefully highlighted and supported the clinical importance of adding these disorders to the nomenclature” (p.4). Although the classification of SPD within the DSM-5 in 2013 has begun to spur more interest, more awareness, research, and treatment for this disorder is needed. Definitions of terms used within this study are included in Appendix A.

Today, stigma persists and individuals with SPD continue to feel isolated and misunderstood. In regards to SPD, Limburg (2011) states, “some sufferers…have had the experience of disclosing their [SPD] to a therapist, only to find the problem dismissed, because the skin they display to the therapist really doesn’t look that bad” (p. 1). There needs to be a general awareness of SPD in order to help these individuals. Additionally, Nirmal, Shenoi, Rai,
Sreejayan, and Savitha (2012) state, “early institution of psychotherapeutic intervention is essential for the effective management of this condition” (p. 3).

**Theoretical Framework**

As a dance/movement therapist. My theoretical framework aligns with aspects of two of the DMT pioneers: Marian Chace and Trudi Schoop. I find Chace’s approach to be beneficial in creating an initial outline for each of the groups I lead. Her four core concepts (body action, symbolism, therapeutic movement relationships, group rhythmic activity) and organization of the DMT session (warm-up, theme development, closure) instill organization, structure, and reintegration for individuals within a DMT session (Levy, 2005; Sandel, Chaiklin & Lohn, 1993). Chace (1975) stated this clearly:

Since muscular activity expressing emotion is the substratum of dance, and since dance is a means of structuring and organizing such activity, it might be supposed that dance could be a potent means of communication for the reintegration of the seriously ill mental patient. (p. 71)

Additionally, I find Schoop’s approach as a nice compliment to Chace’s structure. Schoop’s emphasis on the value of humor within the therapeutic process resonates with my own personal approach in a DMT setting. To help individuals express their emotions, Schoop used “humor and her own body” (Levy, 2005, p. 64). Similarly, she “believed strongly in the healing aspects of humor, feeling that we all have much to laugh about, including the benefits of being able to laugh at ourselves” (Levy, 2005, p. 64). I find humor to be an effective way to genuinely connect with clients. Having a basic structure for each group, and emphasizing the importance of humor lends itself to a positive and effective DMT session.
In treating excoriation disorder. DMT can potentially contribute to the treatment of SPD because of its previous success with related disorders, further discussed in Chapter Two. Although DMT may be sufficient in itself to treat SPD, for the purposes of this research I have chosen to propose the integration of DMT with SFT to treat SPD. I believe that the utilization of both of these modalities will offer a more comprehensive therapeutic experience than DMT alone. Although DMT and SFT are similar in many ways, SFT provides language and direction to this therapeutic approach. I also believe that this therapeutic integration will help frame the individuals’ relationship with SPD in an alternative way than the current choice treatment methods. My hope is that the therapeutic integration of DMT and SFT will offer an additional therapeutic modality for individuals with SPD to try on.

As a researcher. My theoretical framework as a researcher is influenced by the aforementioned DMT pioneers, as well as by other forms of therapy that can be used to compliment DMT. This study suits my theoretical framework because it utilizes the combination of DMT and SFT. As I integrate the two therapeutic modalities of DMT and SFT I started to see how limitless the possibilities were in terms of DMT collaborative approaches. Participant III illuminated this, within the study, by saying, “DMT is really a method looking for a theory…there’s psychoanalytic DMT, there’s CBT DMT, etc…” This resonates with me, and encourages me as an emerging professional to always be searching for collaborative therapeutic approaches that could benefit the individuals with whom I work.

Solution-Focused Therapy

SFT, also referred to as Solution Focused Brief Therapy, was developed in the 1980s by Steve de Shazer, Insoo Kim Berg, and the Brief Family Center in Milwaukee (Bannink 2007; Iveson 2002). This therapeutic modality is a form of positive psychology that focuses on
solution building rather than problem solving, recognizing that although the cause of a problem may be complex, the solution does not need to be (See Definitions in Appendix C) (Bannink 2007). In regards to the basis of this therapeutic model, Bannink (2007) states:

[SFT] proposes: the development of a solution is not necessarily related to the problem; the client is the expert; if it is not broken, do not fix it; if something works, continue with it; if something does not work, do something else (p. 88).

SFT utilizes questions and compliments as interventions, and focuses on the goals of each individual. Therapists utilize the miracle question to help the client envision what life would be like without this problem, scaling questions to help the client measure and track their own experiences, exception-seeking questions to help the client find times when the problem was absent, and coping questions to help draw out coping skills the client possesses (Bannink 2007; Iveson 2002). Additionally, the therapist values empathy and the therapeutic relationship. Chapter Two and the Theoretical Synthesis document (See Appendix C) discuss many of these techniques in further detail.

For this research I chose to focus on a strengths based approach as opposed to a problem focused approach in order to contrast the current therapeutic modalities being used to treat SPD. As discussed in Chapter Two, currently primarily the behavioral therapy approaches are being used to treat individuals with SPD, which focus on problem solving. By introducing a therapeutic modality with a contrasting focus I hope to expand therapeutic modalities available for individuals with SPD.

**Purpose of the Research Study**

The purpose of my study was to understand how a positive psychology DMT approach would be a viable treatment method for individuals with SPD. In examining the thoughts and
ideas of mental health professionals, I was able to start answering this question. Consequently, the dialogue of using DMT and SFT as a therapeutic method to treat people who deal with SPD has begun! Currently there is no research in the area of DMT on SPD, and I would like to contribute to this literature. Furthermore, additional treatment methods are needed to help individuals with SPD, and I would like to discover how DMT would be a viable option. By contributing to the literature, and exploring ways DMT would be a viable treatment method, I hope to give individuals with SPD more therapeutic possibilities, as well as lay the groundwork for future research.
Chapter Two: Literature Review

SPD is a pervasive, yet widely misunderstood disorder (Bohne, Keuthen & Wilhelm, 2005; Limburg, 2011). This chronic disorder fluctuates in intensity over time, and is characterized by repeated and recurrent picking of the skin, with resulting noticeable tissue damage and distress (Arnold, Auchenbach & McElroy, 2001; Grant, Stein, Woods & Keuthen, 2012; Stein, et al., 2010). The guilt, confusion, diminished quality of life, and shame individuals with SPD experience is, in part, due to the general lack of awareness for this disorder (Arnold, et al., 2001; Bohne, et al., 2005; Grant, et al., 2012; Keuthen, et al., 2001; Odlaug, Kim, & Grant, 2010). There is a great need for more research and therapeutic interventions available for individuals with SPD. These avenues could also promote/increase general awareness of this disorder, which is crucial in helping individuals find appropriate treatment modalities (Odlaug & Grant, 2008). Bohne, et al. (2005) states, “public awareness of these common and debilitating disorders should be increased so that sufferers can be correctly diagnosed …, less stigmatized …, and encouraged to seek treatment for their problem” (p. 231). The more mental health care providers are made aware of SPD through literature, the more likely an individual with SPD will receive the therapeutic treatment they need.

Currently, behavioral therapy approaches are the therapeutic methods with the highest success rate for SPD (Deckersbach, Wilhelm, Keuthen, Baer, & Jenike, 2002; Deckersbach, Wilhelm, & Keuthen, 2003; Flessner, Busch, Heidman, & Woods, 2008; Grant, et al., 2012; Schuck, Keijzers, & Rinck, 2011; Teng, Woods, & Twohig, 2006; Twohig, Hayes, & Masuda, 2006; Woods, 2002). Although there is merit in these approaches, more variety of treatments needs to be researched and become accessible for individuals with this disorder. Odlaug, et al. (2010) stated that in regards to SPD, “treatment options are still limited” (p. 296).
DMT may be a viable therapeutic method for individuals with SPD because of its success with related disorders, such as anxiety, depression, OCD, and BDD (Dempsey, 2009; Erwin-Grabner, Goodill, Hill, & Von Neida, 1999; Jeong, Hong, Soo Lee, & Park, 2005; Koch, Morlinghaus, & Fuchs, 2007; Schmoll, 2010; Trivedi & Gupta, 1986). After examining the effectiveness of DMT in different samples, Ritter and Low (1996) asserted that DMT is an effective therapeutic intervention for people dealing with a wide spectrum of symptoms. As mentioned above, although DMT was seen as successful as a sole treatment, the integration of SFT helps provide language and direction to the therapeutic approach.

Currently, no literature exists on the effects of DMT on SPD. Based on the literature found, this review will primarily focus on DMT and SPD as separate entities. Although this dichotomy will be evident, these two entities can be linked through literature on the possible etiologies of SPD. This is possible, because there is research on these etiologies and the effects of DMT. This literature review will define SPD, explore its possible etiologies, as well as discuss the current treatment modalities for SPD. Chapter Two will also link DMT’s effectiveness with SPD’s possible etiologies in order to introduce DMT as an effective therapeutic method for individuals with SPD. Finally, through existing literature, this review will propose the collaboration of DMT and SFT.

**Excoriation Disorder**

Although the earliest reports of severe skin picking go back as far as 1875, much of what is known about SPD has been recently researched and published (Grant, et al., 2012; Keuthen, Koran, Aboujaoude, Large, & Serpe, 2010; Odlaug, et al., 2010). This delay in research and literature could be partially attributed to the fact that SPD only recently became an official diagnosis in May 2013. The recognition of SPD as an official disorder is an event that has been
much anticipated by many individuals who deal with SPD, as well as individuals within the mental health and research community who have been actively advocating for this disorder (American Psychiatric Association, 2013; Stein & Phillips, 2013; Trichotillomania Learning Center, 2014).

SPD is a disorder listed in the Obsessive-Compulsive and Related Disorders section of the DSM-5. The diagnostic criteria for this disorder are: recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop picking, skin picking causes clinically significant distress or impairment in important areas of functioning, and is not due to physiological effects of a substance, medical condition, or symptoms of a mental disorder (American Psychiatric Association, 2013).

Although SPD is listed in the DSM-5 under the heading of Obsessive-Compulsive and Related Disorders, there is debate that it would be a better fit if included under the overarching heading of body-focused repetitive behaviors (BFRB) with disorders such as trichotillomania, and compulsive nail biting. McGuire, et al. (2012) term BFRBs “an umbrella term for debilitating, repetitive behaviors that target one or more body regions” (p. 855). (Grant, et al., 2012; Teng, Woods, Marcks, & Twohig, 2004).

Although the DSM-5 terms this disorder SPD, many other terms exist. SPD has also been referred to as pathological skin picking (Grant, Odlaug & Chamberlain, 2012; Odlaug & Grant, 2007; Odlaug & Grant, 2010), dermatillomania (Keuthen, et al., 2001; Limburg, 2011; Schuck, Keijsers, & Rinck, 2012), compulsive skin picking (Keuthen, et al., 2001; Odlaug & Grant, 2007; Odlaug & Grant, 2008), neurotic excoriation (Bohne, Wilhelm, Keuthen, Baer, & Jenike, 2002; Grant, Odlaug & Chamberlain, 2012; Keuthen, et al., 2000), psychogenic excoriation (Arnold, et al., 2001; Bohne, et al., 2002; Stein, et al., 2010; ), a BFRB (Hajcak, Franklin,
Simons, & Keuthen, 2006; Hayes, Storch, & Berlanga, 2009; Lochner & Stein, 2010), an impulse control disorder (Grant, Mancebo, Pinto, Eisen, & Rasmussen, 2006; Grant, Odlaug & Chamberlain, 2012; Hayes, et al., 2009), and a pathologic grooming disorder (Chamberlain, & Fineberg, 2006; Grant & Christenson, 2007; Keuthen, et al, 2010; Stein, ). For this study the term SPD has been chosen, in accordance with the DSM-5.

As mentioned previously, individuals with SPD are preoccupied with, and repeatedly pick at their skin. This picking results in tissue damage, tension, and distress from these episodes (Bohne, et al., 2002; Grant, Odlaug & Chamberlain, 2012; Grant, et al., 2012; Odlaug, et al., 2010; Stein, et al., 2010; Wilhelm, et al., 1999). Individuals with SPD spend a significant amount of time picking their skin each day, which affects their functioning and can lead to serious medical complications (Odlaug, et al., 2008). There is also a feeling of relief, or gratification during or immediately following an individual’s skin picking session (Stein, et al., 2010). Furthermore, Grant, et al. (2012) states that individuals with SPD either engage in focused picking, where they have full awareness of the skin picking, or automatic picking, where they have little awareness of the skin picking. Although skin picking to a degree is common, it becomes a disorder when the action and distress disrupts everyday life. Keuthen, et al.’s (2000) study differentiated people who engage in skin picking and people with SPD, and found that there was a major difference between the two subject groups in the “duration, focus, and extent of picking, techniques used, reasons for picking, associated emotions, and picking sequelae” (p. 210). Generally, individuals with SPD engage in longer, more focused, and emotionally intertwined picking sessions.

