Factor Structure, Validity and Reliability of the Revised Version of Skin Picking Scale

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Abstract

Background: The purpose of this study was to examine the factor structure, validity and reliability of the Skin Picking Scale-Revised Version.

Materials and Methods: In this descriptive and validation study, participants were 550 (250 male and 300 female) of the University of Isfahan were selected randomly from 15000 students. In order to examine the factor structure of the SPS-R we conducted both exploratory and confirmatory factor analyses and Cronbach's alpha.

Results: Convergent validity of SPS-R with YBOCS-BDD, OCI-R and DASS 21-item were r=0.45, r=0.51 and r=0.70 (p<0.001). Exploratory and confirmatory factor analyses revealed two factors, one assessing impairment and the other symptom severity (4 items each). These factors could determine 58.1% of the variance. The Cronbach's alpha for the two factors were above 0.88. Also, results were shown to possess good psychometric properties, as well as discriminant validity and classification accuracy, in both clinical and community populations.

Conclusion: It can be concluded that this instrument is a useful measure for assess skin-picking disorder symptoms in clinical assessment.

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Introduction

The concept of the obsessive-compulsive (OC) spectrum has been discussed in the literature and increasingly studied. The term “spectrum” has been used to mean many things; in the literature, and in this article, “OC spectrum” refers to a group of disorders that are presumed to be distinct from, but related to, obsessive–compulsive disorder (OCD), and which are characterized by repetitive thoughts and/or behaviors [1]. Richter et al. [2] found greater lifetime rates of comorbid OCSDs, such as tic disorders, BDD, trichotillomania, skin-picking, and eating disorders in OCD patients (37%) compared with patients with panic disorder and social anxiety disorder, suggesting specificity for segregation of OCSDs above anxiety disorders in general [3]. Skin picking disorder (SPD) is a disorder characterized by recurrent and ample picking of the skin that is not solely due to a dermatological condition. Patients usually experience an urge prior to picking and have difficulty controlling the behavior. Picking usually results in tissue damage and may lead to permanent disfigurement [4]. Recently, a work group formed by the American Psychiatric Association suggested that SPD be included as a specific diagnosis in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-V [5]). Skin-picking was the most common lifetime (10.4%) and current (7.8%) impulse-control disorder, followed by nail-biting (4.8% and 2.4%, respectively). OCD subjects with current impulse-control disorders showed significantly worse OCD symptoms and poorer functioning and quality of life [6]. There is also growing awareness of the distress and disability associated with other stereotypic behaviors such as skin picking [7, 8]. SPD has received limited research attention, and few validated measures of skin picking exist. For example, the Yale-Brown Obsessive Compulsive Scale modified for Neurotic Excoriation (Y-BOCS-NE) is a semi-structured clinician-rated measure that has been used to evaluate treatment efficacy in adults with compulsive skin picking (CSP) [9, 10]. The most widely used instrument for a assessment of SPD is the Skin Picking Scale (SPS; 8), a six-item self-report questionnaire designed to assess SPD severity over the past week. Keuthen et al. [8] examined preliminary psychometric properties of the scale in small samples of SPD patients (N=28) and non-pathological skin pickers (N=77; i.e., college students admitting to occasional skin picking). The findings showed the SPS had good internal consistency (α=0.80) and was capable of discriminating between the SPD patients and the non-pathological skin pickers [8, 10]. Although these studies have provided some basics about instruments skin picking disorder, still there is some problems in diagnostic and assessing skin picking disorder and there is a need for a standard assessment tool to assess special skin picking disorder. In the current study, we examined the psychometric properties of a revised eight-item version of the scale, the Skin Picking Scale-Revised (SPS-R). A positive feature of the SPS-R is
three impairment domains in a proposed DSM-5 diagnostic criteria for SPD (i.e. skin lesions, subjective distress and functional impairment [11]. The main aim of this study was to presentation a strong standard assessment tool to assess skin picking disorder and determine its validity (construct and concurrent), reliability and comparison of its factors in patients with SPD and normal peoples.

