Trichotillomania: Behavioral Assessment and Treatment Interventions

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Abstract

This article examines the behavioral treatment of Trichotillomania. A brief overview of the diagnosis and assessment of Trichotillomania is provided. Guidelines for a structured clinical evaluation when working with people diagnosed with Trichotillomania are supplied. The most effective behavioral interventions and treatments for working with client's diagnosed with Trichotillomania are discussed.
Keywords: Trichotillomania, Behavioal Assessment,Behavior Treatment

Introduction

The reported incidence of Trichotillomania is rising with an estimated prevalence rate of 1%, suggesting that nearly 2.5 million people in the United States have this disorder (Diefenbach, Reitman, & Williamson, 2000). Increased attention should be given to the assessment and treatment of Trichotillomania to fulfill the escalating needs of those dealing with this mental disorder. There is a tendency for the severity of this disorder to be overlooked due to the underestimation of prevalence, and high rate of comorbidity with other psychological disorders (Mulinari-Brenner & Bergfeld, 2001). This article will provide suggestions for the behavioral assessment and treatment of Trichotillomania.

It is helpful for individuals to become familiar with the diagnostic features of Trichotillomania to establish the proper assessment and treatment of this disorder. The disorder was introduced in 1987 as an impulse control disorder (American Psychiatric Association, 1987). Trichotillomania is currently defined in the DSM-IV TR (American Psychiatric Association [APA], 2000) as the recurrent pulling out of one's own hair resulting in noticeable hair loss, in which an individual experiences persistent tension prior to pulling out the hair or when attempts are made to resist the behavior. Once the behavior is occurring or has occurred, the individual may feel pleasure, gratification, or relief. For the disorder to be considered clinically significant, that is not a result of a general medical condition or another mental disorder (American Psychiatric Association, 2000).

Trichotillomania often begins or is recognized in late childhood or early adolescence with an average age of onset at 13 years (Christenson, Mackenzie, Mitchell, & Callies, 1991; Simeon et al., 1997; Stein, Christenson, & Hollander, 1999; Walsh & McDougle, 2001). Despite the early onset, there is no consensus over the etiology of Trichotillomania (Diefenbach et al., 2000; Stein et al., 1999). Various explanations have been offered, that include viewing it as a feature of Obsessive Compulsive Disorder (OCD) as evidenced in the high comorbity rates (Christenson, Mackenzie, & Mitchell, 1991; Elliott & Fuqua, 2000), psychoanalytic perspectives (Diefenbach et al., 2000; Stein et al., 1999) and neurobiological factors (Ashton, 2001; Ravindran, Lapierre, & Anisman, 1999).

For the purpose of this article, trichotillomania will be addressed from a behavioral perspective and behavioral assessment and treatment interventions will be reviewed. Behaviorists believe that Trichotillomania is basically a coping behavior that develops in response to stressful stimuli. The hair pulling behavior is reinforced through classical and operant conditioning that culminates in an individual reverting to hair pulling as a technique used to reduce tension (Diefenbach et al., 2000; Stein et al., 1999). In the remainder of this article, effective behavioral interventions will be reviewed.

Behavioral Assessment of Trichotillomania

As in the assessment of all mental and emotional disorders, the clinician should conduct a clinical interview that provides a thorough assessment of a multitude of factors. Emphasis may be given to age of onset, frequency (e.g., does hair pulling occur daily, is it persistent or only present in times of distress, does it follow a pattern) and quantity (i.e., pulling hair strands or clumps), emotional state (before, during and after hair pulling), self employed efforts to reduce or stop the behavior, past treatment interventions and family patterns (Bordnick, 1997; Christenson, Mackenzie, & Mitchell 1991; Mulinari-Brenner & Bergfeld, 2001; Simeon & Favazza, 2001; Stein et al., 1999). Environmental (external), motoric (physical response), sensory, affective and cognitive factors that influence pulling behaviors should also be explored in the clinical interview (Stemberger, Stein, & Mansueto, 2003).

The goal of assessment is to determine a diagnosis and acquire information to assist in developing the treatment plan (Diefenbach, Tolin, Crocetto, Maltby, & Hannan, 2005). Before treatment can be implemented it is necessary to assure that hair pulling is the behavior that the client wishes to address in counseling (Mansueto, Golomb, Thomas, & Stemberger, 1999). Following confirmation that symptoms associated with Trichotillomania are the identified problems; antecedents, behaviors and consequences should be discussed with the client (Mansueto et al., 1999; Stemberger et al., 2003).