According to the literature, between 1.4 and 5.4 percent of the general population have SPD (Bohne, et al., 2002; Grant, et al., 2012; Prochwicz, Kaluzna-Wielobob, & Starowicz-Filip,
disorder is prevalent cross-culturally. Research also states that SPD is more common in the female population (Grant, et al., 2012). Possible reasons for this gender difference could be that females are more likely to request help for SPD, or skin tissue damage is less important to males (Arnold, et al., 2001; Grant & Christenson, 2007; Hayes, et al., 2009; Stein, et al., 2010). In their article, Grant and Christenson (2007) stated that men and women who have SPD exhibit few clinical differences, with men more likely to have a co-existing anxiety disorder.

There is no concrete age of onset for this disorder, and it can consequently begin at any time in an individual’s life (Grant, et al., 2012). Additionally, Grant, et al. (2012) stated that there are no significant clinical differences in individuals with SPD based on age of onset. One difference is that the earlier the age of onset, the more likely the individual is to engage in focused picking (Odlaug & Grant, 2007). SPD commonly begins during adolescence, starting with the picking of acne (Grant, et al., 2012). This disorder can also start with the picking of scabs, infected areas, mosquito bites, scars, or even healthy skin (Grant, et al., 2012; Wilhelm, et al, 1999). Although any skin surface area can be the primary target for individuals with SPD, the most common sites are the face and upper body (Bohne, et al., 2005; Grant, et al., 2012; Hayes, et al., 2009; Odlaug, et al., 2008; Odlaug, et al., 2010).

**Possible Etiologies of Excoriation Disorder**

The causes of SPD can vary between individuals, and there is currently no consensus on its origin or etiology (Grant, et al., 2012; Hayes, et al., 2009; Odlaug, et al., 2010; Teng, et al., 2004). Literature suggests SPD could be due to, or be comorbid with: eating disorders, alcohol use, attention deficit disorder, bipolar disorder, obsessive compulsive disorder (OCD), anxiety disorder, body dysmorphic disorder (BDD), depression, biological factors, or an inability to self-
regulate (Deckersbach, et al., 2003; Grant, et al., 2012; Hayes, et al., 2009; Odlaug, et al., 2010; Wilhelm, et al., 1999). For the purpose of this literature review, OCD, anxiety disorder, BDD, depression, and an inability to self-regulate will be discussed as possible etiologies of SPD.

**Obsessive-compulsive disorder and anxiety.** OCD is defined as “an anxiety disorder characterized by recurrent obsessions, compulsions, or both that are time consuming... cause significant distress, or interfere with the individual’s functioning...” (American Psychological Association, 2009, p. 335). Literature suggests that OCD and anxiety are the most probable causes of SPD (Grant, et al., 2006; Hajcak, et al., 2006; Wilhelm, et al., 1999). Significantly higher levels of anxiety, stress, and worry were present in individuals with SPD compared to the general population (Cullen, et al., 2001; Hajcak, et al., 2006). Skin picking may function as a stress reducing behavior, therefore creating an anxiety and distress reducing cycle that is prevalent in OCD (Grant, et al., 2006). According to the research, the likelihood that SPD will be diagnosed in an individual is increased if the individual currently has OCD (Cullen, et al., 2001; Grant, et al., 2005; Grant, Mancebo, Eisen, & Rasmussen, 2010; Hajcak, et al., 2006; Lochner & Stein; 2010). Furthermore, Grant, et al. (2010) proposed that if individuals with co-occurring SPD and OCD are left untreated for their SPD, their obsessive-compulsive behaviors would become more severe. Although OCD does not occur exclusively in individuals with SPD, there is an obvious relationship between these two disorders (Cullen, et al., 2001; Odlaug, et al., 2010).

**Body Dysmorphic Disorder.** Literature suggests that SPD and BDD are highly comorbid (Grant et al., 2006, Phillips & Taub, 1995). BDD is defined as “a somatoform disorder characterized by excessive preoccupation with an imagined defect in physical appearance or markedly excessive concern with a slight physical anomaly” (American Psychological Association, 2009, p. 61). It is clear that BDD may cause SPD, as individuals with SPD often
pick to remove a slight imperfection in their appearance (Grant, et al., 2006; Grant, et al., 2012; Odlaug, et al., 2010; Phillips & Taub, 1995). Although individuals with BDD can be preoccupied with imagined defects on any part of their body, people with SPD focus on their skin.

**Depression.** Depression is defined as “a fluctuation in normal mood ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency” (American Psychological Association, 2009, p. 134). Literature suggests that depression has a strong association with SPD (Cullen, et al., 2001; Teng, et al., 2004). Although increased levels of depression seem to be prevalent in individuals with SPD, it is unclear if depression causes SPD or if SPD causes depression (Teng, et al., 2004). The sadness associated with depression could lead an individual to pick their skin, or the resulting distress caused by skin picking could lead an individual to depression.

**Inability to self-regulate.** Self-regulation is defined as “the control of one’s own behavior through the use of self monitoring…, self-evaluation…, and self-reinforcement” (American Psychological Association, 2009, p. 457). Siegel (1999) furthered this thought by suggesting that self-regulation is when individuals are able to manage their emotions, and thus develop the self. Siegel stated, “many psychiatric disturbances involve affect dysregulation; … mood disorders (such as depression and bipolar illness) …anxiety disorders (including panic disorder, phobias, obsessive-compulsive disorder…)…” (p. 243). Consequently, the literature suggests that SPD behaviors occurs when an individual is dysregulated and, therefore, attempts to regulate their emotions through the picking of their skin (Odlaug, et al., 2010; Siegel, 1999; Teng, et al., 2004; Wilhelm, et al., 1999).
Current Treatment Methods for SPD

The current treatments for SPD are various behavioral therapy approaches and pharmacological treatments. In clinical settings these two treatments are often combined (Deckersbach, et al., 2002; Deckersbach, et al., 2003; Grant, et al., 2012; Schuck, et al., 2011). For the purpose of this literature review some of the behavioral approaches will be discussed.

Behavioral therapy approaches.

Habit reversal. Habit reversal (HR) is defined as “a technique of behavior therapy in which the client must learn a new correct response to a stimulus and stop responding to a previously learned cue” (American Psychological Association, 2009, p. 219). According to the literature, HR reduced skin picking for individuals with SPD (Arnold, et al., 2001; Deckersbach, et al., 2002; Deckersbach, et al., 2003; Teng, et al., 2006). Teng, et al. (2006) found that individuals with SPD who are treated with HR have reduced symptoms immediately post treatment as well as at a three-month follow up. Furthermore, literature suggests that participants with SPD who are involved in an HR intervention found it to be an effective form of therapy (Deckersbach, et al., 2002; Grant, et al., 2012; Teng, et al., 2006).

Cognitive-behavior therapy. Cognitive-behavior therapy (CBT) is currently the most common behavior therapy approach for SPD and other BFRBs (Grant, et al., 2012). The American Psychological Association (2009) defines CBT as:

A form of psychotherapy that integrates theories of cognition and learning with treatment techniques derived from cognitive therapy and behavior therapy. CBT assumes that cognitive, emotional, and behavioral variables are functionally interrelated. Treatment is aimed at identifying and modifying the client’s maladaptive thought processes and problematic behaviors through cognitive restructuring and behavioral techniques to
achieve change. (p. 89)

Literature suggests that CBT is an effective method in treating SPD and, as mentioned previously, is often coupled with HR to increase its effectiveness (Deckersbach, et al., 2002; Deckersbach, et al., 2003; Grant, et al., 2012; Schuck, et al., 2011). Schuck, et al. (2011) found that even a brief form of CBT was highly effective in decreasing an individual with SPD’s urge to pick their skin.

Acceptance and commitment therapy. Acceptance and Commitment Therapy (ACT) is defined by the American Psychological Association as:

A form of CBT based on the premise that ineffective strategies to control thoughts and feelings actually lead to problem behaviors. It helps clients abandon these ineffective control strategies and instead willingly experience difficult thoughts and feelings as a necessary part of a worthy life. Clients then clarify their personal values and life goals, and learn to make life-enhancing behavioral changes accordingly. (p. 4)

Current literature has shown ACT to be an effective treatment in treating other BFRBs, and therefore researchers believe it to be an effective treatment for SPD (Hayes, et al., 2009; Twohig, et al., 2006). In response to their research on ACT and female college students who chronically pick their skin, Hayes, et al. (2009) stated that ACT “shows considerable promise as a treatment approach” (p. 318).

Acceptance-enhanced behavior therapy. Acceptance-Enhanced Behavior Therapy (AEBT) is a CBT approach that combines psychoeducation, HR and ACT (Grant, et al., 2012; Flessner, et al., 2008). Research suggests that AEBT would be especially beneficial in individuals with SPD who primarily pick automatically, because this treatment was specifically designed to target “experientially avoidant processes” (Flessner, et al., 2008, p. 582; Grant, et al.,
Therefore, AEBT is most effective in treating SPD individuals who pick at their skin with little awareness.

*Comprehensive model for behavioral treatment of Trichotillomania.* The Comprehensive model for behavioral treatment of Trichotillomania (ComB) is a CBT approach to help manage BFRB disorders. In this approach the therapist helps the patient learn to increase awareness of his/her repetitive behavior and then teach them how to respond differently to external and internal cues that trigger pulling or picking. Additionally, clients learn alternative ways to address sensory, affective, and cognitive triggers. This model includes the categories of sensory, cognitive, affective, motor, and place/environment (Mansueto, Goldinger Golomb, McCombs Thomas, & Townsley Stemberger, 1999). In regards to ComB’s success with Trichotillomania, Mansueto et al. (1999) states the following:

[This model] attends to the diverse and idiosyncratic nature of factors that encourage and maintain hair pulling and related this information to the modalities of human experience…it provides a conceptual bridge to various behavioral interventions and suggests a broad array of therapeutic strategies geared to the individual characteristics of each case of hair pulling. (p. 20)

*BFRB Precision medicine initiative.* BFRB Precision medicine initiative (BPM) is a new research initiative that was launched in April 2014 (Trichotillomania Learning Center’s Board of Directors, 2014, p. 1). The research process for this potential treatment follows three steps. These steps are, identifying phenotypes, analyzing neurobiology and identifying treatments. The primary focus on steps one and two are the possible biological components of the BFRBs. The third step of identifying treatments is focused on both therapeutic and pharmacological. In regards to therapeutic treatment, the intent is to “personalize to the
individual [and] aim to optimize existing behavioral therapy interventions…” (Trichotillomania Learning Center’s Board of Directors, 2014, p. 1). The goal of this broad initiative is to increase remission rates for individuals with BFRBs from the current 10-20 percent to 70 percent (Trichotillomania Learning Center’s Board of Directors, 2014).

### DMT as a Treatment Method

Researchers agree that more therapeutic interventions for SPD need to be researched (Bohne, et al., 2002; Bohne, et al., 2005; Deckersbach, et al., 2003; Flessner, et al., 2008; Grant & Christenson, 2007; Keuthen, et al., 2010; Limburg, 2011; Odlaug & Grant, 2007; Odlaug, et al., 2010; Twohig, et al., 2006; Woods, 2002). Based on the effectiveness of DMT with related disorders, the literature suggests that DMT would be a viable treatment method. Research on DMT has shown favorable outcomes for reducing anxiety (Dempsey, 2009; Erwin-Grabner, et al., 1999; Jeong, et al., 2005; Koch, et al., 2007; Low & Ritter, 1996), depression (Jeong, et al., 2005; Koch, et al., 2007; Low & Ritter, 1996; Schmoll, 2010), OCD symptoms (Jeong, et al., 2005), BDD (Schmoll, 2010), and has increased individual’s self-awareness (Erwin-Grabner, et al., 1999). In these studies DMT was successful because it allowed individuals to move their anxiety instead of solely verbalizing it, it was relaxing for individuals with depression, and created a body reconnection with BDD participants (Dempsey, 2009; Erwin-Grabner, et al., 1999; Jeong, et al., 2005; Koch, et al., 2007; Schmoll, 2011). Low & Ritter (1996) found that, after as little as one hour of DMT, inpatient psychiatric patients demonstrated significantly decreased levels of anxiety and depression.

Trichotillomania is a BFRB disorder related to SPD. In the same way individuals with SPD compulsively pick their skin, individuals with trichotillomania compulsively pull out their hair (Odlaug, Kim & Grant, 2010; Trivedi & Gupta, 1986). There is currently more literature on
trichotillomania than SPD because it was already a recognized disorder in the DSM-IV-TR (American Psychiatric Association, 2000). For this reason, selected literature on this related disorder was researched within this study. Additionally, various literatures on music therapy were researched because of its similarities to dance/movement therapy. Both are under the umbrella of Creative Arts Therapies; one utilizes music as therapeutic interventions and the other uses movement and dance (Trivedi & Gupta, 1986). Trivedi and Gupta (1986) conducted a case study on an individual with trichotillomania, using music therapy as the creative arts therapy intervention. In this study the use of music therapy, along with supplementary interventions, led to a full recovery of trichotillomania (Trivedi & Gupta, 1986). This case study is important in bridging the gap between SPD and DMT because of the similarities between the disorders and therapeutic interventions.

