PREVALENCE AND ASSOCIATED FACTORS OF SKIN PICKING DISORDER AT BORUMEDA GENERAL HOSPITAL, DERMATOLOGY CLINIC, WOLLO, NORTH EAST, ETHIOPIA, 2020

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Abstract

Background: Skin picking disorder is a psychocutaneous disorder that is characterized by compulsive and repetitive picking of skin, which results in psychological distress, severe tissue damage and functional impairment. Skin-picking disorder, also known as psychogenic excoriation, or neurotic excoriation, and is currently included under the Obsessive-Compulsive Related Disorders (DSM-5). Skin picking is more prevalent than expected, but under recognized despite prevalence range between 1.4 % and 5.4% in general population and most common among dermatology clinic with prevalence rate of 2%. But not known about prevalence of skin picking disorder among dermatology clinic in Ethiopia.

Objective: The aim of this study was to assess the prevalence and associated factors of skin picking disorder at Borumeda general hospital, dermatology clinic, Wollo, Northeast, Ethiopia, 2020.

Method: Institution based cross sectional study design was conducted. Participants were selected by using systematic random sampling technique and data was collected from 422 participants by using pretested, semi-structured, interviewer administered questionnaire. The outcome was assessed using a standard psychopathic checklist revised version. Data was coded, entered to epi data 3.1 and finally exported to SPSS version 25 for analysis. Logistic regression model was used for test of association. P-value < 0.05 at 95% CI was declared as statistically significant.

Result: A total of 422 participants were involved. Of them 214(50.7%) were male and their mean age was 32.4 years, SD ± 8.3. From the study finding the prevalence of skin picking disorder among dermatologic patients was 4.3%. Independently associated factors were including, having comorbidity with OCD [AOR= 4.22, 95%CI: (1.307, 13.014)], CMD [AOR=4.203 95% CI: (1.307, 13.014), Child hood sexual abuse [AOR= 9.672, 95%CI (1.8, 50.09)], and poor social support [AOR=0.091,95% CI= (0.19,0.445)].

Conclusion and recommendation; Skin picking disorder is highly prevalent in dermatologic patients, Hence, integrated working of psychiatry professional and dermatologist is recommended for early detection and management of the problem.

Key words: skin picking, excoriation, prevalence, dermatology, Boru-Meda, Ethiopia.

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Table of Contents

Abstract I

Acknowledgment II

List of figures VI

List of Acronyms VII

Chapter One: Introduction 1

1.1. Background 1

1.2 Statement of the problem 2

1.3 Significance of the study 4

CHAPTER TWO: LITERATURE REVIEW 5

2.1 Prevalence of skin picking disorder 5

2.2 Factors associated with skin picking disorder 6

Chapter Three: Objective 8

3.1 General objective 8

3.2 Specific objectives 8

Chapter Four: Methods and Materials 9

4.1 Study area and period 9

4.2 Study design 9

4.3. Population 9

4.3.1. Source population 9

4.4 Eligibility 9

4.4.1 Inclusion criteria 9

4.4.2 Exclusion criteria 9

4.5. Sample size and sampling procedures 10

4.5.1. Sample size determination 10

4.6 Sampling procedures 10

4.8 Operational definitions 11

4.9. Data collection procedures and instruments 11

4.10 Data quality control 12

4.11 Data processing and analysis 13

4.12 Ethical considerations 13

4.13 Dissemination plan 13

Chapter five: Result 14

5.1 Socio demographic characteristics 14

5.2 Substance related characteristic of respondents 16

5.3 Common mental disorder relating characteristic of respondents 16

5.8 Factors Associated with Skin picking disorder 18

Chapter Six: Discussion 22

Chapter Seven: Conclusion and Recommendation 25

7.1 Conclusion 25

Annexes 26

Annex-I references 26

List of tables

Table 1 Socio demographic characteristics of among dermatologic patients at Borumeda hospital, 2020(n=422) 14

Table 2 the prevalence of skin picking disorders among dermatologic patients at Borumeda hospital, 2020(n=422) 18

Table 3 Bivariate analysis of factors associated with skin picking disorder among dermatologic patients at Borumeda hospital, 2020(n=422) 19

Table 4 Multivariate analysis of factors associated with skin picking disorder among dermatologic patients at Borumeda hospital, 2020(n=422) 21

List of figures

Figure 1 summary of conceptual frame work developed from literature review on prevalence and associated factors of skin picking disorder among dermatologic conditions, 2020............7

Figure 2 Level of social support of among dermatologic patients at Borumeda hospital, 2020(n=422)..17

List of Acronyms

BDD - Body Dysmorphic Disorder

ED - Excoriation Disorder

DSM-5 - Diagnostic and Statistical Manual for Mental Disorder

OCD - Obsessive Compulsive Disorder

NE - Neurotic Excoriation

SPD - Skin Picking Disorder

SPS - Skin Picking Scale

LMICs - Low- and Middle-Income Countries

PSPD - Pathological Skin Picking Disorder

CMD - Common Mental Disorder

Chapter One: Introduction

1.1. Background

Skin picking disorder is persistent picking of one's skin resulted in skin lesions, psychological distress, sever tissue damage, functional impairment and repeated attempts to decrease or stop skin picking. Individuals with skin-pulling attempt to decrease or stop skin picking, but are unable to do so. Some picking of scabs is likely universal, but in the case of skin picking disorder , there is associated clinically significant distress or impairment (1). Skin picking disorder is a chronic problem characterized by recurrent and excessive picking of the skin that is not solely due to a dermatological condition or other medical condition. Patients typically experience an urge prior to picking and have difficulty controlling the behavior. Skin picking behaviors have been introduced in the medical literature since the 19th century (2); and recently including in diagnostic and statistical manual for mental disorder (DSM-5) as independent psychiatric disorder (1,3).

Neuroimaging study suggested that skin picking disorder symptoms such as impulsiveness associated positively with increased cortical thickness in the left insula, while severity of skin picking negatively associated with cortical thickness in the left and right supramarginal gyrus (4). According to diagnostic and statistical manual for mental disorder, the diagnostic criteria of skin picking disorder is recurrent skin picking resulting in skin lesions, repeated attempts to decrease or stop skin picking, and clinically significant distress or impairment in social, occupational, or other important areas of functioning caused by picking. Skin picking that meets the DSM-5 criteria of SPD cannot be attributable to the psychological effects of substance abuse or other medical conditions and cannot be better explained by the symptoms of another mental disorder(1).

The cause or maintenance of the skin picking is related to social variables such as beauty ideal of flawless skin which is explained by different social medias, and most commonly starts in early adolescence (5). So, having low self-esteem from skin irregularities results in psychological distress (6). Anxiety, which is resulting distress, precipitate skin picking and the reports showed that the patient get relief from this anxiety through picking their skin. The same studies suggest that patients with skin picking have problem in their social life and family for which reason they miss from work/school and limit going out in public (7).

Pathological skin-picking behaviors can focus on sites with distressed skin (e.g., pimples, scabs) as well as healthy skin and picking may be done using different means like; fingers, fingernails, and small instruments like pins or tweezers (8). Individuals with skin picking spend considerable time for picking, as well as additional time engaging in inspection/checking behaviors and compensatory concealment behaviors (e.g., using makeup, placing bandages) (9).

Skin picking disorder was historically conceptualized as a benign problem,-but recent studies have explained significant rates of psychiatric comorbidity (3), distress and psychosocial impairment (7), associated financial burden, and medical sequel (3,7). Severe, refractory pathological skin picking may result in physical disfigurement and severe medical consequences and, rarely, may warrant neurosurgical intervention (10).This complication may be managed through systematic examination and involvement of a multidisciplinary team. And treated through both pharmacological and psychotherapy, e.g (habit-reversal therapy) (11). Therefore, the current study is aimed to assess the magnitude of skin picking disorder and associated factors among patients with dermatological disease. This may be important to involve psychiatry professionals with dermatological professionals to improve patient's quality of life.

1.2 Statement of the problem

There is scarcity of studies on magnitude of skin picking among dermatologic patients. However, studies suggested that skin picking disorders are commonly occurred in general population ranging from mild to severe status. Clients with sever skin picking found to differ in their level of distress and impairment when compared with those mild skin picking (10). Many other studies reveal that severe skin picking behaviors commonly occur among females (9,12). However, non-clinical samples have not confirmed that females are severely affected by skin picking than men (5,13).

Complication of Skin picking usually resulted in tissue damage that may result in body disfigurement(8). As a result, many patients get emotionally distressed and functionally impaired due to the disfigurement or the inability to control the behavior (9,12).

Research has identified significant physical and psycho-social impact and impairment as a result of skin picking. Of the Physical bodily damage seemingly may include infection, bleeding and injuries with varying degrees of damage, in addition to lasting tissue damage and pitted,- scarring and even surgery may be needed depending on the severity (10).

Social withdrawal and experiential avoidance are common results of picking (8); in which many sufferers avoid social and public events, causing disruption to individuals daily activities (12,14), and seek to treat skin damage due to picking (12).

The context and phenomenology of skin picking appear variable. Evidence suggests that the majority of problematic skin pickers involve different bodily sites, most frequently the face, arms, scalp and legs are observed. Additionally Skin picking symptoms can also cause significant psychological distress, including that the individual has elevated rates of suicidal ideation (14).

Skin picking is sometimes precipitated by roughness, scabs and bumps on the skin's surface even if many attempt to improve the appearance of their skin (13) .Despite many report indicate that it occurs automatically without individual conscious thought or awareness (15). Other report, picking is sometimes correlated with a negative emotional state, like anxiety, tension or boredom (3).

In dermatologic clinic the prevalence of skin picking was estimated to be 2% (16). In other hand the prevalence of psychiatric comorbidity in the outpatient has been estimated to be as high as 25% to 30% (5,17).Study showed that patient referrals to psychiatry is limited due to patient resistance, which make dermatologists to the bulk of care. Survey studies have shown that only about 18% of dermatologists reported an understanding of psycho-dermatology and 42% had never received training in the subject (17).