Materials and Methods

Participants: In this descriptive study the data for the Iranian sample were collected in 2012. The Iranian sample consisted of 550 students participants (250 male and 300 female) attending University of Isfahan of Iran. Participants ranged in age from 16 to 35 years (10.5±2.4). Missing values were estimated in SPSS, using the Estimated Means (EM) procedure. Multi-stage cluster sampling method was used to select the sample. In the first step, 5 colleges were selected randomly among all colleges. In the second step, among selected colleges, 2 academic branches were selected in a random manner. And in the third step 40 classes and among 280 male and 320 female students were selected randomly and participated in the study. Moreover, we had 20 patients with skin picking disorder and 20 peoples without skin picking disorder for assessment of the diagnostic validity. Patients were drawn from consecutive referrals made by general practitioners and psychiatrists to dermatologist and cosmetic surgery clinics in the city of Isfahan, Iran. Skin picking disorder diagnosis was established using the structured clinical interview for DSM-IV diagnoses (SCID, based on the Diagnostic and Statistical Manual of Mental Disorders-4th Edition, Text Revision (DSM-IV-TR) [12]. The diagnoses were made by the first author, holding a master’s degree in clinical psychology. Thirty-one individuals met the criteria for diagnosis of Skin picking disorder set by DSM-IV-TR, of which 20 individuals were willing to participate in our research study; their major problem was Skin picking disorder.

Measure: The measuring tools in this study have been Skin Picking Impact Survey, Yale-Brown Obsessive Compulsive Scale Modified for BDD and Depression Anxiety Stress Scales 21-item version. Skin Picking Impact Survey (SPIS): [13]. The SPIS is a comprehensive survey covering a wide range of SPD related issues. The portion of the survey used in the current study included the questionnaires described below (i.e. SPS-R, DASS-21, & SDS) and questions concerning time spent picking per day and the level of urge/arousal prior to picking. Skin picking scale-revised (SPS-R). The SPS-R is a self-report measure designed to assess these verity of SPD symptoms during the past week. The original SPS [8] contains six items covering the following domains: 1. frequency of urge to pick, 2. intensity of urge to pick, 3. time spent picking, 4. interference due to skin picking, 5. distress due to picking/distress when prevented from picking and 6. Avoidance behavior due to picking. In the revised 8-item version, the distress item was replaced with a less ambiguous emotional distress item, and items assessing control over the behavior and skin damage due to picking were added. The new items were not administered along with the SPS, but later in the survey. All items of the SPS-R are rated on a 5-point scale from 0 (e.g., none) to 4 (e.g., extreme). Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS) [14]: This is a reliable and valid 12-item semi-structured clinician administered instrument that evaluates current BDD severity. It assesses BDD-related preoccupations, repetitive behaviors, insight, and avoidance [3]. The reliability and validity of the BDD-YBOCS Farsi version was and translated version was demonstrated by Rabiei et al. [15]. In both healthy and clinical samples, they showed that alpha coefficients ranged from 0.78 to 0.93 for the BDD-YBOCS total score and for its subscales (preoccupations, repetitive behaviors). Depression Anxiety Stress Scales 21-item version (DASS-21) [16]: The DASS-21 is a self-report measure designed to assess current symptoms of depression, anxiety and stress. On each of the three (7-item) scales, participants are asked to rate how much the items applied to them during the past week using a Likert scale from 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). Thus, scores can range from 0 to 21 on each scale. Previous studies have demonstrated acceptable psychometric properties of the DASS-21 and data from a non-clinical sample showed average score of 3.51 (SD¼ 3.78), 2.12(SD¼ 3.64), and 1.22 (SD¼ 1.77) for the stress, depression and anxiety scales, respectively [17]. OCI-R [18]: The OCI-R is an 18-item self-report questionnaire that assesses obsessive-compulsive symptoms, with a total score ranging from 0 to 72 and subscale scores ranging from 0 to 12. The original version was translated to German by two of the authors (S.G. and W.E.) and back-translated by a bilingual psychotherapist. The back-translation was verified by the authors of the original version.