Dance/movement therapy and solution focused therapy. The complementary nature of SFT toward other therapeutic approaches makes it a prime choice to integrate with DMT to enrich the therapeutic experience (Iveson, 2002). Ylonen and Cantell (2009) stated, “we, as dance/movement psychotherapy researchers think that it is fruitful to deepen our understanding of DMT in an open way by searching different points of view from several theories (p. 216).”

The similarities between the therapeutic methods of DMT and SFT make them compatible. The literature on DMT, SFT and related psychotherapies, such as art therapy, has been reviewed to articulate these similarities. Both forms of treatment report lasting effects in time-limited situations for a vast array of populations (Anderson-Klontz, Dayton & Anderson-Klontz, 1999; Bannink, 2007; Johnson & Miller, 1994; Ritter & Low, 1996; Nims, 2007; Taylor, 2009).

The structure of DMT and SFT are both collaborative in nature, emphasizing the client as
the expert (Anderson-Klontz, et al., 1999; Bannink, 2007; Matto, Corcoran, & Fassler, 2003; Nims, 2007; Sandel, Chaiklin, & Lohn, 1993; Tyson & Baffour, 2004; Ylonen & Cantell, 2009). In response to the integration of SFT and art therapy, Tyson and Baffour (2004) stated, “…clients bring to the therapeutic process a rich supply of ‘strengths’ that can be used to help facilitate positive change…” (p. 213). Furthermore, the use of empathy within this relationship is central to both DMT and SFT (Matto, et al., 2003; Riley & Malchiodi, 2003).

The use of imagery is shared by both DMT and SFT (Anderson-Klontz, et al., 1999; Matto, et al., 2003; Nims, 2007; Ylonen & Cantell, 2009). Anderson-Klontz, et al. (1999) discussed the benefits of imagery through the integration of SFT and psychodrama. They stated that imagery “enables clients to build a bridge from the hypothetical frame to their present situation” (p. 115). Through specific techniques, DMT and SFT offer clients a space to reflect on their past and future life narratives. In SFT the miracle question allows a client to positively reinvent his/her future (Anderson-Klontz, et al., 1999; Bannink, 2007), and DMT offers an opportunity to embody past and future life narratives (Ylonen & Cantell, 2009). In regards to DMT specifically, Ylonen and Cantell (2009) state, “DMT can offer a space for a symbolic world where the participants can re-story their identity by shaping kinesthetic narratives” (p. 224).

With the compatibility of DMT and SFT, some conclusions can begin to be made in treating an individual with SPD. The combination of SFT and creative arts therapy treatment methods can provide a multisensory engagement that deepens the experience for clients (Anderson-Klontz, et al., 1999; Matto, et al., 2003; Riley & Malchiodi, 2003). In regards to the integration of SFT and art therapy, Riley and Malchiodi (2003) stated that, “therapeutic change is expedited through both specific interventions and creative expression” (p. 82). In addition, Riley
and Malchiodi mentioned the importance of the body and moving through the solution, stating, “the physical action of the art activity also reinforces investment in the decision-making process and stimulates thinking through possible solutions” (p. 84).

The combination of DMT and SFT will also allow the client to reframe his/her experience with SPD. Referring to the combination of art therapy and SFT, Matto, et al. (2003) stated that through the experience of reframing, clients are “introduced to a novel way of viewing some aspect of themselves, their problem, or situation. A new perspective on the problem can generate new actions in accordance with this frame of reference” (p. 270). In the same way, individuals with SPD will be able to reframe their relationship with SPD and find different ways to deal with their various underlying etiologies.

The integration of the creative arts therapies and SFT focuses on the solution rather than the problem. Riley and Malchiodi (2003) reiterated what de Shazer stated, in saying that “everyone has the ‘keys’ to unlock the doors that will stimulate positive change; the therapist’s task is to help the client find the right keys, rather than understand why the lock won’t open” (p. 83). Based on supporting literature, there is reason to believe that the right key for positive change for certain individuals with SPD may be the integration of DMT and SFT.

**Conclusion**

Based on the literature, many questions arise regarding the implementation of this DMT and SFT program for individuals with SPD. The goal of this study is to stimulate future research where this therapeutic modality is implemented on participants with SPD. Some questions that arise in preparation for future research are: What specific DMT and SFT interventions would be most effective for individuals with SPD? How many DMT and SFT sessions (individual, group, or both) would be ideal for individuals with SPD? What type of results would be yielded from
studying this therapeutic modality on participants with SPD?

Once a group of individuals with SPD has been formulated for a research study, the principal researcher would begin to answer these questions by utilizing interventions that have been highlighted in the SFT and DMT section of this literature review. Specifically, starting with creating interventions that explore imagery and the miracle question. By tracking the results over time, and adapting interventions to the group, these questions could begin to be answered.

SPD is clearly a problem that needs to be researched, destigmatized, and treated. The purpose of my study was to see how a DMT and SFT therapeutic approach would be a viable treatment for individuals with SPD. In this literature review, SPD was defined, possible etiologies of SPD were explored, DMT’s effectiveness with these possible etiologies was discussed, and the possible therapeutic method of DMT and SFT to treat SPD was introduced. Through the data collected from professionals in the field of both DMT and SPD, the current literature will be extended.
Chapter Three: Methods

Methodology

A collective case study methodology was utilized for this qualitative research study. The principal researcher chose to use this methodology in order to focus on the issue of how a DMT and SFT therapeutic approach would be a viable treatment method for SPD. By interviewing professionals who were knowledgeable in varying aspects of the research, the principal researcher was able to understand multiple angles of the issue being researched. These angles aided the researcher in understanding the issue more comprehensively.

True to the nature of a collective case study, multiple cases were used to illustrate the one issue the research is addressing (Creswell, 2007). By drawing upon the professional views of each participant, the principal researcher was able to begin to answer the research question: How is a positive psychology based DMT approach a viable treatment method for SPD? Furthermore, this methodology allowed the researcher to illuminate the participants’ “different perspectives on the issue” (Creswell, 2007, p.74). As mentioned above, acquiring these varying perspectives on the research question was imperative to the purpose of the study—acting as a catalyst for further research. The views of the participants within this study will inform future research on this issue, and will consequently determine the type of information available for professionals and individuals with SPD. Therefore, resourcing the views of these mental health professionals will help with the greater purpose of advocating for individuals with SPD and “give voice to the powerless and voiceless” (Tellis, 1997, p. 1).

Participants

According to Mertens (2005), case study research can consist of one or multiple cases. The principal researcher chose to do the former, and therefore recruited a small sample size of
ten participants for this single case. This size was found to be sufficient in staying true to the intent of the research, to lay the groundwork for further research. Future research in DMT, SFT, and SPD might use a larger sample size.

Participant recruitment for this research study was a lengthy and difficult process. Although many emails were sent out, it was a struggle to secure the 10-14 participants needed for this study. After six months of active recruitment attempts, ten individuals gave their consent to participate in this study. Five of these participants were dance/movement therapists who all had obtained their BC-DMT credentials, and also have experience with individuals in a private practice setting. The principal researcher chose to narrow in on dance/movement therapists who had experience with private practice, because it increased the likelihood of them having worked with individuals who had SPD or similar disorders.

The remaining five participants were professional members of the Trichotillomania Learning Center (TLC). These individuals have obtained their MA or PhD in their chosen mental health field, and identify themselves as mental health providers familiar with trichotillomania, SPD and other BFRBs (Trichotillomania Learning Center, 2014).

In this study, two participants were male, and eight participants were female. Participants were chosen based on profession and not based on any other demographics. All of these individuals reside in North America, and were recruited via email.

**Procedure**

For this study the procedure was separated into two sections. First, the principal investigator researched and created a theoretical synthesis document combining DMT and SFT. Second, this document was utilized to recruit participants and construct the semi-structured
interview questions. Following each individual interview, the principal researcher used a journal to record her personal feedback from the interview.

Data was collected for this study from one-on-one participant interviews and researcher journal entries. The interviews were conducted via Skype calls to each of the offices or homes of the participants, in accordance with their preferences. The principal researcher called each individual participant from a secure location in her residence in Winnipeg, Manitoba, Canada.

The informed consent form was emailed to each participant in the initial recruitment email. In this email, it was indicated that this form needed to be signed prior to participating in this study. Each participant acknowledged and signed the written informed consent form (See Appendix B). Participants emailed or faxed the signed forms back to the principal investigator, and were encouraged to keep a copy for their records.

Theoretical synthesis. In preparing for participant recruitment the similarities between DMT and SFT were researched. The principal researcher found journal articles on SFT and various creative art therapies. The similarities between these therapeutic modalities were highlighted and this information was used to discuss how these two forms of therapy were compatible, and (drawing on these compatibilities as well as previously researched articles on SPD) how they might be used together as a treatment modality for SPD. These findings were written in a document in essay format (See Appendix C as well as Chapter Two). The participants were asked to become familiar with this theoretical synthesis prior to their scheduled interview.

Participant recruitment. The principal researcher started the recruitment process for this study by visiting the American Dance Therapy Association (ADTA) and the Trichotillomania Learning Center (TLC) websites. Utilizing memberships to both of these
organizations allowed her to gather contact information for potential dance/movement therapists with BC-DMT credentials, and professional members of TLC.

**Dance/movement therapist participants.** To recruit dance/movement therapist participants for this study, the principal researcher went to the member directory in the member’s-only section of the ADTA website. In the advanced search function, dance/movement therapists with BC-DMT credentials who do private practice work were selected. It was chosen to narrow the search to dance/movement therapists who do private practice work in hopes that this type of therapeutic setting would yield a higher likelihood of coming across individuals with SPD or similar disorders. The principal investigator thought these professionals would see individuals with SPD more readily because of the prevalence of individuals with related disorders (anxiety, depression, OCD, BDD) that seek out private practices. From this list on the ADTA website, an initial interest email was sent out to a number of dance/movement therapists. In this email the principal researcher explained her research, outlined the criteria for SPD, and asked if there was any interest in participating in this study (See Appendix D). When interest was evident, an invitation to participate in this study was emailed (See Appendix E), with the theoretical synthesis and informed consent form attached. When an individual responded via email in favor of participating in this study, a thirty-minute phone or Skype interview was scheduled. If a response to this initial email was not received within a two-week period of time, a follow-up email was sent (See Appendix F), and a third and final follow-up email was sent if no response was given another two weeks later (See Appendix G). This email cycle was continued until there were five dance/movement therapist participants.

**Professional members of TLC.** The principal researcher visited the TLC website to find potential professional members of TLC participants for this study. Initially, the TLC program
coordinator was emailed for participant recommendations, which provided some names and contact information. Further contact information for various professional members of TLC was found from the Find a Treatment Provider tab. These potential participants were emailed, with the attachments of: a document from the ADTA explaining more about DMT (See Appendix H), the theoretical synthesis (See Appendix C), and the informed consent form (See Appendix B). Similarly to recruiting dance/movement therapist participants, an initial invitation email was sent (See Appendix I), follow-up email after two weeks (See Appendix J), and a final follow-up email after an additional two weeks (See Appendix G). When the principal researcher did receive a positive response, a thirty-minute phone or Skype interview was scheduled. Various individuals found on the TLC website were emailed until there were five professional members of TLC participants.

**Tools.** The tools used in this study to collect data were one-on-one participant interviews and a researcher journal. Each interview was scheduled at a convenient time for the participant, approximately thirty minutes in duration. The researcher journal was completed immediately following each participant interview.

**Participant interviews.** The theoretical synthesis was used as a base to formulate questions for the semi-structured interview (See Appendix K). The questions within the interview aimed to uncover the participants’ feedback on the synthesized material, and to provoke them through dialogue, to address their opinion on the issue of how a positive psychology based DMT approach would be a viable treatment method for SPD. Utilizing a semi-structured interview for this study gave opportunities for the participants to ask questions, and for new questions to be formulated. For each scheduled interview: the participant was called via Skype, given a brief refresher on the study, and then asked the interview questions. The
interviews were recorded using the principal researcher’s smart phone. Each recording was given a pseudo name to identify the participant, emailed to a secure email address, and transcribed by the principal researcher at a later date.

**Researcher journal.** As mentioned previously, the principal researcher also kept a journal of her personal reflections immediately following each interview. In this journal the principal researcher reflected on her thoughts about the information from the interview in the form of written word. Observations, thoughts, ideas, emotions, and feelings that surfaced in response to each individual interview were documented (See Appendix L). This journal was meant to help keep biases in check, as well as further synthesize information on DMT, SFT, and SPD.