Other studies considered skin picking as symptoms of body dysmorphic disorder that particularly linked to dermatologists. Approximately one third of patients compulsively pick at their skin, trying to remove minor blemishes or to otherwise clear or perfect their skin (13). Some patients take time with the compulsive repetitive behavior of skin picking for which different studies shows that patients spend 8 to 12 hours of their day by skin picking. Most commonly they use their fingers, pins, knives, removers, needles, staple razor or blades, (13). This repetitive behavior results in skin damage, which can be life threatening in some extreme cases (18).

A review of many literatures indicates that data regarding magnitude of skin picking in people with dermatologic conditions are limit, rather some studies employed among university students shown prevalence of skin picking ranges between 2.04% to 4.6% (2,13).whereas various studies report skin picking disorder which was estimated to range between 1.4% to 5.4% of the general population with high prevalent rate in women(3,7)

Despite skin picking having impact on dermatologic disease patient both as resulting in poor treatment out come and poor quality of life, under detected and misdiagnosed as primary dermatologic disease. Hence, To date no studies have examined the prevalence of SPD and comorbid disorder among dermatologic patients in Ethiopia, even African countries. Aim of this study fills this gap by assessing the magnitude and associated factors of skin picking disorder in dermatologic patients.

1.3 **Significance of the study**

Research on Skin Picking Disorder among Dermatologic patient has been limited by small sample sizes, with little attention given to the medical consequences of picking behavior. Because there have been few systematic studies of a series of rigorously diagnosed individuals with Skin Picking, the present study's purpose was to construct a detailed epidemiological, and the factors associated to the illness of individuals meeting proposed criteria for Skin Picking. An understanding of the characteristics and medical problems of individuals suffering from this behavior may have clinical importance, in addition to decreasing costs and other relevant expenditures warranted for treatment.

It also helps the clinicians not only need to recognize the emotional and psycho-social impact of picking to provide appropriate mental health care but also need to be aware of possible medical sequel of picking so that appropriate interventions may be made. It also helps researchers who have interest to conduct study on the skin picking as far as a little attention is given for this disorder and limited information is available throughout the world. In addition to this the study will also help for policy makers to understand the magnitude and associated factors of the illness.

CHAPTER TWO: LITERATURE REVIEW

2.1 Prevalence of skin picking disorder

The studies on prevalence of skin picking disorder in dermatologic patients at national level is lacking. The existing studies have examined its occurrence in general population and and non-referred student populations. However, previously estimated prevalence have ranged from 2% to 5% (19) in dermatology and student samples to as high as 37% in patients with body dysmorphic disorder (20).

According to study done in United States of America (USA) of all respondents, 16.6% lifetime pathological skin picking disorder (PSPD) with noticeable skin damage; 60.3% of these denied picking secondary to an inflammation or itch from a medical condition. A total of 1.4% of entire sample meat criteria of picking with noticeable skin damage not attributable to another condition and with associated distress or psycho-social impairment (3).

Study conducted at different countries the prevalence of recurrent skin picking disorder causing distress or significant functional impairment among students was reported by 3.8% to 4.2% in the US (19,21). Similar study employed among 133 German students also revealed the that the prevalence rate of skin picking was 4.6% (13). Study undertaken among 245 samples of Turkish students found to be that 87.8% of students engaged in skin picking while 2.04% had pathological skin picking. In the study changing school, dermatological conditions and loss of close relationship were factors identified as stressors for skin picking episode (2).

The Brazilian sample study employed among 7639 study participants to determine the prevalence, correlates and association of skin picking with quality of life found to be that the prevalence of skin piking was 3.4%. The study reveals that skin picking was associated with suicidal ideation, major depression disorder, and alcohol and nicotine dependence. In addition, skin picking associated with impairment of physical and psychological quality of life comparing with those who without skin picking (22).

Study undertaken among 6000 university students through random email generation to assess the prevalence of skin picking and associated with physical and psychological health, the prevalence of skin picking was 4.2% out of 1,916 respondents. Substance use, impulse control disorders, eating, and anxiety were factors associated with skin picking disorder (21).

Study done in USA showed that the point prevalence of probable skin picking disorder (SPD) was 3.4% with a notable preponderance among women. Which is almost the same with previously conducted research among the community in US and where point prevalence range from 1.2% to 5.4%(3,17).While the prevalence of SPD among Polish students was 7.6% of the sample (23). Another cross-sectional study undertaken to determine the prevalence of body-focused repetitive behavior in Pakistan among Karachi medical students identified that the prevalence of skin picking was high which was 9% (24).

According to two communities-based studies have found that skin picking disorder is not uncommon. There is also community based study employed among 354 study participants in USA the prevalence of skin picking was 5.4% and impairment in daily functioning was related with skin picking (17). As it can be understood from the study even though 63% of respondents engaged in some form of picking, but only certain percent of the sample met for the diagnostic criterion. However, SPD is an under-diagnosed and inadequately managed behavior that is most commonly related to impairment in important areas of functioning in day today activities as well as impact in social interaction.

2.2 Factors associated with skin picking disorder

There is scarcity of studies that have identified associated factors for SPD among dermatologic patients. However, factors associate with SPD were reported in a different study population such as general population and student.

A study done in USA showed that skin picking disorder has been associated with Substance use disorder, obsessive compulsive disorder, depression, post-traumatic disorder, bipolar, and anxiety disorder in general population (25). Other community based study also showed skin picking disorder has association with depression, anxiety, and obsessive compulsive symptoms (17). From study conducted in Brazilian population the authors reported that skin picking symptoms have association with obsessive compulsive symptoms, psychological and sexual abuse (22).

Study conducted among Israeli university students identified factors like compulsive sexual behavior, anxiety and eating disorder to have association with skin picking disorder (7). Study employed among Midwestern university student revealed factors associated with skin picking: such as substance use, anxiety, impulse control disorder and affective disorder (21).

A study done in Great Neck, New York suggest 68% of skin picking patients accounts for OCD, 12% for BDD, 10% for Generalized anxiety disorder, 28% for mood disorder, and 36% for abuse (sexual, verbal, emotional) (10). Other study also showed 44.9% of skin picking patients accounts for body dysmorphic disorders (20). Exposure to childhood sexual abuse also has a significant association with skin piking disorders (26).

Skin picking patients most commonly have obsessive compulsive rituals explained by behavior like perfectionism, rigidity, control and judgmental, and it more frequently prevalent in skin picking disorder ranging from 6% to 52% than in general population which estimated to be between 1% -3%(7). Social factors such as marital hardship, financial loss and unemployment have also been reported to have association with skin picking(27,28). Substance use disorders is most commonly association factors with skin picking (5,29).

Conceptual frame work

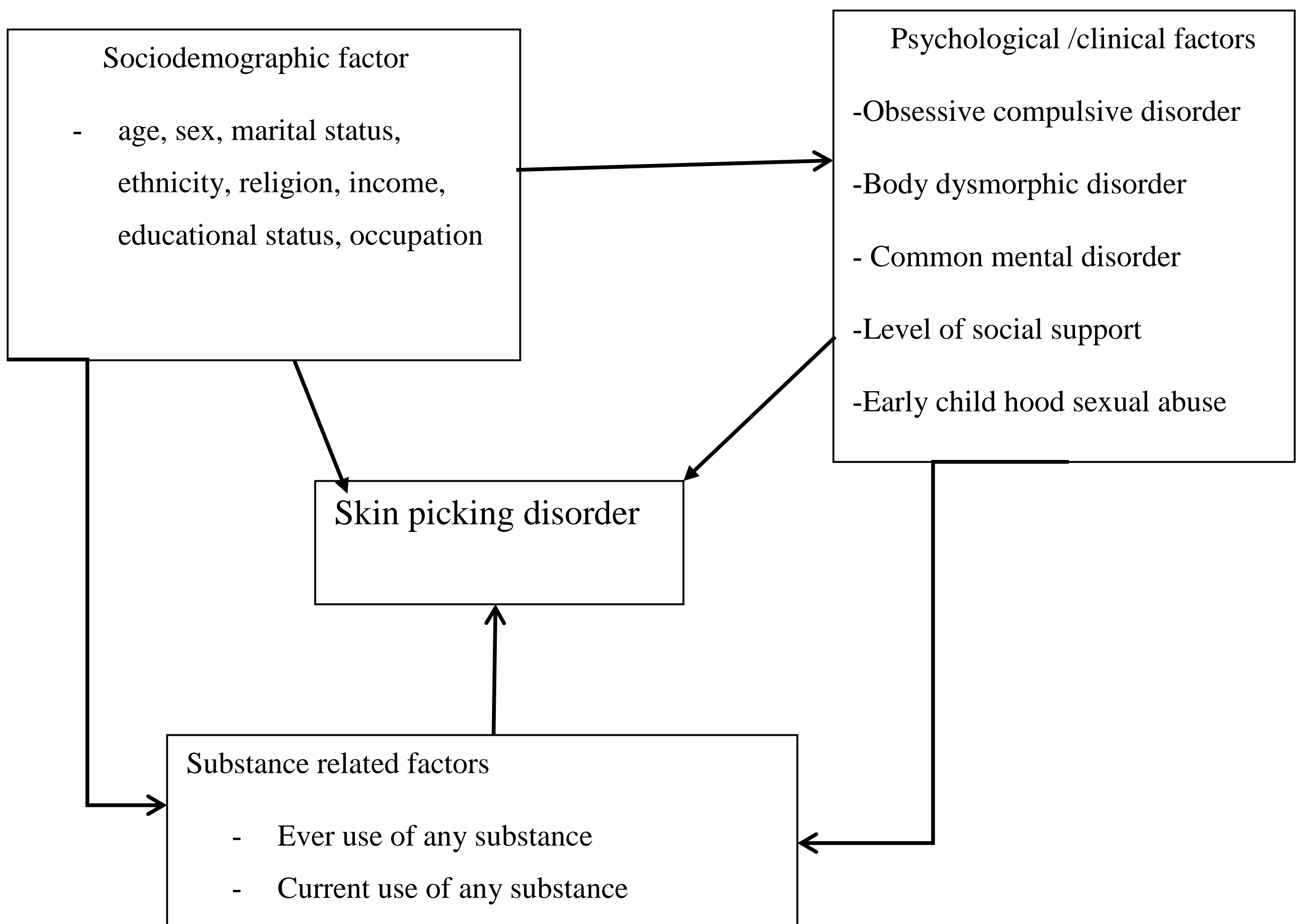


Figure 1 summary of conceptual frame work developed from literature review on prevalence and associated factors of skin picking disorder among dermatologic conditions, 2020.