Data analysis: In order to examine the factor structure of the SPS-R we conducted both exploratory and confirmatory factor analyses. We split the sample into two subsamples and conducted exploratory factor analysis in one sub sample, and then verified the factor structure with confirmatory factor analysis in the other sample. We used principal axis factoring (PAF) for exploratory factor analyses. PAF was chosen because we were interested in exploring the factor structure of the SPS-R by identifying underlying common factors that could then be validated and tested in a separate sample using confirmatory factor analysis. To test the factor structure validity of the Iranian version of the SPS-R and a tow correlated factors model were tested by means of Confirmatory Factor Analyses (CFA). For these analyses the Structural Equation Modeling program AMOS 5 was used [19]. Values of the Goodness of Fit Index (GFI) and the Adjusted Goodness of Fit Index (AGFI) close to 1 represents a good fit, values of the Root Mean Square Residual (RMR) and Standardized Root Mean Square Residual (SRMR) below 0.05 represents a good fit, and values less than 0.08
represents an acceptable fit. In order to examine possible differences of SPS-R factors within the patients with SPD cohort, we performed a multivariate analysis of variance test (MANOVA) on the scores with patients with SPD and peoples without SPD as independent variables. Since in large sample sizes the delta $\Delta \chi^2$ is likely to be significant.

**Results**

**Scale validity:** Considering table 1, the KMO measure of sampling represents the sufficiency of sample size of this study for factor analysis. If the amount of KMO is between 0.8-0.90, it shows that the sample size is good and bartlett's test of sphericity significant ($p<0.01$). As observed in table 2, 2 factors have been derive from SPS-R in total, that these 2 factor have extracted 58.01% of total variance of the scale. As observed in table 2 the loads under 0.4 have been omitted and 2 factors have been extracted.

The SPS-R structure: The factor structure of the Iranian version of the SPS-R was examined by means of CFAs. The model was separately tested for the overall sample and the results of these analyses were subsequently compared. Findings, reported in table 3, demonstrated that the model had overall fit to the data. As the model had the best fit to the data and is closely related to the theoretical assumptions of the SPS-R.

**Convergent validity:** The convergent validity was supported by testing correlation between SPS-R and (BDD-YBOCS), OCI-R and DASS-21. SPS-R and its subscales were positively associated with (BDD-YBOCS), OCI-R and DASS-21 ($p<0.001$). Table 4 shows correlation results between the total score of scale and its factors after factor analysis.

**Discriminant validity:** The discriminant validity of the SPS-R was examined by comparing the scores of clinically SPD peoples with those of control peoples. Results indicated that clinically SPD peoples reported significantly more SPD than control group.

**Discussion**

The current study examined the psychometric properties, factor structure, and convergent, divergent, and discriminant validity of the Iranian version of the SPS-R. Results from the present study indicate that the SPS-R has acceptable psychometric properties, with reliable and valid sub-scales assessing symptom severity and impairment. The model showed an acceptable fit in the sample. This confirms the construct validity of the measure and the underlying assumption of distinct symptom dimensions/subtypes belonging to category SPD. Findings of this study revealed that the Iranian version of the SPS-R has a clear two-factor structure, congruent with its theoretical conceptualization (see Table 2 and 3).

Table 1. KMO (Kaiser-Meyer-Olkin measure of sampling adequacy) and Bartlett's test of sphericity

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMO test</td>
<td>0.914</td>
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<tr>
<td>Bartlett's test of sphericity</td>
<td>3219.210</td>
</tr>
<tr>
<td>Significance level</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Table 3. Model fit indices for the two-factor model of the Iranian version of the SPS-R

<table>
<thead>
<tr>
<th>Two-factor model</th>
<th>N</th>
<th>GFI</th>
<th>AGFI</th>
<th>RMR</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>550</td>
<td>0.97</td>
<td>0.96</td>
<td>0.04</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Table 4. Correlation results of SPS-R and its factors with (BDD-YBOCS) and OCI-R and DASS-21