**Data Analysis**

The data from this study was analyzed qualitatively through sequential analysis. This seven-step data analysis method developed by Mark Chesler in 1987 was used to analyze the data from both the participant interviews as well as the researcher journal entries (Curry & Wells, 2006; Miles & Huberman, 1994). The steps for this method were to: underline key terms within the data, restate key phrases, reduce phrases and create clusters, reduce clusters and attach labels, generalize about clusters, generate a mini-theory, and finally integrate theory into an explanatory framework (Curry & Wells, 2006).

**Step one: underlining key terms.** For step one, the principal researcher went through the data and highlighted information that was found to be most valuable to this research study. This was primarily information that answered the research question or subsequent interview questions. Any additional information from the participants that stood out was also highlighted.
Step two: restate key phrases. Once the information most important to this study was identified, the principal researcher went through the transcribed interview data and re-typed the highlighted information in a more concise way. There was an attempt to “remain as descriptive and literal as possible,” while carrying out this step (Miles & Huberman, 1994, p.87). Identifying each participant with a number, each interview was reviewed separately. This was done so that the source of the information would be easily located when writing about the research.

Step three: reduce the phrases and create clusters. This step was broken down into two smaller steps, similarly to Chesler’s process. Chesler reported “this step was done several times, as different clustering patterns were tried” (Miles & Huberman, 1994, p. 87). First, the principal researcher went through all of the transcribed interviews and located common themes. Using a different colored highlighter to represent each emerging theme, all of the same colored statements were merged together. With this information, a cluster title was created for each theme section. Secondly, the phrases under each cluster were reduced, making them more concise.

Step four: reduce the clusters and attach labels. To carry out step four, all of the clusters that were formed in step three were looked at through the lens of the research question. These cluster titles were listed, numbered, and the frequency of how many times they were noted in the data was documented (See Appendix M). Notating the frequency of each individual cluster gave the researcher an idea of how prevalent each individual theme was within the data.

Step five: generalize about the clusters. To organize this step effectively, a table was created which indicated the cluster name on one side, and item generalizations about each cluster on the other. The principal researcher continued to use numbers to differentiate each cluster, and
additionally used alphabets to differentiate each subsequent cluster item generalizations (i.e. 1A, 1B, 1C). This helped in breaking down the main themes for each cluster.

**Step six: generating mini-theories.** In step six each cluster was examined separately to generate mini-theories, “memo writing that poses explanations” (Miles & Huberman, 1994, p. 88). By focusing on each cluster and subsequent item generalizations, it was possible to sum up the main point of each item and pose explanations. This step resulted in ten items that were used for step seven and the results of this study (See Appendix N).

**Step seven: integrate theory into explanatory framework.** This step was used to integrate “theories in an explanatory framework” (Miles & Huberman, 1994, p. 88).” Drawing from the information in the clusters and mini-theories, themes were uncovered. These themes are further reported in the Results section.
Chapter Four: Results

For this thesis research I set out to see how a combination of DMT and SFT could be a viable therapeutic method for individuals with SPD. My research question was; How is a positive psychology based DMT approach a viable treatment method for SPD? More specifically, how can DMT integrated with the positive psychology method of SFT be viable in treating individuals with SPD? During the interviews I asked the participants semi-structured questions that guided the interview (See Appendix K). These questions were answered during the research process.

With two very different participant groups, and the semi-structured style of the interview, I was expecting to have varying views and points discussed. Although this did occur, common views on how DMT and SFT could be a viable therapeutic method to treat SPD emerged while conducting these participant interviews. During these interviews the participants discussed their thoughts on how this therapeutic modality was potentially viable by recognizing the compatibilities present. These compatibilities are; DMT and SFT are complimentary therapeutic modalities, there is a shared body based component within the disorder and proposed treatment method, individuals with SPD may have an innate somatic component that may respond well to DMT and SFT, and the movement component of the proposed treatment modality may help to reshape an individual’s relationship with SPD.

Additionally, from the semi-structured research questions, participants saw this therapeutic modality as long term, incorporating both individual and group sessions, and primarily as an adjunct therapy. Other data that came forward with this research study included: the differing etiologies of SPD, therapist characteristics that would be beneficial for individuals
with SPD, as well as the importance of educating individuals on this therapeutic modality and disorder.

**How is this Therapeutic Modality Potentially Viable?**

**Therapeutic modalities are compatible.** Participants viewed DMT and SFT as compatible therapeutic approaches. As first highlighted in the theoretical synthesis document emailed to the participants (See Appendix C), and mentioned in Chapter One, DMT and SFT are complementary therapeutic modalities. In this document I discussed the various similarities between DMT and SFT. I also highlighted the research on the effectiveness of SFT and other creative arts therapies (Anderson-Klontz, et al., 1999; Matto, et al., 2003; Riley & Malchiodi, 2003). These studies support the rationale that DMT and SFT would collaborate well together because of its success with similar therapeutic modalities. Participant VII remarked, “you can mix DMT and SFT the same as you do art therapy and SFT.”

In regards to these similarities, Participant VI said, “we are always, as dance/movement therapists, looking at ‘how do we recognize somebody’s movement potential?’” By that very nature we are strengths based, because we are looking at potential not deficits.” Similarly, in regards to this collaborative approach being strengths based, Participant VII stated, “DMT has the potential towards moving to the positive. That doesn’t mean we don’t experience our full range of emotions, but we can let the negative ones pass through us in a dance or in the exercise.”

**Shared body-based component.** This DMT and SFT therapeutic approach was seen as complementary for individuals with SPD because it is a body-based therapy treating a disorder involving the body. For this reason, some participants saw this therapeutic approach as a natural inroad to working with individuals with SPD. Participant VI stated that, “because skin picking
itself has such a big aspect that involves the body, I think DMT makes a lot of sense to include in treatment.” Participant V agreed, stating that individuals “will express their bodies before they express their conscious communication.”

This was seen as particularly true for individuals with SPD. Many of the SPD expert participants in this study compared the benefits of this approach to the benefits of yoga. Participant IX believed that “it’s good for people to stretch out tension in their bodies…I use that for [people with] panic disorders as well.”

These individuals are expressing how they are feeling through movement behaviors; therefore utilizing therapeutic interventions at the body level may be a beneficial approach. Participant VI believed:

There is a distinct movement that accompanies [the picking] for each individual. So, to be able to access the body and the potential to move, to respond to those internal needs, sensations, images, feelings, thoughts, through different movement options [would be beneficial].

Furthermore, a dance/movement therapist participant believed that, “[dance/movement therapists] help people settle into their own bodies using the grounding work and breath work…it is the art of helping people back into their bodies.”

**Individuals may be innately somatic.** On a similar note, some participants suggested that perhaps an individual with SPD was innately a more kinesthetic/somatic individual. And, if this was in fact the case, the combination of DMT and SFT would be a viable therapeutic approach because it would channel the preferred physical component. Participant IV stated:

With that kind of physically directed way of coping, I think that by using the body that person maybe might be more somatic or kinesthetic…that might be their primary channel
of operation. So, by using DMT you could probably work through the body in other ways.

**New relationship with excoriation disorder.** Many participants welcomed a new approach to treating SPD, believing this would give a new outlook for an individual with SPD, as mentioned in Chapter Two. Some participants saw this modality as a means of broadening existing treatment. Participant II stated:

One would hope if you [engage in] DMT and SFT, [an individual with SPD] would potentially open up different perspectives, gain different views of themselves and the treatment, and help them develop a comfort level with themselves and their bodies, as well as reduce some anxiety.

Additionally, having another therapeutic modality to treat SPD would be beneficial because it is complex and individual, and it is not understood exactly how this disorder manifests in each person.

In order for an individual with SPD to make changes in their behavior, they need to alter their relationship with the disorder. Participants discussed how different forms of treatment could help uncover this relationship. Participant VI stated,

Whatever the identified problem is that an individual is experiencing often tends to define and shape their worldview, their life, their day to day functioning, [as well as] other people’s perception of them ... [SPD] starts to take this central place in their life, and so to be able to reconfigure [and] come to some sort of acceptance of, ‘well maybe in some ways this is part of who they are.’ Perhaps not who they are going to be in the future, but certainly part of their past and what’s shaped them as who they are today…. [they can now] reimage the relationship so that there’s meaning behind it and it makes sense
to the individual. [This] can also help to decrease any shame and mitigate any shame and guilt around it as well, which can also be overpowering for the individual.

Additionally, some participants believed that this therapeutic approach might bring a calmness and groundedness to an individual with SPD. Participant X stated, “[SFT and DMT seems] centering and grounding. And anything that promotes awareness, mindfulness, slowing down and noticing and watching your internal physical and emotional experience can be helpful.”

**Therapeutic Setting**

Unanimously, the participants agreed that the DMT and SFT therapeutic approach would be best utilized in a long-term setting. It was emphasized that change takes time, and specifically, it takes time to learn how to establish new habits. Participant III said, “it takes a long time to really build somebody up to be able to live with [skin picking], and know that they aren’t ‘it’.”

The participants also agreed that although it ultimately depends on each individual, a combination of group and individual therapy would be ideal when utilizing DMT and SFT with individuals with SPD. Furthermore, the majority of the participants I interviewed preferred the DMT and SFT therapy approach be utilized as an adjunct therapy to the current behavioral methods.

**Varying Etiologies for Individuals with SPD**

A specific etiology was not agreed upon between the participants in this study. Each participant acknowledged that SPD was a complex disorder, and that it would be beneficial to understand each individual’s etiology[ies] to better understand SPD. The participants’ views on the etiology of SPD ranged from shame, anxiety, boredom, trauma based, depression, addiction,
low self-esteem, sensory, BDD, OCD, and an imbalance of their energy systems. Many also believed that the etiology could be a combination of the above possibilities, and varying in degrees of severity. Participant VII stated, “I find most people I work with [who have SPD], have the secondary diagnosis of eating disorders, depression, schizophrenia, BDD.” This participant further described SPD as having “layers of different things…symptomology on top of symptomology.” Similarly, Participant VI described SPD, “it is not just skin picking; there is a lot of complexity to it.”

**How to treat individuals with Excoriation Disorder**

**Therapist characteristics.** During the participant interviews, many individuals discussed various characteristics that would benefit therapists who treat individuals with SPD. Individuals with this disorder often feel misunderstood, and therefore it is important to approach them sensitively. Furthermore, Participant VIII stated:

> What becomes important in any treatment is understanding the prior treatment; what worked, what didn’t…what can we do in this treatment so that if you feel like you need to leave or [feel as though] the treatment is not working [you can] communicate that.

**Strong therapeutic relationship.** The therapist needs to form a strong therapeutic relationship with the individual with SPD in order for them to feel supported. Participant I noted that individuals with SPD need to “find someone who they trust, who understands what they are doing.” Additionally, Participant VII emphasized the importance of “establish[ing] rapport with the client.”

**Empathy.** Participants discussed that this population also needs a mental health professional with a high level of empathy. Participant X stated, “if you have the open mindedness and willingness to really understand that person’s experience, then the world opens
up and all kinds of [interventions] can be tried.” Furthermore, Participant VI stated, “you want to help integrate their embodied experience with their cognitive experience of it. How they think about the images, the sensations, the feelings, [and] the movement that occurred.” Empathizing and listening to what the individual needs can accomplish this integration.

**Instill hope.** The therapist also needs to be able to instill hope in the individual with SPD. The client needs to know that it is possible to decrease the skin picking episodes, as well as possible to stop skin picking. Participant VIII stated, “the idea is for the person who is suffering with this, and for others around them, to learn how to see beyond what’s in front of [them]. There is more to them.” Participant I believed that individuals with SPD:

- Need to know that other people have stopped. [There is] hope…What happens is, the suffering is so great that [the individual] can’t imagine there will ever be an end to this.
- So, I think [it is important to instill] the idea that it is possible to stop, to heal your skin, to move forward with their lives.

**Patience.** Therapists treating individuals with SPD need to be patient. As mentioned previously, it is possible for each individual with SPD to have differing etiologies. Participant VII remarked, “as a therapist you need to stay grounded, and if there’s a sense of ‘well I gotta make this happen, I’ve gotta change this person’s habits [because] they are hurting themselves,’ it’s counterproductive.” The therapist also needs to be mindful of their client when creating interventions. Participant VIII described this as using a trial and error type of approach by “doodle[ing] different interventions with each individual in order to find what would work.” An intervention that might work for one individual may not work for another, and it is important that a treatment for an individual with SPD meets their individual needs. Participant IX stated, “We don’t start the treatment and try to fit the person into it, [instead] we try to figure out what the
triggers and inputs are and try to design a treatment around those.” Additionally, Participant V described this as “listening to the necessity for the DMT interventions to be paced, at a rate that feels safe and digestible.”

**Foster a new relationship with excoriation disorder.** With these tools, the therapist is able to help the individual change their relationship with SPD. It is the hope that the individual will be able to create a new relationship with this disorder, one that allows them to accept the past and move forward. Participant VIII believes that an individual with SPD needs to get to a place where “[they can] go about [their] life and do things that are meaningful for [them] and not have [SPD] interfere.” Additionally, Participant VI noted:

Looking at [SPD] as a relationship can in some ways afford more separation from it, and how you are going to interact with it. Rather than necessarily shoving it away, like a lot of times we think of problems, ‘I want this problem to go away.’