Chapter Three: Objective

3.1 General objective

- ✓ To assess prevalence and associated factors of skin picking disorder at Borumeda general hospital, dermatology clinic, Wollo, North east Ethiopia, 2020

3.2 Specific objectives

- ✓ To assess the prevalence of skin picking disorder at Borumeda general hospital, dermatology clinic, Wollo, North east Ethiopia, 2020.
- ✓ To identify factors associated with skin picking disorder at Borumeda general hospital, dermatology clinic, Wollo, North east Ethiopia, 2020

Chapter Four: Methods and Materials

4.1 Study area and period

The study was conducted Boru Meda primary hospital found in eastern Amhara south wollo zone Dessie town located 10 km north direction from Dessie town, which is 401 km north east of Addis Ababa and 500km away from Bahirdar respectively. It was established in 1955 through the support of missionary organization and initially established to provide dermatology and ophthalmic services for population in the locality but as the government direction oriented towards providing integrated serves, now a day the hospital is delivering almost all types of health services provided by general hospital in Ethiopia. Boru Meda primary hospital health management information service report reveals that currently there are 35,000 dermatologic patients, predominantly from Amhara, Afar and Tigray region getting the services. The study was conducted from August, 2020 to Semptember, 2020.

4.2 Study design

Institution based cross-sectional study design was employed from August, 2020 to **September,2020.**

4.3. Population

4.3.1. Source population

All people with dermatologic compliant who have attended outpatient clinic.at Boru Meda hospital

4.3.2 Study population

People with dermatologic compliant who came for follow up and newly visiting people during study period and who fulfilled inclusion criteria.

4.4 Eligibility

4.4.1 Inclusion criteria

Age ≥ 18

4.4.2 Exclusion criteria

Critically ill patients to the extent they are unable to communicate.

4.5. Sample size and sampling procedures

4.5.1. Sample size determination

The sample size was determined by a single population proportion formula by assuming the 50% as prevalence, 95% confidence interval (CI), 5% margin of error by assuming the following equation:

$$N = (Z_{\alpha/2})^2 \, p\,(1-p)/d^2$$

Where

N = sample size,

$Z_{\alpha/2}$ = standard score value for 95 % confidence level,

P = prevalence (50%)

D = margin of error (5%).

$N = (1.96)^2 \, 0.5\,(0.5)/0.05^2$

N = 384

Finally, by adding 10% non-respondent rate 384+38 sample size was 422

4.6 Sampling procedures

Systematic random sampling technique was used. Secondary data obtained from Boru Meda primary hospital shown that in average 2200 patients have visited dermatology clinic every month. Then the (k) interval was calculated as, k =2200/422 = 5 the first patient was selected by using lottery method. After selected the first patient, the next patients were selected every 5 people intervals.

4.7 Variables of the study

4.7.1 Dependent variables

Skin picking disorder status

4.7.2 Independent variables

Socio-demographic factors: age, sex, marital status, ethnicity, religion, educational status, occupation, place of residence.

Psychological /clinical factors: social support, obsessive compulsive disorder, body dysmorphic disorder, common mental disorder and early child hood sexual abuse.

Substance related factors: alcohol use, smoking (cigarettes and/or shisha), chat chewing and others.

4.8 Operational definitions

Skin picking disorder: The measure of skin picking symptoms, with scores of ≥7 from ranging 0–24.

Obsessive compulsive disorder: is the presence of obsessions and/or compulsions. 8-15 = Mild, OCD; 16-23 = Moderate, OCD; 24-31= Severe, OCD; 32-40 = Extreme, OCD

Body Dysmorphic disorder: Taken as having BDD, where ever the patient scored the following answers, Question 1: Yes, to both parts, Question 3:Yes to any of the questions, Question 4: Answers b or c, 'Yes' answer to question 2 could indicate the presence of either BDD.

Sexual Abuse: 8 and above score of Childhood Trauma Questionnaire-Short Form (CTQ-SF) for sexual abuse subscale.

4.9. Data collection procedures and instruments

Data was collected by two BSc psychiatry professionals and two top dermatology specialists after they have taken training on data collection procedure and tool. English version prepared questionnaires was translated into local language which is Amharic, and back-translated to English by an independent person to ensure its understandability and consistency. Finally, after getting written informed consent from the participant's data was collected by structured Amharic version questionnaires. Each participant was interviewed separately and has a chance to ask the question if there is an ambiguity. In addition to Sociodemographic questionnaires other instruments are included to assess dependent and independent variables and briefly described below:

Skin Picking Scale

Skin picking was assessed using questions from standardized skin picking scale which incorporates 6-items to identify skin picking symptoms, with scores ranging from 0–24. The SPS can be used as a screening measure. A score of ≥7 is taken as a skin picking disorder, with internal consistency α= 0.93 (30).

Obsessive-Compulsive Test - Yale Brown OCD Scale YBOCS

To assess OCD associated with skin picking YBOCS scale was used. YBOCS is golden standard tool to screen OCD for various study population with having ten items. The tool assesses both obsessions and compulsion, and total score is 8-15=mild OCD, 16-23=Moderate OCD, 24-34 Severe OCD 32-40 Extreme OCD.

Assessment tools of Body Dysmorphic Disorder (BDD)

To assess body dysmorphic associated with skin picking BDD scale was used. BDD is the validated tool to screen body dysmorphic disorder and eating disorder for various study population with having four items. Where ever the patient scored the following answers, taken as having BDD

Question 1: Yes, to both parts

Question 3: Yes to any of the questions

Question 4: Answers b or c

'Yes' answer to question 2 could indicate the presence of either BDD.

Assessment tools of common mental disorder (CMD)

To assess common mental disorder associated with skin picking SRQ-20 questioners were used. SRQ-20 is widely used tool that validated into Amharic language for Ethiopian sample. The tool consists of 20 questions with "yes' or "no" answers with cut-off point of 8 and above (31).

Assessment tool for level of social support by using (OSS-3) the Oslo-3 level of Social Support Scale. If the score is 3-8 it indicate poor social support, 9-11 indicates medium social support, and 12-14 shows good social support.

4.10 Data quality control

Training was given for data collectors and supervisor. Pre-test was conducted on 22 participants independent of study population at Dessie referral hospital to identify potential problems in data collection tools and modification of the questionnaire. Regular supervision and support was given for data collectors by the supervisor. Data was checked for completeness and consistency by supervisors and principal investigator on daily bases during data collection time. The internal consistency of the items were determined and showed excellent with Cronbach's alpha (α= 0.94).

4.11 Data processing and analysis

After checking the data for completeness and consistency, it was coded and entered in to a computer using Epi Data version-3.1. Then, the data was exported to Statistical Package for Social Science (SPSS) version 25 for analysis**.** Frequencies, percentages and summary statistics were calculated to define the study population about relevant variables. The bivariate logistic analysis was done to determine simple association between the outcome and independent variables. Variables found to have P-value< 0.25 in the bivariate analysis were entered to multivariate analysis. Multivariate logistic regression analysis was employed to control for possible confounding effects and to determine the presence of a statistically significant independent association between independent variables and outcome variables. The model of fitness was checked by Hosmer and Lemeshow goodness and maximum likelihood should be checked and a P-value < 0.05 was considered statistically significant and strength of the association was presented by odds ratio with 95% CI.

4.12 Ethical considerations

Ethical clearance was obtained from Jimma University Institutional Review Board (IRB) and data collection was started after permission obtained. An official latter of co-operation was also written to Boru meda hospital and specifically to dermatology clinic. Written informed consent was obtained from each respondent. Individual who do not volunteer to continue from the beginning or from any part of the interview was respected right to do so. Privacy and strict confidentiality was maintained during the interview proses them alone where no one other than data collector can hear the information they give. As well as anonymity was kept during data processing and report writing. In addition, to protect the participants from Covid-19 the room was set safe, necessary precautions was taken, windows were opened, physical distance between participant and data collector was maintained to protect the risk of the virus. Participants those who are identified as having skin picking during data collection was linked to psychiatric clinic for further investigation and intervention.

4.13 Dissemination plan

The result of the study will be disseminated to all relevant organizations through presentation and publication. The final result will also be submitted to JUMC, Psychiatry department, post-graduate library, JU research and dissemination office, Boru-meda general hospital, and for other concerned institution through hard copies/soft copies for the possible implementation of the stud finding.

Chapter five: Result

5.1 Socio demographic characteristics

The response rate was 422 (100 %) and the mean age of the respondents was 32.4 years (SD 8.3). The largest number of the respondents 80 (19%) was from the age group of 25 to 29 years. Out of total participants 214 (50.7%) were male, 223 (52%) were Orthodox, and Amhara 367 (87%). Educational status of the majority of the respondents, 90 (21.3%) were secondary school and most of the respondent are 104 (24.4%) were farmer. Majority of the respondents 258 (61.1 %), were married and also more than half 247 (58.5%) of respondents were from rural area (table 1).