<table>
<thead>
<tr>
<th>Variable</th>
<th>SPS-R</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(BDD-YBOCS)</td>
<td>0.45</td>
<td>0.47</td>
<td>0.44</td>
</tr>
<tr>
<td>OCI-R</td>
<td>0.51</td>
<td>0.50</td>
<td>0.67</td>
</tr>
<tr>
<td>DASS-21</td>
<td>0.70</td>
<td>0.69</td>
<td>0.71</td>
</tr>
<tr>
<td>Significance</td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Table 2. Factor analysis of SPS-R and its constituent elements

<table>
<thead>
<tr>
<th>Component</th>
<th>Total Variance Explained</th>
<th>Extraction Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Initial Eigenvalues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Variance %</td>
</tr>
<tr>
<td>1</td>
<td>5.761</td>
<td>44.316</td>
</tr>
<tr>
<td>2</td>
<td>1.780</td>
<td>13.695</td>
</tr>
</tbody>
</table>

Table 5. Analysis of Multivariate of the effect of group membership for variables

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Df</th>
<th>Mean square</th>
<th>F</th>
<th>p-Value</th>
<th>Partial eta squared</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>1</td>
<td>328.61</td>
<td>19.52</td>
<td>0.002</td>
<td>0.56</td>
<td>0.95</td>
</tr>
<tr>
<td>Factor 2</td>
<td>1</td>
<td>355.66</td>
<td>22</td>
<td>0.001</td>
<td>0.59</td>
<td>0.99</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>362.21</td>
<td>28.88</td>
<td>0.001</td>
<td>0.61</td>
<td>0.99</td>
</tr>
</tbody>
</table>
This is congruent with the results of [8-20]. In addition, results indicated the higher positive correlation and significance of this scale and its factors with depression, anxiety, stress and BDD represents good convergent validity of this scale (Table 4). Furthermore, our results strongly support the discriminant validity of the SPS-R. The result showed that the SPS-R scores in SPD group were significantly more than normal group that is indicator of its satisfied diagnostic validity (see Table 5). SPD patients had higher scores than peoples without SPD on the SPS-R and its subscales. This is results congruent with results of [13]. The scale possesses high internal consistency, and the magnitude of the inter-item correlations is suggestive of a low to moderate overlap indicating low item redundancy. Internal consistency coefficient of 0.89 for the total scale and the coefficients of 0.88 to 0.91 for subscales indicate validity and high internal consistency of this scale. This is congruent with the results of [8, 21]. The results of the present study are consistent with those reported in previous studies in confirming the factor structure, reliability, and validity of the subscales of the SPS-R, despite the fact that the other studies have used either a mixed sample of patients with SPD. The fact that all studies have found a good fit for the six subscales suggests that SPD subtypes may manifest in similar patterns in clinical and non-clinical groups. In summary, our findings demonstrate that the Iranian version of the SPS-R is, like the original version, a brief, psychometrically sound and valid measure for the assessment of a broad range of skin-picking disorder symptoms, appropriate for the use in clinical and research settings. The present study replicated and extended previous findings with the original scale in a different cultural context. It would be necessary to determine the structure and reliability over time and with other samples. In addition studies are required to examine the sensitivity of scale to treatment effects and recovery if the scales are to prove useful treatment evaluation tools. Moreover, it is suggested that non volunteer participants, lower educated and other age ranges, and particularly with larger sample sizes. In addition studies are required to examine the sensitivity of both scales to treatment effects and recovery if the scales are to prove useful treatment evaluation tools. Ultimately, only self-report measures were included for each construct. Future studies may help these findings to be improved through using multiple measures of each construct and through using different response formats (e.g., clinician-rated, self-report, interview). However, despite these limitations, All in all, it can be concluded that this instrument is a useful measure for assess skin-picking disorder symptoms in clinical assessment. In conclusion, the current study further demonstrates that the SPS-R is a psychometrically sound, brief instrument that examines many of the main symptom subtypes of SPD. It is easy to administer.

Acknowledgements
The authors would also like to acknowledge the assistance of participants and all of the clinicians and research assistants who conducted the assessments.

Authors’ Contributions
All authors had role in design, work, statistical analysis and manuscript writing.

Conflict of Interest
The authors declare no conflict of interest.

Funding/Support
Baqiyatallah University of Medical Sciences.

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