**Comprehensive approach.** Many of the TLC participants in this study verbalized that individuals with SPD need to be treated with a more comprehensive approach. This approach does not necessarily need to be the ComB (as discussed in Chapter Two), but it needs to consider behavioral, emotional, sensory, cognitive, and biological causes. The consensus was that it is important to address the disorder from multiple ends with new and innovative ways. Participant VIII stated, “you are looking at the individual’s cognition, you [also] have to look at and address affect, motor, and environment. So, it’s not ‘do one and move on to the next.’ Everything happens simultaneously.” Similarly, Participant IX said, “[SPD] is a complex problem with many potential inputs…treatment has to be tailored to each individual, there is no one size fits all.” Participant VIII additionally stated,
I’m always looking for different things that provide or meet that sensory input need that we all have. So [listening when] somebody says ‘this doesn’t work for me,’ let’s keep looking. Let’s find something, and keep those things accessible.

**Education**

**Therapeutic modality.** Participants agreed that there needs to be an educational piece taught to clients and professionals before carrying out this DMT and SFT therapeutic approach. Participant VIII stated:

I think with any kind of treatment there needs to be a psychoeducational approach. And, it really is dependent on the person buying in and making certain things part of their routine, part of the way that they do life.

It was mentioned that clients with SPD would also need to be educated on this form of therapy prior to participating. Participant III stated that individuals with SPD would need the dance/movement therapist to, “educate about the body, educate about sensations, educate about thoughts, behaviors, and the connection of the body/mind...” Additionally, Participant VIII emphasized that the client would need to be taught about mindfulness, “being mindful with your thinking, being mindful of your breathing, being mindful of what you are doing with your body...a big piece of treatment is raising someone’s awareness.” Furthermore, the therapist would need to let the clients know that in order to yield positive results, they need to put in effort and commitment to the therapeutic process.

**Excoriation Disorder.** As previously stated, education and awareness needs to exist on what SPD is in order to lessen the stigma, increase research, and to expand the number of therapeutic modalities available. Participant VIII stated:
There are a lot of myths and misnomers about [SPD] that creates more stigma and makes it much more difficult for people to access help…there is much more room for growth in this area to help clarify what [SPD] is versus what it isn’t.

Participant II mentioned that she has heard individuals with SPD say, “I’ve always wanted to know what I was doing, I didn’t even know there was a name for this,” numerous times. Many participants voiced that therapists need to stop assuming why an individual is engaging in skin-picking, and instead take the time to understand the person and what is specifically going on with them. Additionally, mental health professionals need to inform each other about SPD.

Participant VII stated, “we all need to help inform each other…People don’t come across [SPD] everyday, but when they do they want some literature and some thoughts from other therapists.”

Based on the results of this research study, the combination of DMT and SFT is a potentially viable therapeutic modality to treat individuals with SPD because of the compatibilities between the disorder and the treatment. The etiology of SPD is not agreed upon amongst participants, and there is an educational piece that needs to be addressed on what SPD is and how it manifests in each individual person. Additional research on this disorder would help uncover further needs of the individuals in regards to therapist characteristics, and successful therapeutic approaches. There is also a definite need for individuals with SPD and mental health professionals to be educated on what DMT and SFT would have to offer this disorder. This information would be vital in order to fully understand the effects of this therapeutic modality. These themes will be further discussed and developed in Chapter Five.
Chapter Five: Discussion

This was the first dance/movement therapy research study to look at how DMT could be a viable therapeutic modality for individuals with SPD. Although the therapeutic modality SFT integrated with other creative arts therapies has been researched, this is also the first study to propose the integration of DMT and SFT as a therapeutic modality (Anderson-Klontz, et al., 1999; Matto, et al., 2003; Riley & Malchiodi, 2003). Additionally, this is the first study to look at any of the creative arts therapies to treat individuals with SPD. The purpose of this study was to see how a combination of DMT and SFT would be a viable treatment method for individuals with SPD. My research question was: How is a positive psychology DMT approach a viable treatment method for SPD?

Using Chesler’s method of sequential analysis to analyze qualitative data from the transcriptions of the participant interviews and researcher journal, the results demonstrated that DMT and SFT could be a viable treatment method for individuals with SPD by recognizing their inherent compatibility. The compatibilities between the proposed treatment method and disorder that arose in response to the research question were: DMT and SFT compliment each other, a shared body based component is present between the disorder and proposed therapeutic treatment, DMT may address a strong somatic component potentially evident in individuals with SPD, and this form of therapy involving movement may help reshape the individual’s relationship with SPD.

In this research study, participants also discussed their views on the specifics of this therapeutic modality, the differing etiologies of SPD, beneficial characteristics for a therapist who is treating individuals with SPD, as well as the importance of educating individuals on DMT
and SFT and SPD. These themes were discussed in Chapter Four, and will be further explored in this chapter, along with additional observations that arose from the data.

How is this Therapeutic Modality Potentially Viable?

Differing views. Although the data from the interviews uncovered that all of the participants found reason to believe this therapeutic method was potentially viable, the differences between the two groups of participants (dance/movement therapists and professional members of TLC) were evident in the responses. The dance/movement therapist participants were quick to view this combination therapy as potentially effective. Participant IV stated, “I definitely think it would work, from a theoretical perspective it makes sense.” In comparison, the TLC participants generally had difficulty visualizing this type of treatment. As previously mentioned, some of these participants found that comparing this therapeutic modality to yoga or working out helped them fathom how this would be a viable treatment for this disorder. All of the professional members of TLC participants, and some of the dance/movement therapist participants wanted to see more research, data, and controlled studies on the effects of this therapeutic modality. Participant III stated:

   Something like this that really engages one’s sense or physical senses, it’s something to look at and to study, and to really try to measure and see what kind of outcome you could yield…it has potential, I think it’s something I would be interested in seeing research on, to see studies done, and to hear from participants what their reaction is.

   Additionally, during the interviews, Participants VI and III believed that this combination was not only viable, but is already currently used by dance/movement therapists. Participant III stated, “I see how it is effective because I know people who use it!” Furthermore, Participant VI stated, “I think you are doing a much needed job of highlighting what some of
those similarities are [between DMT and SFT] and how we as dance/movement therapists can incorporate SFT, and often times already do through our techniques.” As some dance/movement therapist participants considered this therapeutic modality to already be in existence, it was easier for them to visualize its impact on individuals with SPD.

**Commonalities.** As mentioned previously, participants viewed DMT and SFT as potentially viable in treating SPD by recognizing the commonalities between the treatment and disorder. These commonalities all stemmed from the fact that the proposed treatment and disorder both have strong movement components. Participants generally believed that utilizing movement to treat a disorder involving movement to this degree would be worth exploring.

A consensus among participants was that individuals with SPD have a large physical component that needs to be fully understood and treated. In reference to individuals with this disorder, Participant IV states, “I use this term ‘loud bodies’ with my clients.” This participant further explains:

Your body is loud, it’s trying to talk to you, and you are not listening. You don’t know how to understand the language of your body, [but] your body is actually talking to you right now. So when somebody’s [engaging in skin picking] their body is doing this for some gain.

Participant VIII stated, “there is definitely a big motor piece that has to be addressed with the hand that’s at work in terms of picking and pulling, and the other hand as well.” This same participant typically walks her clients with SPD through each movement that is involved with their individual skin-picking regime in order to better understand this movement. She states:

If [a client] says to me ‘I go to the bathroom in front of the mirror [to pick]’, I have them really walk me through. How do you stand? How do you position yourself? Which
hands do you [pick] with? What do you do with the other hand? How close do you get to the mirror? That’s really important to know in terms of, what can we do to challenge that?

Additionally, Participant III discussed that therapists need to be careful when utilizing the body as an intervention. Many individuals hold emotions in their bodies, and it may be triggering for them to work through their relationship with SPD in this way. Therefore, the therapist needs to be careful to not push the client too far. Participant IV spoke to this by saying “in [DMT and SFT] you need to make sure you don’t deregulate the client, you don’t want to have the client to become over activated.”

**Therapeutic Setting**

**Long-term therapy.** As briefly mentioned in Chapter Four, the participants in this study viewed the therapeutic approach of DMT and SFT in a similar way. As part of the semi-structured interview questions, participants were asked how they would view DMT and SFT as a therapeutic modality. Although the length of therapy might depend on the individual, the implementation of DMT and SFT was generally seen as a long-term therapy. One participant saw the SFT part of the therapy as short-term, whereas Participant IV saw short-term therapy as “giving quick fixes,” and not having the ability to get to the root of the issue at hand.

I thought there would be more discrepancy between participants with this question because of the participants’ diverse therapeutic backgrounds. Specifically, I thought the professional members of TLC would see this therapy as short-term because of their emphasis on CBT. With the disorder seeming to live in individuals for some length of time, it was agreed that long-term therapy would be the best choice to start undoing these ingrained behaviors and to best
support the strengths of each individual. There was a general belief that change takes time, and this needs to be fostered for the client.

**Individual and group therapy.** Participants believed that this therapeutic method would ideally incorporate individual and group components. Although, many participants mentioned that it is not often the case where an individual would be able to access or afford both of these types of therapies. The individual treatment would aid the derivation of the etiology of each client, uncovering triggers and addressing the strong shame component. The client would also have the ability to own and explore their relationship with SPD. Participant I believed that, “people need the one-on-one experience to be able to really focus in on healing and releasing the negative aspects of the picking.” Additionally, emphasizing the sensitive nature of this disorder, Participant VIII noted, “with this kind of behavior there is so much shame …it’s hard to talk about it with even just one person.”

Group treatment could help lift individuals’ feelings of loneliness and misunderstanding. Sharing the truths of their disorder and being witnessed by others could help individuals better cope with SPD. Participant VIII said:

The group piece really can work to lift the stigma, to get people talking ‘I’ve tried this, I do this,’ to get a dialogue going, to challenge some of that thinking, or even to hear somebody say ‘this is so hard.’

In response to the importance of the group therapy aspect, Participant III stated, “we are only as sick as our secrets.”

**Adjunct therapy.** Participant views varied when asked what they thought about DMT substituting or complementing the behavioral approaches currently used for SPD. Some participants believed this therapeutic approach would be very effective as a sole therapeutic
treatment; Participant V stated, “because it is a therapy modality that is directly engaging the body…it would be the treatment of choice for this disorder.” Similarly, Participant VI believed that “because there is such a physical component to [SPD], a body based component, I think it’s a natural inroad to working with people with SPD.”

The majority of the participants believed that SFT and DMT would be most effective as an adjunct therapy or in combination with the current behavioral approaches used to treat SPD. Many participants did not view the DMT and SFT modality as complex enough for treating individuals with SPD. Participant III believed that “[DMT and SFT] need to talk to each other and learn from each other about what it means to do behavioral therapy.”

On this subject, Participant VIII stated “[we need to] always be open to looking at different types of ways to compliment treatment.” Other participants noticed that DMT and SFT would be a natural fit with the behavioral therapies, specifically with the ComB model that is currently used for individuals with SPD and Trichotillomania, further discussed in Chapter Two. Participant II stated, “I think [DMT and SFT] would be a terrific adjunct to the [ComB model], specifically in the affect and sensory components.”

Additionally, Participant II said, “I think [DMT and SFT] could be an interesting addition to what exists out there…it might provide some unique focus to certain [individuals with SPD], which would always be welcome.” In regards to DMT and the behavioral approach of CBT, Participant IV stated, “I see CBT as a top-down approach, and DMT as a bottom –up approach. [Where] they meet in between, the body/mind comes together…I’ve always thought these two theories work well together.”
Varying Etiologies for Individuals with SPD.

DSM 5: Obsessive-compulsive disorder and related disorders. As discussed in Chapter Two, the etiology of SPD is not completely understood. There seems to be many possible etiologies and combinations of etiologies from which SPD can stem. As mentioned previously, SPD now has an official classification in the DSM-5 under the category of OCD and Related Disorders. This classification does not aid individuals on agreeing on one etiology for SPD, as participants in this study had varying views on the etiology (American Psychiatric Association, 2013). Participants believed that having an official diagnosis for SPD is a step in the right direction, but more research is needed to really understand where this disorder fits within the DSM. There were discrepancies about the disorder being placed under the OCD heading; some participants believed an overarching heading of BFRB would better suit SPD. A few participants in this study believed that SPD was related to OCD, but were not the same. Participant VIII stated,

With OCD there is a lot of rumination about doing the behavior and fear that if you don’t do the behavior something bad will happen. And that kind of thought process is not present to my knowledge when there is a BFRB.

Another point that was made was that medication that works for individuals with OCD does not work the same for individuals with SPD. Additionally, there is much more that needs to be researched regarding medication to fully understand how it works for each individual.