Table 1 Socio demographic characteristics of among dermatologic patients at Borumeda hospital, 2020(n=422)

Variable	Category	Frequency	Percent (%)
Age	24 and below	61	14.5
	25-29	104	24.6
	30-34	92	21.8
	35-39	70	16.6
	40-44	54	12.8
	45-49	15	3.6
	50 and above	26	6.2
Sex	Male	214	50.7
	Female	208	49.3
Religion	Orthodox	223	52.8
	Muslim	164	38.9
	Protestant	28	6.6
	Catholic	4	0.9
	Others	3	0.7

Ethnicity	Amhara	367	87.0
	Oromo	20	4.7
	Tigre	14	3.3
	Affar	21	5.0
Level of education	Illiterate	158	37.4
	primary school	73	17.8
	secondary school	90	21.3
	college and above	101	23.9
Occupation	civil servant	37	8.8
	Unemployed	37	8.8
	private employed	43	10.3
	Merchant	57	13.5
	house wife	88	20.9
	Student	43	10.2
	day laborer	13	3.1
	Farmer	104	24.4
Residency	Urban	175	41.5
	Rural	247	58.5
marital status	married	258	61.1
	never married	115	27.1
	divorce	26	6.2
	Widowed	23	5.5

5.2 Substance related characteristic of respondents

Majority of the participants (81.5%) have no habit of substance use experience. Out of substance users, 18.5% of the respondents were categorized under ever substance users and 17.5% were current substance users. Of the current substance users 16.8%, 10.7%, and 11.6 % of respondents were khat, alcohol and tobacco users respectively. Moreover 27.8% of the skin picking disorder's patients had history of substance use in their life time. Of them 22.2%, 11.1%, 27.8 were khat, alcohol and tobacco users respectively.

5.3 Common mental disorder relating characteristic of respondents

Out of the total participants, 134 (31.8%) were identified as having common mental disorder. In term of symptoms, 160 (37.9%) had headache, 97 (23.0%) had poor appetite, 94 (22.3%) had sleep problem, 18% had frightened, 12.6% had hand shake, 13.0% were tense or worried, 11.4% had poor digestion, 11.6% had trouble thinking, 12.1% had feeling of unhappy,15.4% had crying more than usual, and 18.7% had difficult to enjoy daily activity.

Regarding skin picking disorder, the result showed 66.7% of those who were identified as having skin picking disorder were also found to have occurrence of common mental disorders.

5.4 Obsessive-Compulsive disorder relating characteristic of respondents

Our study showed that 131 (31.0%) of respondents were diagnosed for OCD using Yale Brown OCD Scale. The finding revealed of those identified for OCD 27.3% mild, 3.1% moderate, and 0.2% were severe. The study finding proved that 55.6% of skin picking disorders have presence of OCD, while 50.0%, 5.6% of them have mild and moderate OCD respectively.

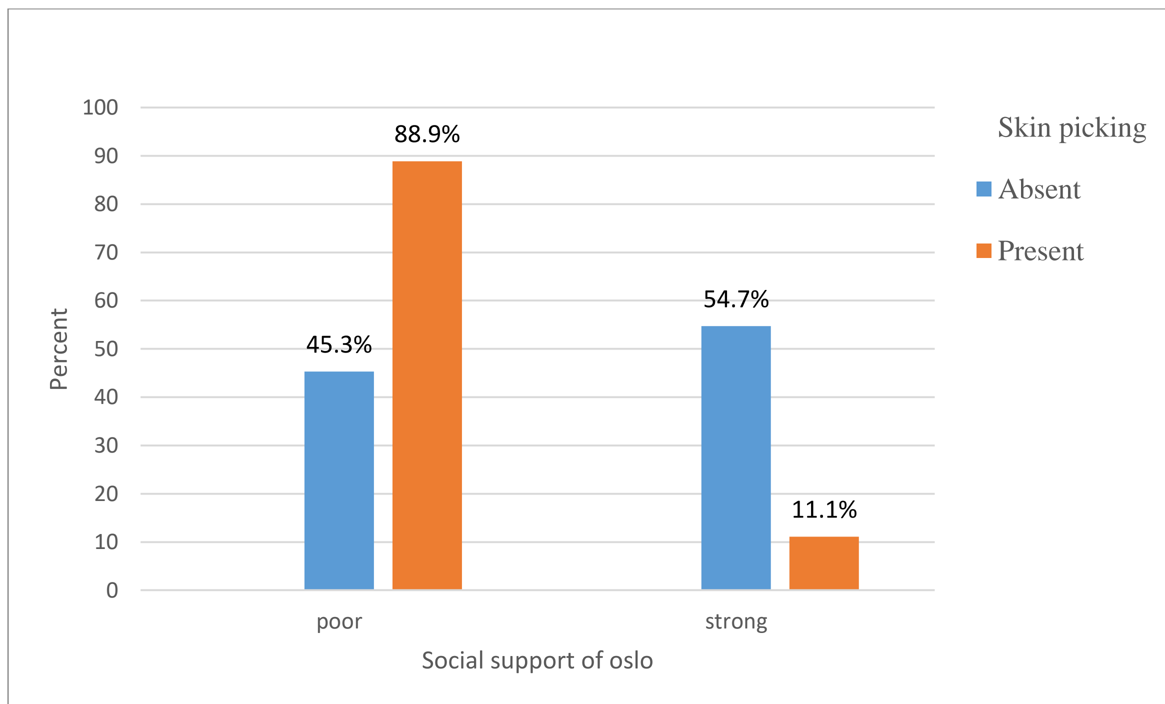
5.5 Body Dysmorphic Disorder (BDD) relating characteristic among dermatologic patients at Borumeda hospital, 2020(n=422).

Of the respondents 77 study participants were answered "yes" for questionnaires used for assessment of Body Dysmorphic Disorder (BDD) that indicates 18.2% of respondents having BDD. Our finding proved that 44.4% of skins picking disorders have concurrent body dysmorphic disorders.

5.6 Respondent's level of social support

Using the Oslo-3 Social Support Scale (OSS-3), majority of 199 (47.2%) of respondents have poor support. Although, 34.1%, 18.7% of them have moderate and strong social support respectively. Of those identified for skin picking disorders 88.9 % have poor social support while, 11.1% of them have strong social support.

Figure 2 Level of social support of among dermatologic patients at Borumeda hospital, 2020(n=422)



5.7 Skin picking disorder relating characteristic of among dermatologic patients at Borumeda hospital, 2020(n=422

This study proved that the prevalence of skin picking disorder among dermatologic patients was 4.3%. Concurrence of skin picking disorder was detected among 44.4% of patient with BDD, 66.7% of CMD, and 55.6% of OCD cases. More female 10 (55.6%) than male 8 (44.4%), none married 10 (55.6%) than married 7(38.9%), were found to have skin picking disorder. Skin picking disorder found to be higher among those who had poor social support 16 (88.9%

Table 2 **the prevalence of skin picking disorders among dermatologic patients at Borumeda hospital, 2020(n=422)**

Skin picking disorder	Frequency	Percent
Absent	404	95.7
Present	18	4.3
Total	422	100.0

5.8 Factors Associated with Skin picking disorder

In our study skin picking disorder had no association with sex, religion, ethnicity, marital status, occupation and place of residency in the bivariate logistic regression. Also there was no association of skin picking disorder with those who used alcohol, khat, and other substances. However, OCD, BDD, tobacco products, and sexual abuse showed association with skin picking disorder in the bivariate (unadjusted logistic regression model) at a p-value of <0.25.

In a bivariate analyses age, marital status, ethnicity, religion, occupation, sex, residency, level of education, OCD, BDD, CMD, child sexual abuse, level of social support, and using of substances such as tobacco, khat and alcohol were checked for associations on the cut off p value of less than 0.25. Then, in the bivariate logistic regression the following independent factors were candidate for multivariate OCD (p-value= 0.001), BDD (p-value=0.001), sexual abuse (p-value= 0.001)., level of education (p-value= 0.107), CMD (0.00), level of social support(p-value=0.005), and using tobacco (p-value = 0.136).

Multivariate analysis also was done to observe the prevalence of association between each variables and Skin picking disorder. P-value less than 0.05 are considered for statically significant and associated factors. In multivariate analysis Skin picking disorder's symptoms have significant association with dermatologic patients who have co-occurrence of OCD (p-value=0.012), CMD (P-value=0.016), child hood sexual abuse (p-value=0.007) and poor social support (p-value=0.003). However, no association is observed between Skin picking disorder and participant age, level of education, using tobacco, and BDD.

After adjusted for confounding the odds of people with CMD and OCD were four times more likely to have Skin picking disorder [AOR= 4.203, 95%CI: (1.307, 13.014)] and OCD [AOR= 4.203, 95%CI: (1.307, 13.014)] than their counterparts respectively.

Having child hood sexual abuse were 9.6 times more likely [AOR= (9.672, 95%CI (1.8, 50.697)] to have skin picking disorder. Having strong social support decrease the risk of skin disorder by 91% [AOR=0.091,95% CI= (0.19,0.445)].

Table 3 Bivariate analysis of factors associated with skin picking disorder among dermatologic patients at Borumeda hospital, 2020(n=422)

Variable		Skin picking disorder		COR &95% CI	P-value
		Yes %	No %		
Sex	Male	8(3.7)	206 (96.3)		
	Female	10 (4.8)	198 (95.2)	1.301(0.503,3.363)	0.588
Age	**<24**	**4 (6.6)**	**57 (93.4)**	**0.693(0.486,0.987)**	**0.042**
	25-29	5 (4.8)	99(95.2)		
	30-34	7 (7.6)	85(92.4)		
	35-39	1(1.4)	69(98.6)		
	40-44	1(1.9)	53(98.1)		
	45-49	0(0.00)	15(100.0)		
	>50	0(0.00)	26(100.0)		
Level of education	Illiterate	7(4.4)	151(95.6)	0.786(0.519,1.191)	0.257
	Primary school	7(9.6)	66(90.4)		
	Secondary school	1(1.1)	89(98.9)		

	College and above	3(3.0)	98(97.0)		
Marital status	Married	7(2.7)	251(97.3)	1.159(0.689,1.952)	0.578
	Never married	10(8.7)	105(91.3)		
	Divorce	1(3.8)	25(96.2)		
	Widowed	0(0.00)	23(100.0)		
Residency	**Urban**	**10(5.7)**	**165(94.3)**	**0.552(0.213,1.42)**	**0.221**
	Rural	8(3.2)	239(96.8)		
0ccupation	Civil servant	2(5.4)	35(94.6)		
	Unemployed	3(8.1)	34(91.9)	0.913(0.742,1.124)	0.393
	Private	2(4.7)	41(95.3)		
	Merchant	1(1.8)	56(98.2)		
	Housewife	3(3.4)	85(96.6)		
	Student	3(7.0)	40(93.0)		
	Daly labor	2(15.4)	11(84.6)		
	Farmer	2(1.9)	102(98.1)		
Tobacco use	**Yes**	**5(1.2)**	**44(10.42)**	**0.428(0.135,1.357)**	**0.149**
	No	**13 (3.08)**	**360(85.3)**		
Alcohol use	Yes	2 (0.47)	43 (10.2)	0.953(0.212,4.86)	0.950
	No	16 (3.7)	361 (85.5)		
Khat	yes	4 (0.94)	67(15.87)	0.976(0.275,3.467)	0.970
	no	14 (3.32)	337 (79.85)		
CMD	**yes**	**12(2.84)**	**122(28.91)**	**4.623(1.696,12.601)**	**0.003**

	No	6(1.4)	282(66.8)		
BDD	yes	8(1.89)	69(16.35)	3.884(1.480,10.196)	0.006
	No	10(2.3)	335(79.3)		
OCD	yes	10(2.36)	121(28.67)	2.924(1.126,7.588)	0.027
	No	8(1.8)	283(67.06)		
Oslo	Poor	16(8.04)	183(92.0)	0.104(0.23,0.456)	0.003
	Strong	2(0.9)	221(99.1)	9.661(2.193,42.567)	0.003
Sexual abuse	yes	4(0.94)	5(1.18)	22.8 (5.518,94.203)	0.000
	no	14 (3.3)	399 (94.5)		

Table 4 Multivariate analysis of factors associated with skin picking disorder among dermatologic patients at Borumeda hospital, 2020(n=422)

Variable		Skin picking disorder		COR &95% CI	P-value
		Yes %	No %		
Level of education	Illiterate	7(4.4)	151(95.6)		
	Primary school	7(9.6)	66(90.4)	1.709(0.36,6.699)	
	Secondary school	1(1.1)	89(98.9)	0.206(0.013,3.266)	
	College and above	3(3.0)	98(97.0)	1.057(0.207,5.409)	
Tobacco use	yes	5 (1.18)	44(10.43)	0.578(0.126,2.653)	
	no	13 (3.08)	360(85.305)		

CMD	**Yes**	**12(2.8)**	**122(28.9)**	**4.203(1.307,13.014)**	**0.016**
	No	**6(1.4)**	**282(66.8)**		
BDD	Yes	8(1.8)	69(16.3)	0.712(0.104,4.864)	0.305
	No	10(2.3)	335(79.3)		
OCD	**Yes**	**10(2.3)**	**121(28.6)**	**4.22(1.37,13.014)**	**0.012**
	No	**8(1.8)**	**283(67.06)**		
Oslo	**Poor**	**16(8.0)**	**183(92.0)**		
	Strong	**2(0.9)**	**221(99.1)**	**0.091(0.19,0.445)**	**0.003**
Sexual abuse	**Yes**	**4(0.94)**	**5(1.2)**	**9.672(1.8,50.69)**	**0.007**
	No	**14(3.3)**	**399(94.5)**		

Chapter Six: Discussion

This study showed high percentage (4.3%) of skin picking disorder in dermatologic patients. The associated factors of this finding were include common mental disorders [(AOR=4.203 95%CI:(1.307,13.014)], Obsessive compulsive disorders [(AOR=4.22 95% CI:(1.307,13.014)], child hood sexual abuse [(AOR=9.672 95% CI:(1.8, 50.09)], poor social support [(AOR=0.091 95% CI:(0.19,0.445)].

Even though the prevalence of skin picking among dermatologic patients at national level is lacking our finding was consistent with the previously estimated range from 2% to 5% (3).This finding is in line with study conducted in German among 133 students that revealed the prevalence rate of skin picking was 4.6% (13). Moreover, the finding is consistent with a study conducted among students that reported the prevalence of recurrent skin picking disorder to be 3.8% to 4.2% in the USA (19,20). The result is again consistent with the study undertaken among university students through random email generation to assess the prevalence of skin picking and associated with physical and psychological health, in which study the prevalence of skin picking was 4.2% out of 1,916 respondents.

However, the prevalence in our study is higher than a finding from a Turkish study conducted among a samples of 245 university students, which 2.04% of the participants found to have

pathological skin picking. The discrepancy could be the sample size which was smaller than the current study (422), population culture and study population (2). The prevalence of skin picking disorder among 7639 participants was 3.4% in study done at Brazil (32). The prevalence in our study is higher than the Brazilian study, which might be responsible for population culture and socio-economic status.

On the other hand, our result was lower than study employed among Polish and Pakistan students in which the prevalence of skin picking disorder were 7.6%, and 9% respectively. Possible reason for the discrepancy may be explained in part due to the difference in the screening instrument used, sample size difference and difference in the population studied. There was also other community based study in USA showed higher prevalence of skin picking 5.4%, than our study (17). The discrepancy might in part due to difference with the study setting and population studied.

Factors associated with skin picking disorders

As far as, there is limitation of studies that have identified associated factors for skin picking disorder among dermatologic patients, the current study findings were compared and contrasted with a different study population such as general population and student.

From this finding majority of skin picking disorders (66.7%) patients have comorbid common mental disorders. This finding is in line with study finding from general population that reported 53.1% and 63.4% of skin picking patients have depression and anxiety respectively (25). Even though, the study populations were different the presence of depression and anxiety seemed to be high in skin picking symptoms. This may be attributed to the psychological emotion response such as disgust, shame and avoidance that experienced by patients with skin picking disorders (33)**.** In line with others studies (7,17,21), current study shows that people with skin picking disorder were four times more likely to have common disorder.

Consistent with a study done in Great Neck, New York (68%), from this finding 55.6% of skin picking patients accounts for obsessive compulsive disorder. In agreement with other studies (10), patients with obsessive compulsive disorder were four times more likely to have skin picking disorder. This close relationship might be due to the similarity of clinical features of both disorders, for example people with skin picking disorders pick their skin again and again, in response to recurrent thoughts to touch or pick the skin, which similar to

repetitive behavior in response to recurrent thought or urges in obsessive compulsive disorder.

People with childhood sexual abuse were 9 times more likely to have history skin picking disorder. In line with other studies (10,26,34), patients with skin picking disorder have significant association with childhood sexual abuse. This can be attributed to that exposure to childhood sexual abuse leads to a decreased self-esteem, negative self-image, and feelings of incompetence.

Skin picking disorder was significantly higher among patients who had poor social support than patients who had strong social support. The finding shows that 88.9% of patients with skin picking disorder have poor social support and having strong social support decrease the risk of skin picking disorder by 91%. Supported by reported from previous study (22). This may be related to fact that poor social support system gives patients a feeling of being neglected and isolated which increase stress that precipitate skin picking symptoms. In contrast strong social support is vital for prevention of such feelings.

6.1 Strength and Limitation of the study

Doing the study at the time of covid-19 is the strength of this study. However, our study is out of limitation. Since, the study was conducted using face-to-face interviews, which may result in misclassification of variables like childhood sexual abuse, and substance use status due to social desirability bias.

Chapter Seven: Conclusion and Recommendation

7.1 Conclusion

This study shows nearly 1 in 25 suffer from skin picking disorder in dermatologic patient. Based on the findings people with OCD and CMD are 4 times more likely to develop skin picking disorders compared to their counterparts. In addition, people with history of childhood sexual abuse are 9 times more likely to have skin picking disorder compared to those who do not have history of childhood sexual abuse. Having strong social support decrease the risk of skin disorder by 91%.

7.2 Recommendation

Since the prevalence of skin picking disorder is significant in dermatologic clinic the following recommendation are forwarded to the responsible body.

1. The Ministry of health shall give attention to the comorbidity between skin picking and dermatologic disorders so as to arrange a platform for early screening and management of the problem.
2. Borumeda hospital shall establish or facilitate practice of screening to all dermatologic patients for skin picking disorder.
3. Dermatology department/unit shall arrange trainings on the screening and referral method of skin picking problem for dermatologists and health workers working in the unit
4. Dermatology department shall collaborate with Psychiatry department to facilitate early screening and treatment of dermatologic patients with skin picking disorder.
5. Dermatologists and researchers shall give attention towards skin picking problem among dermatologic patients.
6. Recommendation for researchers was that further study on this area is interesting to overcome the limitation that has the researchers of this study have faced.

Annexes

Annex-I references

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Annex-II Information Sheet and Consent Form

Dear Sir/madam;

How are you my name is ______________________. I am research assistant and working with Mrs Rabia shumet from Jimma University. She is doing a research on the prevalence and associated factors of skin picking disorder at borumeda dermatology clinic. From January 2020 to august 2020, as partial fulfillment for Degree of Masters Science in integrated clinical and community mental health. I am going to give you information and invite you to be part of this research. If you agree to participate, you was required to have face to face interview, which was take about 20 minutes of your time.

The information that we was obtain using this interview was used only for research purpose and also I need to assure you that confidentiality is our main quality.

Therefore; I politely request your cooperation to participate in this interview. You do have the right not to respond at all or to withdraw in the meantime, but your input has great value for the success of our objective.

Did you agree _____________yes no

Thank you for your cooperation!!

Annex-II English Version Questionnaires

Section I. Socio demographic and socio economic characteristics

Section I: socio demographic information				
Q No.	Questionnaires	Alternative Responses	Skip	Code
101	How old are you?	Age in years ______		
102	Sex	1. Male 2. Female		
103	What is your religion?	1. Orthodox 2. Muslim 3. Protestant 4. catholic		

		5. Others ______		
104	What is your marital status?	1. Married 2. Never married 3. Divorced 4. Widowed		
105	What is your ethnicity?	1. Amhara 2. Oromo 3. Tigre 4. Others________		
106	What is the highest level of school you have attended?	1. Unable to read and write 2. Able to read and write 3. Primary school 4. Secondary school 5. Diploma 6. Degree and above		
107	What is your job?	1. Civil servant 2. Unemployed 3. Private employee 4. Merchant 5. House wife 6. Student 7. Day labourer 8. Others		

		___________		
108	What is your current living place?	1. Urban 2. Rural		

Section II: Questioners for Assessment of excoriation (skin picking) disorder.