Anxiety and depression. A majority of the participants in this research study believed that anxiety and depression play a role in SPD. It is not completely understood what order anxiety, depression, and SPD present themselves, but it is believed to be cyclical. Participant I remarked, “it’s a vicious cycle; picking, depression, more picking, depression, shame…”
regards to the anxiety component, Participant VII stated, “people [with SPD] have a high level of brain functioning that keeps them in the worry and anxiety.”

**Shame.** Many participants talked about how individuals with SPD experience a high level of shame. After they have picked, individuals tend to be overwhelmed with shame and guilt. This shame component distinguishes SPD from trichotillomania, Participant II noted, “although there are feelings of shame in individuals with both of these disorders, these feelings tend to be greater in individuals who deal with SPD.”

**Somatic.** Participants noted that the etiology of SPD could very well be a somatic one. Participant VIII stated, “there’s a lot with this particular behavior, it’s very functional, and lots of times depression and anxiety are not necessarily culprits or factors…sometimes that’s absent.” The act of picking could be a self-soothing or self-nurturing act, implying that SPD is a behavior pattern and not necessarily a disorder. Additionally, Participant IX noted that the visual and tactile senses are very involved for the individual with SPD.

**Other.** Various other possible etiologies were discussed throughout the interviews. One participant believed that SPD was a coping tool to manage feelings related to trauma, believing that the behavior sourced from a previous traumatic experience. Participant I believed SPD was a result of an imbalance in that individual’s energy system. This participant stated, “you can talk until your face turns blue, or the grass turns blue and the sky turns green, but unless you do energy based work you’re not going to release [SPD].”

Additionally, Participant VIII stated that, “boredom is a nesting place for these behaviors to surface and intensify.” This participant suggested that individuals with SPD have a lot of energy that needs to be regulated, and when it is not regulated it manifests itself into skin picking. Additionally, a few individuals believed that SPD criteria parallels addiction. Whatever
the etiology may be, individuals with SPD seem to hold a lot of secrecy, sadness, and low self-esteem.

**How to Treat Individuals with Excoriation Disorder**

During the participant interviews, many participants highlighted what effective treatment for individuals with SPD entailed. This disorder is complex and full of layers, which deepens the individuals’ feelings of being misunderstood. Every participant noted that therapists need to be very strategic and intentional with how they approach individuals with SPD, as well as what type of therapy they carryout.

It was also noted that some therapeutic modalities may not be beneficial for individuals with SPD, and it is important to be mindful of what each individual needs. Participant X discussed the downfalls of the behavioral approach of HR. She believed HR was “a very limited approach…[and] just using HR isn’t quite enough [for individuals with SPD].” Participant I believed that the pharmacological approach of n-acetyl cysteine (NAC) that is currently being used for individuals with BRFBs, “does not help” (Grant, et al., 2012). Additionally, Participant VIII discussed her views on medication for individuals with SPD, “I don’t think [medication] should ever be the primary treatment [for SPD], it can be used in conjunction with talk therapy, whatever form is being utilized.”

**Therapist characteristics.** As mentioned in Chapter Two, the theme of treating individuals with SPD in a gentler, human way was prevalent. Specifically SPD therapists need to create a strong therapeutic relationship with a high level of empathy, hope, and patience. It is this relationship that allows the therapist to execute effective interventions.

Within the therapeutic process, it is beneficial to take a client’s history to better understand their individual etiology and relationship with this disorder. Participant IX stated the
therapist needs to “get a well rounded picture of the situation for the individual with SPD.” This holistic view of the individual and their relationship with SPD will be beneficial in finding the correct treatment plan.

**Comprehensive approach.** SPD is a complex disorder, and a generic step-by-step type of therapy probably will not work. Individuals with SPD need to be treated with a comprehensive therapeutic approach, addressing the disorder at multiple ends. Participants agreed that therapists need to put time and effort into finding out what each individual person needs. Therapists need to look at the emotions as well as the behaviors of the individual. Participant V believed that individuals with SPD “need to find alternate ways to express their feelings, more direct ways…” Biological strategies need to also be considered. Participant IX believes that treating SPD “may involve biological strategies, it may involve behavioral strategies, cognitive strategies; behavioral is just one part of the comprehensive treatment.”

Within this comprehensive approach, therapists may need to find new and innovative ways to treat these individuals. Many participants believed that the DMT and SFT therapeutic modality could address this need for innovative treatment ideas. Other participants mentioned hypnosis, additional mindfulness strategies, and one participant talked about an app she created to help individuals manage their picking and pulling.

The integration of DMT and SFT could possibly maximize treatment outcomes for individuals with SPD because it is a comprehensive treatment. This therapeutic modality targets the affective, cognitive, somatic, behavioral, and interpersonal domains as discussed throughout this thesis.


**Education**

**Therapeutic modality.** The participants in this study wanted more information on SFT and DMT to be able to fully see how it would operate. Some participants had a difficult time visualizing a potential therapeutic approach. Although each participant was emailed a document on what DMT and SFT would potentially look like when integrated, many participants needed more research and information to fathom this therapeutic modality. The professional members of TLC participants wanted to know what this approach was, as well as what it was not. Some questions that were asked by the participants were, “How is this different than working out? I am burning off energy, I’m listening to music, so why do I need to do a separate therapy for that when I already belong to a gym?” and “Can I liken this to yoga: breathing, meditation, training?”

This proposed, hypothetical therapeutic modality did spark interest, but more education is needed on this approach in order to proceed with carrying it out on individuals with SPD. More research and data needs to be generated for many of these participants to be able to visualize this approach.

Individuals with SPD also need to be educated prior to treatment. In educating on DMT and SFT, there would need to be information presented on the body/mind connection, being mindful of the picking behavior, forming a new relationship with SPD, and understanding that most of this work is subconscious. Individuals will need to learn to be mindful of what triggers them to pick their skin, and how they can become more conscious of these.

**Excoriation disorder.** More awareness and education needs to be available for individuals with SPD, mental health professionals, and the general public. This education would help individuals with SPD to not feel so alone, misunderstood, and stigmatized.
As mentioned previously, there is currently very limited literature available on SPD. Many participants are hopeful more research will result from SPD recently becoming an official diagnosis in the DSM-5. Some participants said that they would like to see more research on the possible biological component of SPD. Participant VIII stated that SPD “could incorporate possible biological approaches.” Similarly, Participant IX believes “there is a lot that is still being researched, in terms of brain scans, and in terms of looking at what kind of medication could compliment any kind of treatment you are doing.” Participants hope that by educating individuals about SPD, and increasing research on this disorder, more effective therapeutic treatments will emerge.

Additionally, some participants noted that there are limited individuals within the mental health and medical field who understand this disorder. Participant X remarked,

There are so few psychologists that know how to treat [skin] picking… and when seen by dermatologists, it’s seen as sort of a psychosis, [additionally] people in the medical field don’t understand it … they just get angry or frustrated.

In response, Gieler, et al. (2013) stated that because SPDs “have symptoms that are clearly correlated with mental disorders, [they] therefore require some familiarity with psychiatric issues on behalf of dermatologists and an efficient referral practice” (p.4). One participant offered a possible solution to creating more awareness within this community—having individuals within the mental health and medical fields inform their colleagues about this disorder and its implications.

Conducting this study doubled as a way to spread awareness for SPD. Some of the dance/movement therapist participants had never heard of this disorder prior to our interview, and within the interview were having ah-ha moments about previous and current clients. One
dance/movement therapist participant used my study as a reason to research this disorder prior to our interview. During our interview she shared with me various DMT (and SFT) interventions she believed would be beneficial for individuals with SPD, because of their success on her clients with related disorders. Additionally, one SPD expert participant thanked me for spreading awareness with my research, and encouraged me to share my research with TLC when my thesis was completed. These instances further emphasize the need to bring awareness to this disorder.

**Limitations**

**Recruiting participants.** There were many limitations within this research study, the most noteworthy being that it was difficult to recruit participants. I sent out many emails to potential participants with little response. I had targeted two very small populations of participants: dance/movement therapists, and professional members of TLC. The recruitment process was very time consuming, taking six months to recruit participants and complete all ten interviews. This long duration impacted the study because it delayed the gathering and analyzing of the data. Other than this long duration, the integrity of the study was not affected by the delay. I was still able to recruit participants with relevant experience.

**Researcher journal.** The researcher journal I had used as a secondary data collection method was not as central to this process as I had predicted. The purpose of this journal (See Appendix L) was to record my observations, thoughts, ideas, emotions, and feelings immediately following each participant interview. The process of filling out the journal helped me get my feelings out regarding the interview, and summarize the main points of each interview. In general, the data I gathered from this did not prove to be useful for this study.
Participant dichotomy. Gathering research from two very diverse groups of participants was difficult when formulating results. There were clearly two very different schools of thought present within the data from the participant interviews. One group of participants completely understood how this DMT and SFT integrated approach would be beneficial, but did not really understand the disorder. The other group of participants had a hard time commenting on a hypothetical therapeutic modality, whereas they were well versed in SPD. Having this diversity created a dichotomy within my data, which made it difficult to compare the data and extract themes.

Dance/movement therapy is behavioral. The way I separated DMT and the behavioral approaches was an oversight. I neglected to discuss how movement is behavioral, and therefore the DMT and SFT method is also a behavioral method. Participant VI stated, “[we need to recognize that movement is behavior.” I believe I could have found the similarities between the current behavioral methods and this proposed approach to create a more compelling rationale. When you compare HR to DMT, it is evident that both forms of treatment encourage making a change to an individual’s current behavior, which could definitely incorporate movement. Similarly, when comparing CBT to DMT we see many parallels. One similarity is that both therapeutic methods view treatment as all encompassing. Just as in CBT it is assumed that the “cognitive, emotional and behavioral variables are functionally interrelated,” the mind and body are seen as interrelated within the DMT practice (American Psychological Association, 2009, p.89).

Using this information, I could have addressed that because the behavioral methods are successful in treating SPD, there is reason to believe that the SFT and DMT therapeutic approach would be viable. This is illustrated in a prior example in this Chapter, where one participant
walks her client through their sequence of movements while engaging in skin picking. It may have been wise to compare CBT to DMT and HR to DMT prior to this study.

**Implications for Future Research**

With this study, I have researched how a positive psychology DMT approach would be a viable treatment method for SPD. This was a topic that had previously never been researched. Although the purpose of this study was to propose DMT as a treatment for SPD, the positive outcome has opened the doors to future research. My intention is to eventually carry out an additional study using this treatment method for individuals with SPD participants.

Some research questions that would guide future research would be: What are the effects of DMT, SFT, and CBT on individuals with SPD? Are there specific individuals with SPD who respond best to this form of treatment? If so, is there a common etiology between these individuals? Does training mental health professionals the best practice to treat individuals with SPD create a more effective therapeutic experience for the patient? Could this training lessen the stigma on individuals with SPD? How can this therapeutic modality spread awareness for SPD? Further research could also extend this therapeutic approach to individuals with alternative BFRBs.

**Summary**

The intention of this study was to see how the combination of DMT and SFT would be a viable treatment option for individuals with SPD. The purpose of this study was to create more potential therapeutic modalities for individuals with SPD, by proposing DMT as a viable therapeutic method for this population. Through this thesis research study I have found that this therapeutic modality is seen as a potentially viable treatment method for individuals with SPD because of its commonalities. The data further suggests that understanding the varying etiologies
of SPD is essential in treating individuals with this disorder. Additionally, the data uncovered that there are specific therapist characteristics that benefit treating individuals with SPD, and a need for more education and awareness for SFT and DMT, as well as for SPD. It is my hope that additional research will help uncover more answers.
References


Odlaug, B. L., Kim, S. W., & Grant, J. E. (2010). Quality of life and clinical severity in pathological skin picking and trichotillomania. *Journal of Anxiety Disorders, 24*, 823-829. doi: 10.1016/j.janxdis.2010.06.004


Appendix A: Definition of Terms

Definition of Terms

Dance/Movement Therapy (DMT): The American Dance Therapy Association (ADTA) defines DMT as “the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual” (American Dance Therapy Association, 2009, p.1).

Excoriation (Skin Picking) Disorder (SPD): SPD is a disorder listed in the Obsessive-Compulsive and Related Disorders section of the DSM-5 (American Psychiatric Association, 2013). The diagnostic criteria listed for this disorder are: recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop picking, skin picking causes clinically significant distress or impairment in important areas of functioning, and is not due to physiological effects of a substance, medical condition, or symptoms of a mental disorder (American Psychiatric Association, 2013).

Positive Psychology: Positive psychology is a field of psychology that focuses on the “psychological states, individual traits or character strengths, and social institutions that make life most worth living” (American Psychological Association, 2009, p. 382). This is a strengths-based model, where the focus is not on the pathology.