Instructions: For each item, pick the one answer which best describes the past week. If you have been having ups and downs, try to estimate an average for the past week. Please be sure to read all answers in each group before making your choice.

1. Frequency of urges how often do you feel the urge to pick your skin?

0 = No urges 1 = Mild, occasionally experience urges to skin pick, less than 1 hr/day

2 = Moderate, often experience urges to skin pick, 1–3 hrs/day

3 = Severe, very often experience urges to skin pick, greater than 3 and up to 8 hrs/day

4 = Extreme, constantly or almost always have an urge to skin pick

2. Intensity of urges how intense or “strong” is the urges to pick your skin?

0 = Minimal or none

1 = Mild

2 = Moderate

3 = Severe

4 = Extreme

3. Time spent engaged in skin picking how much time do you spend picking your skin How frequently does it occur How much longer than most people do it take you to complete routine activities because of your picking

0 = None

1 = Mild, spend less than 1 hr/day picking my skin, or occasional skin picking.

2 = Moderate, spend 1–3 hrs/day picking my skin, or frequent skin picking.

3 = Severe, spend more than 3 and up to 8 hrs/day picking my skin, or very frequent skin picking.

4 = Extreme, spend more than 8 hrs/day picking my skin, or near constant skin picking.

4. Interference due to skin picking how much does your skin picking interfere with your social or work (or role) functioning? (If currently not working determine how much your performance would be affected if you were employed.)

0 = None

1 = Mild, slight interference with social or occupational activities but overall performance not impaired.

2 = Moderate, definite interference with social or occupational performance, but still manageable.

3 = Severe, causes substantial impairment in social or occupational performance.

4 = Extreme, incapacitating.

5. Distress Associated with skin piking how much distress do you experience as a result of your skin picking? How would you feel if prevented from picking your skin? How anxious would you become?

0 = None

1 = Mild, only slightly anxious if skin picking prevented, or only slight anxiety during skin picking.

2 = Moderate, anxiety would mount but remain manageable if skin picking prevented, or anxiety increases to manageable levels during skin picking.

3 = Severe, prominent and very disturbing increase in anxiety if skin picking is interrupted, or prominent and very disturbing increase in anxiety during skin picking.

4 = Extreme, incapacitating anxiety from any intervention aimed at modifying activity, or incapacitating anxiety develops during skin picking.

6. Avoidance have you been avoiding doing anything, going any place, or being with anyone because of your skin picking? If yes, then how much do you avoid?

0 = None

1 = Mild, occasional avoidance in social or work settings.

2 = Moderate, frequent avoidance in social or work settings

3 = Severe, very frequent avoidance in social or work settings.

4 = Extreme, avoid all social and work settings as a result of the skin picking.

The Skin Picking Scale (SPS) is a 6-item measure of skin picking symptoms, with scores ranging from 0–24. The SPS can be used as a screening measure. A score of ≥7 is taken as having skin picking disorder

Section III. Psychological factors SRQ 20 to assess common mental disorder

s.no		Yes	no
1	Do you often have headaches?		
2	Is your appetite poor?		
3	Do you sleep badly?		
4	Are you easily frightened?		
5	Do your hands shake?		
6	Do you feel nervous, tense or worried?		
7	Is your digestion poor?		
8	Do you have trouble thinking clearly?		
9	Do you feel un happy?		
10	Do you cry more than usual?		
11	Do you find it difficult to enjoy your daily activities?		
12	Do you find it difficult to make decision?		
13	Is your daily work suffering?		
14	Are you unable to play a useful part in life?		
15	Have you lost interest in things?		
16	Do you feel that you are worthless person?		
17	Has thought of ending your life?		
18	Do you feel tired all the time?		
19	Do you have uncomfortable feelings in your life?		
20	Are you easily tired?		

Section IV: Substance use assessment			Skip
401. In your life, which of the following substances have you ever used? (non-medical use only)	No	Yes	If 'No' for each of Q401 (a,b,c), don't ask related Q402 (a,b ,c)
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	1	2	
b. Alcoholic beverages (beer, wine, spirits/liquor, tela, etc.)	1	2	
c. Khat	1	2	
402. In the past three months, which of the following substances have you used?	No	Yes	
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	1	2	
b. Alcoholic beverages (beer, wine, spirits/liquor, etc.)	1	2	
c. Khat	1	2	

Section V Obsessive-Compulsive Test - Yale Brown OCD Scale YBOCS

	0	1	2	3	4
Obsessions are frequent, unwelcome, and intrusive thoughts					
501. How much time do you spend on obsessive thoughts	None	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	More than 8 hrs/day
502. How much do your obsessive thoughts interfere with your personal, social, or work life	None	Mild	Definite but manageable	Substantial interference	Sever
503. How much do your obsessive thoughts distress you	None	Little	Moderate but manageable	Sever	Nearly constant, Disabling
504 How hard do you try to resist obsessions?	Always try	Try much of the time	Try some of the time	Rarely try. Often yield	Never try. Completely yield
505. How much control do you		Much	Some	Little	No control

have over your obsessive thoughts	Complete control	control	control	control	
Compulsions are repetitive behaviors or mental acts that you have a strong urge to repeat that are aimed at reducing your anxiety or preventing some dreaded event					
506. How much time do you spend performing compulsive behaviors?	None	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	More than 8 hrs/day
507. How much do your compulsive behaviors interfere with your personal, social, or work life?	None	Mild	Definite but manageable	Substantial interference	Sever
508. How anxious would you feel if you were prevented from performing your compulsive behaviors?	None	Little	Moderate but manageable	Sever	Nearly constant, Disabling
509. How hard do you try to resist your compulsive behaviors?	Always try	Try much of the time	Try some of the time	Rarely try. Often yield	Never try. Completely yield
5010. How much control do you have over your compulsive behaviors?	Complete control	Much control	Some control	Little control	No control

Your Score:

If you have both obsessions and compulsions, and your total score is;

8-15 = Mild OCD; 16-23 = Moderate OCD; 24-31= Severe OCD; 32-40 = Extreme OCD

Section VI: Questioners for Assessment of Body Dysmorphic Disorder (BDD

This questionnaire asks about concerns with physical appearance. Please read each question carefully and circle the answer that is true for you. Also write in answers where indicated.

601) are you worried about how you look? Yes No

If yes: Do you think about your appearance problems a lot and wish you could think about them less? Yes No

If yes: Please list, the body areas you don't like: ____________________________________

____

NOTE: If you answered "No" to either of the above questions, you are finished with this questionnaire. Otherwise please continue.

602. Is your main concern with how you look that you aren't thin enough or that you might get too fat? Yes No

603. How has this problem with how you look affected your life?

Has it often upset you a lot? Yes No

Has it often gotten in the way of doing things with friends, dating, your relationships with people, or your social activities? Yes No

If yes: Describe how:____

____

Has it caused you any problems with school, work, or other activities? Yes No

If yes: What are they? ____

Are there things you avoid because of how you look? Yes No

If yes: What are they? ____

____

604. On an average day, how much time do you usually spend thinking about how you look? (Add up all the time you spend in total in a day, and then circle one.)

(a) Less than 1 hour a day (b) 1-3 hours a day (c) More than 3 hours a day

Section VII. Level of Social support (using the Oslo-3 Social Support Scale (OSS-3)

701	How many people are you so close to that you can count on them if you have great personal problems?	1. None 2. 1-2 3. 3-5 4. 5+
702	How much interest and concern do people show in what you do?	1. None 2. Little

		3. Uncertain 4. Some 5. A lot
703	How easy is it to get practical help from neighbours if you should need it?	1. Very difficult 2. Difficult 3. Possible 4. Easy 5. Very easy

Section VIII CTQS-F assessment tool for early childhood sexual abuse

Code		Item (When I was growing up……)	Never true	Rarely true	Sometimes true	Often true	Very often true
801	Sexual Abuse	someone tried to touch me in a sexual way or make m touch them	1	2	3	4	5
802		Someone threatened me to hurt me or tell lies about me unless I did something sexual with them	1	2	3	4	5
803		someone tried to make me do sexual things or watch sexual things	1	2	3	4	5
804		someone molested me	1	2	3	4	5
805		I believe that I was sexually abused	1	2	3	4	5

Sexual Abuse: None=5; Low=6-7; Moderate=8-12; Severe=13+

Sexual abuse absent—if none or low(less than or equal to 7)

Sexual abuse present- if moderate to severe (greater than or equal to 8)

Annex-II የመረጃ እና የስምምነት ፎርም

የተከበሩ አቶ/ወ/ሮ/ወ/ሪት;

እንደት ነዎት ስሜ______________________. እኔ የጥናቱ እረዳት እና ከወ/ሪት ረቢአ ሹሙት ጋር በጅማ ዩኒቨርስቲ አብሬ እየሰራሁ እገኛለሁ።ጥናቷን በቆዳ መንጨት እና ተያያዥ ችግሮች ዙሪያ በቦሩ ሜዳ ሆስፒታል በቆዳ ህክምና ክፍል ከጥር 2020 እስከ ነሐሴ 2020 እ.ኤ.አ በሁለተኛ ድግሪ በተቀናጀ ክሊኒካል እና ማህበረሰብ እዕምሮ ጤና ነው።በዚህ ጥናት ላይ እንድሳተፉ በትህትና እጠይቀወታለሁ።.ለመሳተፍ ከተስማሙ ፊት ለፊት ቃለ መጠይቅ ያስፈልገዎታል 20 ደቂቃ የሚወስድ ካለወት ሰአት ።

ከዚህ ቃለ-መጠይቅ የምናገኘው መረጃ የሚጠቅመው ለጥናት ብቻ ነው።በተጨማሪም ሚስጥር መጠበቅ ዋነኛ መለያችን መሆኑን እናረጋግጥልዎታለን።ስለዚህ ለዚህ ቃለ-መጠይቅ እንድተባበሩኝበአክብሮት እጠይቀዎታለሁ። ሁሉንም ያለመመለስ መብት አለዎት ወይም በመካከል ማቋረጥ ነገር ግን የእርስዎ ግብዕት ወይም አስተዋፅኦ ለግባችን መሳካት ትልቅ ዋጋ አለው።

ይስማማሉ ______________አወ አልስማማም

ስለትብብርዎ አመስግናለሁ !!

ክፍልI: የተሳታፊውን የግል ሁኔታ የተመለከቱ ቃለ መጠይቆች				
ተ.ቁ	መጠይቆች	አማራጭ መልሶች	ይዝለሉት	ኮድ
101	እድሜ	እድሜ በአመት ______		
102	*ፆታ*	1. ወንድ 2. ሴት		
103	ሐይማኖት ?	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ______		
104	የጋብቻ ሁኔታ ?	1ያገባ/ች 2 ያላገባ/ች 3 የፈታ/ች		

		የሞተበት/በት		
105	ብሔርዎት ምንድነው?	1. አማራ 2. ኦሮሞ 3. ትግሬ 4. ሌሎች_______		
106	የትምህርት ደረጃ ?	1. መፃፍም ማንበብም የማይችል/ችል 2. ማንበብና መፃፍ 3. የመጀመሪያ ደረጃ(1-8) 4. ሁለተኛ ደረጃ 5. ድፕሎማ 6. ድግሪና ከዛ በላይ		
107	ስራዎት ምንድነው?	1. የመንግስት ሰራተኛ 2. ስራ አጥ 3. የግል ስራተኛ 4. ነጋደ 5. የቤት እመቤት 6. ተማሪ 7. የቀን ስራተኛ 8. ሌሎች__________		
108	አሁን የሚኖሩት የት ነው?	1. ከተማ 2. ገጠር		

ክፍል II: የቆዳ መንጨትን ለማወቀ የተዘጋጀ ቃለ መጠይቅ

ትዕዛዝ: ለእያንዳንዱ ጥያቄየበለፈውን ሳምንትዎን በደንብ የሚገልፀውን ይምረጡ። በባለው ሳምንት የስሜት መውጣት መውረድ ካለወት በአማካይ ይናገሩ።እባክዎ ሁሉንም ጥያቄዎች እርግጠኛ ሆነው ያንብቡ ከመምረጥዎ በፊት ።.

1. ቆዳውን የመንጨት ስሜት/ፍላጎት ምን ይክል ጊዜ ይሰማዎታል?

0 = ምንም ፍላጎት የለም/ምንም 1 = መጠነኛ, አልፎ አልፎ የሚደረግ, በቀን 1 ሰዐት ያነሰ

2 = መካከለኛ, በአብዛኛው የሚደረግ/ቆዳን መንጨት, ከ1–3 ሰዐት በቀን

3 =ከባድ Severe, በጣም ብዙ ጊዜ የሚደረ/ቆዳን መንጨት ከ 3 ሰዐት በላይ እና እስከ8 ሰዐት በቀን

4 =በጣም ከባድ , ሁል ጊዜ በተቋሚነት/በተደጋጋሚ የሚደረግ

2. ቆዳዎን የመንጨት ፍላጎትዎ ምን ያክል አስቸጋሪ/አስጨናቂ ነው?

0 = ዝቅተኛ/ምንም

1 = መጠነኛ

2 = መካከለ

3 =ከባድ

4 = በጣም ከባድ

3. ምን ያክል ሰዐት ያሳልፋሉ ቆዳዎን ለመንጨት? ለምን ያክል ጊዜ ይፈጠራል?ብዙ ሰዎች ከሚሰሩት ምን የተለየ እርስዎ መደበኛ ስራዎን ለመስራት/ለማከናዎን/ለማጠነቀቅ ምን ያክል ጊዜ ይፈጅበዎታል ቆዳ በመንጨትዎ ምክንያት።

0 = ምንም

1 = መጠነኛ, ከ1 ሰዐት ያነሰ በቀን ወይም አልፎ አልፎ ቆዳ መንጨት

2 =መካከለኛ,ከ1–3 ሰዐት, ወይም በተደጋጋሚ ቆዳን መንጨት

3 = ከባድ,ከ3 ሰዐት በላይ እስከ 8 ሰዐት ወይም በጣም ተደጋጋሚ የሆነ ቆዳን መንጨት

4 =በጣም ከባድ,ከ8 ሰዐት በላይ በቀን, ቋሚ በሚባል ሁኔታ

4. ቆዳዎን በመንጨትዎ ምክንያት በስራዎ በማህበራዊ ህይወትዎ ላይ ምን ያክል ተፅዕኖ አሳድሮብዎታል? (በአሁኑ ሰዐት የማይሰሩ ከሆነ/ስራ ከለሌዎት አቋምዎ ምን ያክል ይጎዳ ነበር በለው ያስባሉ ስራተኛ ቢሆኑ)

0 = ምንም

1 = መጠነኛ, መጠነኛ ተፅዕኖ በስራ ወይም በማህበራዊ ነገር ግን ሁሉም አቋም ያልተጎዳ

2 = መካከለኛ, ግልፅ ተፅዕኖ ነገር ግን መቆጣጠር የሚቻል

3 = ከባድ, በማህበራዊ ወይም በስራ ላይ ተፅዕኖ ያሳደረ/ያመጣ.

4 = በጣም ከባድ, ሙሉ ለሙሉ መስራት አለመቻል/መቸገር

5. ቆዳዎን በመንጨትዎ ምክንያት ምን ያክል ይጨነቃሉ/ይረበሻሉ? ቆዳዎን ባይነጩ/ሳነጩ ቢቀሩ ምን ይሰማወታል? እንደት ይረበሻሉ?

0 = ምንም

1 = መጠነኛ, በትንሹ መረበሽ ቆዳ ካልተነጨ ወይም ትንሽ መጨነቅ/መረበሽ ቆዳ ከተነጨ/ሲነጭ ብቻ

2 = መካከለኛ , ጭንቀት ይኖራል ነገር ግን ቆዳ መንጨትን መቆጣጠር ይቻላል ። ወይም ጭንቀት ይጨምራል ቆዳ መንጨትን ለመቆጣጠር በሚሞከርብት ጊዜ ።

3 = ከባድ, ቆዳ መንጨት በሚቋረጥበት ጊዜ መረበሽ/መጨነቅ ይጨምራል , ወይም ጭንቀት/መረበሽ ቆዳ በሚነጭበት ጊዜ ይጨምራል።

4 = በጣም ከባድ,ማንኛውንም እንቅስቃሴ /ስራ ለመስራት የሚያስቸግር ጭንቀት ወይም የሚያስቸግር ጭንቀት ቆዳን በመንጨት ጊዜ.

6. ቆዳዎን በመንጨትዎ ምክንያት ነገሮችን ከማከናወን ተወስነዋል/አስወግደዋል/ማንኛውም ቦታ መሄድ ወይም ከሰው ጋር መሆን/መቆየት?መልስዎ አወ ከሆነ ምን ያክል አስወግደዋል?

0 = ምንም/የለም

1 = መጠነኛ, አልፎ አልፎ ከማህበራዊ ወይም ከስራ ቦታ መወገድ/ማስወገድ

2 = መካከለኛ , ከስራ ወይም ከማህበራዊ ጉዳይ በተደጋጋሚ መወገድ

3 =ከባድ, ከስራ ወይም ከማህበራዊ ጉዳይ በጣም በተደጋጋሚ መወገድ/መቅረት

4 = በጣም ከባድ, በቆዳ መንጨት ምክንያት ሁሉንም ማህበራዊ ጉዳይና ስራን ማስወገድ/መተው

የቆዳ መንጨት ስኬል/ልኬት 6 መልኪያዎች አሉት።መለኪያዎቹ ከ 0-24 ይደርሳሉ።የቆዳ መንጨት ስኬል እንደ መለያ መሳሪያ ሆኖ ያገለግላል።

ከ ≥ 7 በላይ ከሆነ ቆዳ የመንጨት ችግር እንዳለ ያሳያል/ያመለክታል

s.no		አወ	የለም
1	አብዛኛውን ጊዜ እራስ ህመም አለብዎት?		
2	የምግብ ፍላጎትዎ ቀንሷል?		
3	ጥሩ ያልሆነ እንቅልፍ የተኛሉ?		
4	በቀላሉ የፍርሀት ስሜት ይሰማወታል?		
5	እጅዎን ይንቀጠቀጣል?		
6	የመረበሽ,የመጨነቅና የመፍራት ስሜት ይሰማዎታል?		
7	ምግብ በልተው ቶሎ አይፈጭም?		
8	ያልተሰብ ሀሳብ የመጣብውታል?		
9	የመከፋት ስሜት ይሰማዎታል ወይም የደስታ ስሜት ማጣት አለዎት?		
10	ከቀድሞው የተለየ መከፋት ወይም ማልቀስ አለዎት?		
11	የቀን ከቀን ስራዎትን ለማከናወን ይቸገራሉ ወይም ይከብድወታል?		
12	ውሳኔ ለመወሰን ይቸገራሉ?		
13	የቀን ከቀን ስራዎ ላይ ችግር ተፈጠረ?		
14	በህይዎትዎ ለመዝናናት ወይም ለመደስት ተቸግረዋል?		
15	በነገሮች የፍላጎት መቀነስ ወይም ማጣት አለዎት?		
16	የማልጠቅም ነኝ የሚል ስሜት አለዎት?		
17	እራስዎን ለማጥፋት አስበው ይውቃሉ?		
18	ብዙውን ጊዜ የድካም ስሜት ይሰማወታል?		
19	በህይወትዎ ሊቆጣጠሩት የማይችሉት ስሜት ይሰማወታል		
20	በቀላሉ ይደክመዎታል ወይም የድካም ስሜት ይሰማዎታል?		