Solution Focused Therapy/Solution Focused Brief Therapy (SFT): Iveson (2002) defines solution-focused therapy as “an approach to psychotherapy based on solution-building rather than problem-solving. It explores current resources and future hopes rather than present problems and past causes… It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments” (p. 150).
Appendix B: Informed Consent Form

Columbia

Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: Excoriation (Skin Picking) Disorder and Dance/Movement Therapy: Finding a Link

Principal Investigator: Karissa Martens

Faculty Advisor: Laura Allen, BC-DMT, LCPC, GL-CMA

Chair of Thesis Committee: Laura Downey, BC-DMT, LPC, GL-CMA

INTRODUCTION

You are invited to participate in a research study to explore how a positive psychology based dance/movement therapy (DMT) approach is a viable treatment method for Excoriation (Skin Picking) Disorder (SPD). This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called ‘informed consent.’ You will receive a copy of this form for your records.

You are being asked to participate because the main researcher (myself) believes you fall into the following two categories: as a dance/movement therapist with R-DMT or BC-DMT credentials, or is an expert in the field of SPD.
PURPOSE OF THE STUDY

The purpose of this research study is to begin the dialogue of using a positive psychology based dance/movement therapy approach as a therapeutic method to treat people who suffer with SPD. Currently no such research exists on DMT and SPD, and the main researcher would like to fill in this research gap in hopes of finding more successful therapeutic methods to help SPD sufferers.

PROCEDURES

If you agree to participate in this study, you will be asked to do the following:

- Read over and sign the informed consent form, send it back to me, and a copy will be sent to you for your records
- Contact me if you have any questions regarding the research study at any time
- Read over the document, which synthesizes information on both DMT and SPD treatment in a positive psychological lens (utilizing Solution Focused Therapy as the specific positive psychology lens). Become familiar with the information.
- Schedule an interview with me at a convenient location, or via Skype. The interview will be 30 minutes in length. Please have the document I have prepared readily available to possibly aid you within the interview. The interview will cover questions pertaining to DMT, SPD, and how a positive based psychological DMT approach is a viable therapeutic treatment method for SPD. The interview will be semi-structured; therefore I will be using some questions as a framework for the interview. Sharing your feedback, input, recommendations, and questions are encouraged. The interview will be audio taped, and manually transcribed by the main researcher.
- Give at least 24 hours notice if the scheduled interview needs to be cancelled
- Grant permission for portions of your interview to be included, and possibly quoted in the final presentation of my research study. You may choose whether you would prefer to identify yourself, or use a pseudonym.
- If interview is conducted via Skype, it will take place in a safe and comfortable place of your choice, with the main researcher in a private setting at home. If the interview is conducted in person, it will be conducted in a safe, private/semi-private, and comfortable setting agreed upon ahead of time by you and the main researcher.
- After your initial interview, you will be contacted at a later stage of the study to review the findings of the study, provided to you by the main researcher. You will be invited to provide feedback, clarification and/or additional information you feel is relevant to your research data.
POSSIBLE RISKS OR DISCOMFORTS

The risks of this study are:

- Shared details of the written interview transcripts may un-intentionally reveal your identity, or the identity of others mentioned in your interview. To minimize this risk, you have the choice to remain anonymous and give a pseudonym. Written interview data and audio recordings will be protected via secure laptop password and firewall protection, and backup copies will be stored in a secure place in my home office.

- Possible inconveniences as a result of being involved in this study may include the time it takes to complete the interviews, the time it takes to review the findings, and any unforeseen interruptions.

POSSIBLE BENEFITS

You may not directly benefit from this research; however, I hope that your participation in the study may advance future research in the areas of Dance/Movement Therapy, Excoriation (Skin Picking) Disorder, and therapeutic treatment methods for individuals suffering with SPD.

CONFIDENTIALITY

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator’s supervisors, unless the participant chooses to identify themselves in the study.

- Audio recordings and written interview data will be protected via secure laptop password, and a back up copy will be stored in a secure home office in order to protect privacy and confidentiality. Firewall protection on my computer will be used to help provide as much confidentiality as possible to electronic information (internet, email communication, electronic record keeping).
- The main researcher will be keeping a personal journal to reflect on the interviews. This journal will be kept in a secure location in the main researcher’s home office.
- Study records will be kept for 5 years in the main researcher’s secure home office. The main researcher will transcribe audio taped interviews manually. All of the records will only be accessible to the main researcher.
• Personal study notes may be kept indefinitely with the data stripped of all identifiable information.
• When study data is released, it will be furnished to the main researcher’s Faculty Advisor, Laura Allen, BC-DMT, LCPC, GL-CMA, and to the Columbia College Chicago Dance/Movement Therapy and Counseling Thesis Committee. Information to be furnished will include direct interview quotes, selected interview data, and data analysis and research findings. The purpose of this disclosure is to represent and share the thoughts and ideas of the dance/movement therapists and researchers participating in this study. The confidentiality choice of each participant will be honored in regards to use of names and identifying information in the study.

The following procedures will be used to protect the confidentiality of your information:

1. The main researcher will keep all interview study records password and firewall protected, and in a secure location in a home office.
2. Any audio recordings will be destroyed after 5 years
3. All electronic files containing personal information will be password and firewall protected.
4. Personal communication through e-mail will be exchanged through my private e-mail account
5. If the interview is conducted via Skype, I as the main researcher will find a secure and private location to contact you from. If the interview is conducted in person, it will take place in a secure, private/semi-private, and safe location.
6. Information about you that will be shared with others will respect your confidentiality choice of either using a pseudonym, or your real name.
7. No one else besides the main researcher will have access to your original data.
8. At the end of this study, the researchers may publish their findings. Your use of name/pseudonym will be respected in any future publications or presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Please take no longer than two weeks to make a decision. I will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator Karissa Martens or the faculty advisor Laura Allen if you have any questions concerning your rights as a research
subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312-369-7384.

**COST OR COMMITMENT**

- You may incur minimal fees from your involvement in this research study, such as Skype charges, parking fees, or public transit.
- The time commitment for the involvement of this study includes the potential travel time to and from an interview location, the 30-minute interview, and additional time for discussing the findings of the study.

**PARTICIPANT STATEMENT**

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

_________________________  _________________  ____________
Participant   Print Name:          Date:

_________________________  _________________  ____________
Principal Investigator’s Print Name:          Date
Signature
Appendix C: Theoretical Synthesis

Theoretical Synthesis of Dance/Movement Therapy and Solution Focused Therapy to Address Individuals with Excoriation (Skin Picking) Disorder

Karissa Martens

Columbia College Chicago
Definitions

Dance/Movement Therapy (DMT): The American Dance Therapy Association defined DMT as “the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual (American Dance Therapy Association [ADTA], 2009).”

Excoriation (Skin Picking) Disorder (SPD): SPD is a disorder listed in the Obsessive-Compulsive and Related Disorders section of the DSM-5 (American Psychiatric Association, 2013). The diagnostic criteria listed for this disorder are; recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop picking, skin picking causes clinically significant distress or impairment in important areas of functioning, and is not due to physiological effects of a substance, medical condition, or symptoms of a mental disorder (American Psychiatric Association, 2013).

Positive Psychology: Positive psychology is a field of psychology that focuses on the “psychological states, individual traits or character strengths, and social institutions that make life most worth living (American Psychological Association, 2009, p. 382).” This is a strengths based model, where the focus is not on the pathology.

Solution Focused Therapy/Solution Focused Brief Therapy: Iveson (2002) defines solution focused therapy as “an approach to psychotherapy based on solution-building rather than problem-solving. It explores current resources and future hopes rather than present problems and past causes… It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments (p. 150).”
Theoretical Synthesis

Introduction

The current literature on SPD is primarily on the effectiveness of the behavioral therapy approaches, which currently have the highest success rates for SPD (Deckersbach, Wilhelm, & Keuthen, 2003; Deckersbach, Wilhelm, Keuthen, Baer, & Jenike, 2002; Flessner, Busch, Heidman, & Woods, 2008; Grant, Stein, Woods, & Keuthen, 2012; Schuck, Keijsers, & Rinck, 2011; Teng, Woods, & Twohig, 2006; Woods, 2002). The behavioral approaches that are primarily used are habit reversal and cognitive behavioral therapy (Grant, et al., 2012). Although there is great value in these approaches, more variety of treatments need to be researched and accessible. Many researchers have cited the need for more treatment options available for individuals with SPD (Bohne, Wilhelm, Keuthen, Baer, & Jenike, 2002; Odlaug & Grant, 2010; Schuck, et al., 2011; Twohig, Hayes, & Masuda, 2006).

In order to address this need for more treatment options for individuals with SPD, my research question is, “How is a positive psychology based DMT approach a viable treatment method for SPD?” I have chosen to use Solution Focused Therapy (SFT) as the positive psychology lens to be integrated with DMT. The complementary nature of SFT toward other therapeutic approaches (Iveson, 2002) makes it a prime choice to integrate with DMT to enrich the therapeutic experience. Ylonen and Cantell (2009) stated, “we, as dance/movement psychotherapy researchers think that it is fruitful to deepen our understanding of DMT in an open way by searching different points of view from several theories (p. 216).” The following will address why DMT and SFT are compatible, as well as how this combination might be a treatment modality for individuals with SPD.
Why are DMT and SFT Compatible?

It is the similarities between the therapeutic methods of DMT and SFT that makes them compatible. To find these similarities, I have reviewed literature on DMT, SFT, and related psychotherapies, such as art therapy. Both forms of treatment report lasting effects in time-limited situations for a vast array of populations (Anderson-Klontz, Dayton & Anderson-Klontz, 1999; Bannink, 2007; Johnson & Miller, 1994; Low & Ritter, 1996; Nims, 2007; Taylor, 2009). For example, Low and Ritter (1996) found that, after as little as one hour of DMT, inpatient psychiatric patients demonstrated significantly decreased levels of anxiety and depression.

The structure of DMT and SFT are both collaborative in nature, emphasizing the client as the expert (Anderson-Klontz, et al., 1999; Bannink, 2007; Matto, Corcoran, & Fassler, 2003; Nims, 2007; Sandel, Chaiklin, & Lohn, 1993; Tyson & Baffour, 2004; Ylonen & Cantell, 2009). In response to the integration of SFT and art therapy, Tyson and Baffour (2004) stated, “…clients bring to the therapeutic process a rich supply of ‘strengths’ that can be used to help facilitate positive change... (p. 213).” Furthermore, the use of empathy within this relationship is central to both DMT and SFT (Matto, et al., 2003; Riley & Malchiodi, 2003).

The use of imagery is shared by both DMT and SFT (Anderson-Klontz, et al., 1999; Matto, et al., 2003; Nims, 2007; Ylonen & Cantell, 2009). Anderson-Klontz, et al. (1999) discussed the benefits of imagery through the integration of SFT and psychodrama. They stated that imagery “enables clients to build a bridge from the hypothetical frame to their present situation(p. 115).” Through specific techniques, DMT and SFT offer clients a space to reflect on their past and future life narratives. In SFT the miracle question allows a client to positively reinvent his/her future (Anderson-Klontz, et al., 1999; Bannink, 2007), and DMT offers an opportunity to embody past and future life narratives (Ylonen & Cantell, 2009). In regards to
DMT specifically, Ylonen and Cantell (2009) state, “DMT can offer a space for a symbolic world where the participants can re-story their identity by shaping kinesthetic narratives (p. 224).”

**How might DMT and SFT be a Treatment Modality for SPD?**

With the compatibility of DMT and SFT, some conclusions can begin to be made in treating an individual with SPD. The combination of SFT and creative arts therapy treatment methods can provide a multisensory engagement that deepens the experience for clients (Anderson-Klontz, et al., 1999; Riley & Malchiodi, 2003; Matto, et al., 2003). In regards to the integration of SFT and art therapy, Riley and Malchiodi (2003) stated that, “therapeutic change is expedited through both specific interventions and creative expression (p. 82).” In addition, Riley and Malchiodi mentioned the importance of the body and moving through the solution, stating “the physical action of the art activity also reinforces investment in the decision-making process and stimulates thinking through possible solutions (p. 84).”

The combination of DMT and SFT will also allow the client to reframe his/her experience with SPD. Referring to the combination of art therapy and SFT, Matto, et al. (2003) stated that through the experience of reframing, clients are “introduced to a novel way of viewing some aspect of themselves, their problem, or situation. A new perspective on the problem can generate new actions in accordance with this frame of reference (p. 270).” In the same way, individuals with SPD will be able to reframe their relationship with SPD, finding different ways to deal with their various underlying etiologies.

Finally, the integration of the creative arts therapies and SFT focuses on the solution rather than the problem. Riley and Malchiodi (2003) reiterated what de Shazer stated, in saying that “everyone has the ‘keys’ to unlock the doors that will stimulate positive change; the
therapist’s task is to help the client find the right keys, rather than understand why the lock won’t open (p. 83).” Based on supporting literature leading to the above synthesis, there is reason to believe that the right key for positive change for certain individuals with SPD may be the integration of DMT and SFT.
References


Appendix D. Initial Interest Email for Dance/Movement Therapists

Greetings (name),

My name is Karissa Martens and I am a graduate student in the Dance/Movement Therapy and Counseling MA program at Columbia College Chicago. I obtained your name and contact information from the American Dance Therapy Association’s website.