ክፍል IV: የሱስ መጠቀምን ለማወቅ የቀረበ			ይለፉት
401. በህይወትዎ ከሚከተሉት የትኞቹን ሱሶች ተጠቅመው ያውቃሉ? (መድሀኒት ላልሆኑ ብቻ)	የለ ም	አወ	መልስዎ ለጥያቄ ቁጥር 401 (ሀ,ለ,መ)የለም ከሆነ ጥያቄ
a. የትምባሆ ምርቶች (ሲጋራ, የሚቃሙ ትምባሆ,)	1	2	
b. አልኮል(ቢራ, ወይን, ስፕራይት/ለስላሳ መጠጦች, ጠላ, ወዘተ.)	1	2	
c. ጫት	1	2	
402. ባለፉት 3 ወራት ከሚከተሉት ሱሶች የትኞቹን ተጠቅመው ነበር?	የለ	አወ	

	ም		ቁጥር 402 (ሀ,ለ,መ)ን የለፉት
a. ትምባሆሆ ምርቶች(ሲጋራ , የሚቃሙ የትምባሆ ምርቶች ወዘተ)	1	2	
b. አልኮል(ቢራ , ወይን, ስፐራይት/የለስላሳ ምርቶች ወዘተ)	1	2	
c. ጫት	1	2	

	0	1	2	3	4

ኦብሰሽን ተደጋጋሚ የሆኑየማይፈለጉ እና የሚያስጨንቁ ሀሳቦች ናቸው።

501. ምንያህልጊዜ ያጣፋሉ በተደጋጋ ለማሰብ	ምንም	ከ0-1 ሰዐት በቀን	1-3 በቀን	3-8ሰዐት በቀን	ከ 8 ሰዐት በቀን
502.ተደጋጋሚ የሆነ(የማፈለግ)ሀሳብ በግል,በማህበራዊ ወይም በስራዎ ምን ያክል ተፅዕኖ አምጥቶበዎታል?	ምንም	መጠነኛ	ግልፅ ነገ መቆጣጠ የቻል	መካከለኛ	ከባድ
503. ተደጋጋሚ የሆነ(የማይፈለገ) ሀሳብምንያክል ያስጨንቀወታ?ወይም በተደጋጋሚ በሆነው(በማይፈለገው)ሀሳብ ምን ያክል ይረበሻሉ/ይጨነቃሉ?	ምንም	ትንሽ	መካከለ ግን መቆጣጠ የሚቻል	ከባድ	ቋሚየሆነ ተፅዕኖ/ጉዳት
504ምንያክልተደጋጋሚ የሆነውን(የማይፈለግ)ሀሳብን ለመቋቋም ይሞክራሉ ?	አብዛኛውን ጊዜ	ብዙውን ጊዜ	አልፎ አ	በመጠኑ	ሙሉበሙሉ አልሞክርም
505. ምን ያክል ይቆጣጠራሉ ተደጋ ጋሚ (የማይፈለግ)ሀሳብዎ ከመጠን ሲያልፍ/ሲሆን?	ሙሉ ለሙሉ እቆጣጠራለሁ	ብዙ ጊዜ እቆጣጠረዋለሁ	በመጠኑ እቆጣጠ	በትንሹ እቆጣጠራለሁ	ምንም አልቆጣጠረውም

ኮምፐልሽን ማለት ጭንቀትን ለመቀነስ የሚደረጉ ተደጋጋሚ ባህርያት/ድርቶች ናቸው።

506.ምንያክልጊዜ ያጠፋሉ/ያሳልፋሉ ተደጋጋሚየሆኑድርጊቶችን ለመፈፀም /ለማከናወን ?	ምንም	ከ0-1ሰዐት በቀን	1-3 ሰዐት በቀን	3-8 ሰዐት በቀን	ከ 8ሰዐት በላይ በቀን
507.ተደጋጋሚየሆኑት ድርጊቶች/ባህርያት በግል,በማህበራዊ ወይም በስራዎ ላይምንያክልተፅዕኖ	ምንም	መጠነኛ	ግልፅ ግን መቆጣጣር የሚቻል	መካከለኛ	ከባድ

አምጥቶበዎታል/አሳድርበዎታል ?					
508.ምንያክል ይጨነቃሉ/ያስጨንቀዎታል ተደጋጋሚየሆኑ ደርጊቶችን/ባህርያትን ባያደርጉ/ሳያደርጉ ቢቀሩ?	ምንም	ትንሽ	መካከለኛ ነገር ግን መቆጣጠር የሚቻል	ከባድ	ቋሚ የሆነ ተፅዕኖ/ጉዳት
509. ምን ያክል ተደጋጋሚ የሆኑትን ደርጊቶች/ባህርያትለመቆጣጠር ይሞክራሉ?ወይምተደጋጋሚ ድርጊቶችን/ባህርያትንምንያክል ለመቆጣጠር ይሞክራሉ?	አብዛኛውን ጊዜ እሞክራለሁ	ብዙውን ጊዜ	አልፎ አልፎ	በመጠኑ	በፍፁም አልሞክርም
5010.ተደጋጋሚየሆኑ ድርጊቶችን/ባህርያትንከመጣን በላይ ሲሆኑ/ከቁጥጥርውጭ ሲሆኑ እንደት ይቆጣጠራሉ?	ሙሉ በሙሉ	በመጠኑ	በ	በትንሹ	ምንም ወይም በፍፁም አልቆጣጠራቸው ም

ውጤትዎ:
ሁለቱም ኦብሰሽን/ተደጋጋሚ ወይም የማይፍለግ ሀሳብ እና ኮምፐልሽን/ተደጋጋሚ ድርጊት ወይም ባህርይ ካሉብዎት አጠቃላይ ውጤትዎ ;
8-15 =መጠነኛ ኦሲድ; 16-23 = መካከለኛ ኦሲድ ; 24-31= ከባድ ኦሲድ; 32-40 = በጣም ከባድ ኦሲድ

ክፍልVI: የሰውነት አቋምን ለማወቅ የቀረበ ቃለ-መጠይቅ

ይህ ቃለ-መጠይቅ የሰውነት አካል አቋም(ተክለ ሰውነት) ላይ ያለንን ምልከታ ይጠይቃል።እባክዎ እያንዳንዱን በጥንቃቄ እንብበው ይክቡ ለእርስዎ እውነት የሆነውን።በተጨማሪም መልስዎን የት እንደሚገኝ ይፃፉ።

601) ምን እንደሚመሉ ይጨነቃሉ(ስለ መልከዎ)? አወ የለም

መልስዎ አወ ከሆነ:ስለ አቋምዎ ችግር በብዙ ያስባሉ ,ስለ ችግሮች በትንሹ ለማሰብ ይሞክራሉ. አወ የለም

መልስዎ አወ ከሆነ: እባክዎ ከሰውነት ክፍልዎ የማወዱትን/የማይውደ፟ቸውን ይዘርዝሩ: ______________________________

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ማስታወሻ:መልስዎ የለም ከሆነ ከላይ ካሉት ጥያቆዎች በዚህ ጥያቄ እንጨርሳለን/እናበቃለን።ካልሆነ እባክዎ ይቀጥሉ ።

602. ዋነኛ ትኩርትዎ እንደት ቀጭን በሚፈልጉት መጠን እንዳልሆኑ ወይም በጣም ወፍራም መሆነዎነው? አወ የለም

603. ይህ ችግር ህይወትን ምን ያክል ነው ያጠቃው?ብዙውን ጊዜ ይበሳጫሉ/ይናደዳሉ? አወ የለም

አብዛኛውን ጊዜ ነገሮችን ከጓደኞችዎ ጋር መስራት,ከሰዎች ጋር ያለዎት ግንኙነት ወይም ማህበራዊ እንቅስቃሴዎ በጥሩ ሁኔታ ላይ ነው? አወ የለም

መልስዎ **አወ** ከሆነ:እንደት እንደሆነ ይግለፁ:____

____

በትምህርትዎ,በስራዎ ወይም በሌሎች እንቅስቃሴወት ላይ ተፅዕኖ ፍጥሮብዎታል? አወ የለም

አወ ከሆነ: ምንድናቸው? ____

ምን እንድሚመስሉ በማሰብዎ ምክንያት ያስዎገዷቸው ነገሮች አሉ? Yes No

አወ ከሆነ: ምን ምን ናቸው? ____

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604. በአማካይ በቀን ምን ያክል ጊዜ ያሳልፋሉ ምን እንደሚመስሉ በማሰብ? (በቀን የሚያሳልፉትን ሁሉንም ሰዐት ይደምሩና አንዱን ያክቡ)

(a) ከ 1ሰዐት ያነሰ በቀን (b) ከ1-3 ሰዐት በቀን (c) ከ3 ሰዐት በላይ በቀን

ክፍል VII. ማህበራዊ እርዳታን ደረጃ ለማውቅ (OSS-3) በማጠቀም

701	ምን ያክል ሰው እረዳዎት ችግር ባጋጠመወት ጊዜ	1. ምንም 2. 1-2 3. 3-5 4. 5+
702	ሰዎች ምን ያክል ፍላጎትና ትኩረት አሳዮዎት ይህን ሲያደርጉ?	1. ምንም 2. ትንሽ 3. አላውቅም 4. መካከለኛ 5. ብዙ
703	ከጎረቤትዎ እርዳታ ቢፈልጉ ምን ያክል ቀላል ነው?	1. በጣም ከባድ 2. ከባድ 3. ይቻላል 4. ቀላል 5. በጣም ቀላል

ኮድ		(ልጅ እያለሁ/ወጣት….)	በፍፁም እውነት	በትንሹ እውነት	አልፎ አልፎ እውነት	ብዙውን ጊዜ	በአብዛኛው እውነት
801	ፆታዊ ጥቃት	የሆነሰው ፆታዊ ጥቃት ለማድረግ ሙከራ አድርጎብኛል	1	2	3	4	5

802		የሆነ ስዉ ፆታዊ ግንኙነት ከእርሱ ጋር ካላደረኩኝሊጎዳኝ ወይም ስለ እኔውሸትእንደሚናገር እስፈራርቶኝ ያውቃል	1	2	3	4	5
803		የሆነሰውፆታዊነግሮችን እንዳደርግ ወይም እንድመለከት አድርጎኝ ያውቃል	1	2	3	4	5
804		የሆነሰውፆታዊ ጥቃት አድርሶብኝ ነበር	1	2	3	4	5
805		ፆታዊ ጥቃት ደርሶብኛል ብየ አስባለሁ (አምናለሁ)	1	2	3	4	5