For my graduate thesis research, I am exploring the research question: How is a positive psychology based Dance/Movement Therapy (DMT) approach a viable treatment method for Excoriation (Skin Picking) Disorder (SPD)? SPD is a new disorder listed in the Obsessive-Compulsive and Related Disorders section of the recently published DSM-5 (published May 2013). The diagnostic criteria listed for this disorder are: recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop picking, skin picking causes clinically significant distress or impairment in important areas of functioning, and is not due to physiological effects of a substance, medical condition, or symptoms of a mental disorder.

As a new disorder, much research is needed to uncover successful therapeutic modalities! The purpose of my thesis research is to gather responses from professionals in the fields of both DMT and SPD, like you, to start the dialogue of how DMT could be a successful treatment method for SPD. The study will be used as a launching pad for further research to possibly investigate the effects of DMT on individuals with SPD. I have chosen to contact you as a prospective participant because of your work with a variety of individuals in a private practice setting. I invite you to participate in my study if you have come across individuals with SPD, or if this study is of interest to you. I would greatly appreciate your reply, whether or not you are interested and available to contribute your expertise to this study! Thank you for your consideration.

With appreciation,

Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix E. Recruitment Email Script for Dance/Movement Therapists

Greetings (name),

In response to your interest in my thesis research, I write to extend a warm invitation to participate in my emerging research study exploring the research question: How is a positive psychology based DMT approach a viable treatment method for SPD?

The purpose of this study is to gather responses from professionals in the fields of both DMT and SPD, like you, to start the dialogue of how DMT could be a successful treatment method for SPD. The study will be used as a launching pad for further research to possibly investigate the effects of DMT on individuals with SPD.

If you choose to participate in this study, I will ask you to become familiar with the document that I have prepared (see attached synthesis). Within this document, I am presenting synthesized information on both DMT and SPD treatment in a positive psychological lens. I am utilizing Solution Focused therapy as this positive psychological lens. Once familiar, a one-on-one 30-minute semi-structured interview will be scheduled at a location (or Skype meeting) and time convenient for you to discuss this research question.

If you are interested in participating in this study, please refer to the informed consent form for further details (attached). I would greatly appreciate if you could respond to this invitation within two weeks of receiving it. Please feel free to contact me with further questions about the study or the informed consent form. Thank you for your consideration and for the important work you do.

With appreciation,

Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix F. First Follow-up Email Script for Dance/Movement Therapists

Greetings (name),

I am contacting you regarding my previous email regarding my thesis research on Dance/Movement Therapy and Excoriation (skin picking) Disorder. For my thesis, I am exploring the research question: How is a positive psychology based Dance/Movement Therapy (DMT) approach a viable treatment method for the newly recognized diagnosis (in the May 2013 publication of the DSM 5) Excoriation (Skin Picking) Disorder (SPD)? If you are interested in participating in my study, I greatly appreciate your timely response to this email. I have attached my previous email, and the complementary documents.

With appreciation,

Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix G. Second Follow-up Email Script for All Participants

Greetings (name),

Since I have not heard back from you, I will assume you are unavailable to participate in my research study. I understand with your full schedule this may not be a possibility. If you are still interested, please email me. I thank you for your time and consideration,

With appreciation,
Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix H: ADTA: What is Dance/Movement Therapy Document

What is Dance/Movement Therapy?

“Dance/movement therapy can foster creative self-expression, and provides safe and effective options for relating to others and coping with the environment.”

Dance is the most fundamental of the arts, involving a direct expression of one’s self through one’s body. It is an especially powerful medium for therapy.

Based on the assumption that the body and mind are interrelated, dance/movement therapy is defined by the American Dance Therapy Association as “the psychotherapeutic use of movement as a process which furthers the emotional, cognitive, physical, and social integration of the individual.”

The dance/movement therapist focuses on movement behavior as it emerges in the therapeutic relationship. Expressive, communicative, and adaptive behaviors are all considered for both group, individual, couples, & family treatment. Body movement simultaneously provides the means of assessment and the mode of intervention.

Dance/movement therapists are employed in a wide variety of facilities as well as private practice. They address the needs of a broad spectrum of people, including those with specific disorders and disabilities.

Professional training of dance/movement therapists occurs on the graduate level, and the Masters is the terminal degree. The ADTA publishes a list of colleges and universities that provide appropriate education and training, and the association has established an approval procedure for granting recognition to those institutions that fulfill the guidelines for graduate degree programs.
Dance/Movement Therapy Resources


**For additional DMT resources please visit www.adta.org**
Appendix I: Recruitment Email Script for SPD Experts

Greetings (name),

My name is Karissa Martens and I am a graduate student in the Dance/Movement Therapy and Counseling MA program at Columbia College Chicago. I received your name and contact information from the Trichotillomania Learning Center.

I write to extend a warm invitation to participate in my master’s thesis study exploring the research question: How is a positive psychology based Dance/Movement Therapy (DMT) approach a viable treatment method for Excoriation (Skin Picking) Disorder (SPD)? You are being invited to participate because you are an expert in the field of SPD. I have attached a supplementary resource on DMT, if you would appreciate more information on this therapeutic modality. Please contact me if you would like more information, and/or visit www.adta.org.

The purpose of this study is to gather responses from professionals in the fields of both DMT and SPD, like you, to start the dialogue of how DMT could be a successful treatment method for SPD. The study will be used as a launching pad for further research to possibly investigate the effects of DMT on individuals with SPD.

If you choose to participate in this study, I will ask you to become familiar with the document that I have prepared (see attached synthesis). Within this document, I am presenting synthesized information on both DMT and SPD treatment in a positive psychological lens. I am utilizing Solution Focused therapy as this positive psychological lens. Once familiar, a one-on-one 30-minute semi-structured interview will be scheduled at a location (or Skype meeting) and time convenient for you to discuss this research question.

If you are interested in participating in this study, please refer to the informed consent form for further details (attached). I would greatly appreciate if you could respond to this invitation within two weeks of receiving it. Please feel free to contact me with further questions about the study or the informed consent form. Thank you for your consideration and for the important work you do.

With appreciation,

Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix J: First Follow-up Email Script for SPD Experts

Greetings (name),

I am contacting you as a follow-up to my previous email regarding an opportunity to contribute your expert knowledge to new research on Excoriation (skin picking) Disorder. For my master’s thesis study, I am exploring the research question: How is a positive psychology based Dance/Movement Therapy approach a viable treatment method for Excoriation (Skin Picking) Disorder? I am sure you are very busy, and I am appreciative that you might even consider contributing your expertise to this new study. I would be very grateful if you could reply within the next week as to whether or not you are interested and available to participate. For your convenience, I have attached my previous email, and several supporting documents.

With appreciation,

Karissa Martens
2014 MA Candidate
Dance/Movement Therapy and Counseling
Columbia College Chicago
Appendix K. Semi-structured Interview Questions

Dance/Movement Therapy and Excoriation (Skin Picking) Disorder: Finding a Link

Karissa Martens

Date: ____________________________________________

Interview location/mode: ____________________________________________

Pseudonym: _______________________________________________________

Dance/Movement Therapist or SPD Expert (circle appropriate one)

Length of Interview_______________________________________________

*Focus of Inquiry: How is a positive psychology based DMT approach a viable treatment method for SPD?

○ Do you have any initial questions about the document attached on how a positive psychology based DMT approach is a viable treatment method for SPD?

○ Do you have any initial feedback regarding the attached document?

○ Do you view this positive based DMT approach as potentially effective?
  ○ If so, do you think it would be most effective as long-term therapy, short-term therapy, individual therapy, or group therapy? Why?

○ Dance/movement therapists: What do you see as DMT’s greatest contribution to the SPD illness? Do you see any areas where DMT would be ineffective?

○ SPD Experts: What do you feel is currently needed in a treatment for SPD sufferers? Do you think DMT could support any of these needs?

○ What do you think about DMT substituting or complementing the current behavioral approach treatment for SPD? Why?

○ Do you believe this proposed treatment approach would be a viable treatment method for SPD?
Appendix L. Personal Reflection Journal Entry Template

Dance/Movement Therapy and Excoriation (Skin Picking) Disorder: Finding a Link
Karissa Martens

Date:______________________________________________

Interview location/mode:_________________________________

Participant Name/Pseudonym:_________________________________

DMT or SPD Professional:_____________________________________

Observations:

Thoughts:

Ideas:

Emotions:

Feelings:
**Appendix M. Clusters and Frequencies**

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Utilizing DMT &amp; SFT in the form of long-term therapy</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>Combining individual and group SFT &amp; DMT for each client</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Addressing each individual uniquely, knowing that the etiology for individuals with SPD varies</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>Placing importance on the therapeutic relationship; valuing empathy, instillation of hope, and patience</td>
<td>16</td>
</tr>
<tr>
<td>5</td>
<td>Being aware of therapeutic methods that may be detrimental to the client, being a critical thinker</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Treating the individual with SPD with a comprehensive approach</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Understanding that DMT &amp; SFT is a potentially effective approach</td>
<td>21</td>
</tr>
<tr>
<td>8</td>
<td>Primarily utilizing SMT &amp; SFT as an adjunct therapy to the current behavioral methods</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>Educating clients, professionals, and general public about this DMT &amp; SFT therapeutic approach</td>
<td>26</td>
</tr>
<tr>
<td>10</td>
<td>Educating/generating awareness about SPD to increase the forms and effectiveness of therapeutic modalities to target SPD</td>
<td>19</td>
</tr>
</tbody>
</table>
Appendix N: List of Mini-Theories

Mini-Theories

1. When utilizing SFT and DMT to treat individuals with SPD, long-term therapy would be most beneficial in creating change and supporting the positive for each individual.

2. A combination of group and individual therapy would be ideal when utilizing SFT & DMT on individuals with SPD.

3. Although SPD is in the DSM-5 under OCD and related disorders, a specific etiology is not agreed upon. SPD is a complex disorder, which can stem from other etiologies or a combination of them (shame, anxiety, boredom, trauma, depression, addiction, low self-esteem, BDD, imbalance of the energy system).

4. When treating an individual with SPD, it is important for the therapist to foster a strong therapeutic relationship. The therapist needs to be patient, hopeful, and empathic.

5. Some therapeutic modalities may be detrimental to the individual with SPD. As a therapist it is important to be a critical thinker when treating these individuals.

6. It is beneficial to treat individuals with SPD with a comprehensive approach that considers the biological causes as well. It is important to address the disorder from multiple ends with new and innovative ways.

7. The combination of DMT & SFT for treating SPD is potentially effective because these two therapeutic modalities fit nicely together, and it is a body-based therapy treating a disorder involving the body.

8. It is preferred that the DMT & SFT therapy is utilized as an adjunct therapy to the current behavioral methods. This form of therapy is a natural fit with the behavioral therapies, addressing the sensory and affect components of the Comb model that is currently used.

9. There needs to be education for clients and professionals on the DMT and SFT therapeutic approach.

10. Education and awareness need to exist on SPD to lessen the stigma, to increase research, and to increase the amount of therapeutic modalities available.
Appendix O. Electronic Thesis Agreement

Columbia College Chicago Electronic Thesis Agreement

Before your thesis or capstone project can be added to the College Archives, your agreement to the following terms is necessary. Please read the terms of this license.

By signing this document, you, the author, grant to Columbia College Chicago (CCC) the non-exclusive right to reproduce, translate (as defined below), and/or distribute your submission and abstract worldwide in electronic format.

AUTHOR AGREEMENT:

I hereby certify that the thesis or capstone project listed below is my original work and/or that I have the right to grant the rights contained in this license. I also represent that my thesis or capstone project does not, to the best of my knowledge, infringe upon anyone’s copyright.

If my thesis or capstone project contains material for which I do not hold copyright, I represent that I have obtained the unrestricted permission of the copyright owner to grant CCC the rights required by this license, and that such third-party owned material is clearly identified and acknowledge within the text or content of my thesis or capstone project.
I hereby agree that CCC may translate my thesis or capstone project to any medium or format for the purpose of preservation.
I hereby agree that CCC may keep more than one copy of my thesis or capstone project for purposes of security, back-up, and preservation.
I hereby grant to CCC and its agents the non-exclusive licenses to archive and make accessible worldwide my thesis or capstone project in whole or in part in all forms of media, now or hereafter known. I retain all ownership rights to the copyright of the thesis or capstone project. I also retain the right to use in future works (such as articles or books) all or part of this thesis or capstone project.

NAME:  Karissa Martens
TITLE OF WORK: Dance/Movement Therapy and Excoriation (Skin Picking) Disorder: Movement Treating Movement
SIGNATURE: __________________________ EMAIL: karissamartens@gmail.com
DATE: October 31, 2014