The assessment of Trichotillomania is complicated by the tendency for individuals to be hesitant to disclose that they are suffering from Trichotillomania (Stein et al., 1999). Clinicians should make careful observations and employ carefully structured questioning to assist in uncovering information that the client may be resistant to disclose. Clinicians must look for overt and subtle hair pulling from various regions of the body where hair grows by not limiting observations to the scalpel region (Cohen, Stein, & Simeon, 1995; Enos & Plante, 2001; Stein et al., 1999; Walsh & McDougle, 2001). Social isolation may be another factor associated with Trichotillomania, as individuals may withdraw from others due to the belief that they are alone in their struggles (Diefenbach et al., 2000). As with all mental and emotional disorders, mental health professionals should consider the cultural context in which the trichotillomania occurs, as hair pulling may be a socially acceptable ritual rather than a disorder (Stein et al., 1999).

Several instruments have been developed and tested for the assessment of Trichotillomania. The MGH Hairpulling Scale (MGH-HPS) is a self-report instrument that provides information concerning the frequency, intensity, associated stress and attempts to control behaviors connected with Trichotillomania (Diefenbach et al., 2005; Twohig & Woods, 2004). The Psychiatric Institute Trichotillomania Scale (PITS) is a clinician rated assessment tool that assesses multiple features of hair pulling. The NIMH Trichotillomania Severity Scale (NIMH-TSS) is formatted as a clinical interview that assesses hair-pulling behaviors. The NIMH Trichotillomania Impairment Scale (NIMH-TIS) is a global assessment of behaviors and feelings associated with hair loss. The Clinical Global Impression (CGI) assesses similar features of the aforementioned scale with the added feature of assessing comorbid features. The scales vary in reliability and validity (Diefenbach et al., 2005). All of these measures can be helpful tools in the assessment of Trichotillomania.

Role of Functional Assessment in the Treatment of Trichotillomania

In order to decide which treatment modality would be the most effective, some researchers suggest (e.g., Olympia, Heatherfield, Jensen, & Clark, 2002) that a functional assessment should be implemented to identify the relationships between the behavior, antecedent, and consequence events. Regardless of diagnostic intent, functional behavior assessment procedures serve the purpose of designing effective interventions (Hayes & Follette, 1992). When a mental health professional conducts a functional assessment, interviews, direct observations, and systematic manipulations can be employed (O'Neill, Horner, Albin, Storey, & Sprague, 1990), and archival record reviews and behavior rating scales may be used in the

assessment of antecedents and consequences. Olympia et al. (2002) suggest that direct forms of functional assessment provide more valid information, because there is no reliance on memories or information from obtained records. A myriad of assessment techniques can be implemented depending on the resources available to the mental health professional, the particular diagnosis that he or she is working with, and the age if the client.

With regard to trichotillomania, the counselor must focus on determining the environmental variables that maintain problem behaviors. The most popular model is the antecedent-behavior-consequence (ABC) approach to determine triggers and function (Olympia et al., 2000). First, the mental health professional describes an observable behavior and records events that immediately precede (i.e., the antecedent) and follow the behavior (i.e., the consequence). Second, while the antecedents and consequences are recorded, the behavior is documented (Olympia et al., 2000). Lastly, once the consequences are understood, effective treatment interventions can be postulated. Stemberger et. al. (2003) add that assessing antecedents, behaviors, and consequences, is a prerequisite for effective treatment. This approach is effective for counselors because it is based on the assumption that contexts allow the stimulus that is responsible for the behavior and maintaining it over time.

According to Stemberger et al. (2003), antecedents to engaging in behaviors common of individuals diagnosed with trichotillomania can be identified as environmental, motoric, sensory, affective, or cognitive. For example, environmental antecedents include a particular place where hair pulling usually occurs; antecedents of a motoric nature include simple motor habits; other individuals enjoy the sensation associated with hair pulling; some clients feel a calming sense or energized by hair pulling; and cognitive antecedents apply to those who engage in pulling behaviors to get rid of unwanted or ugly hair. The authors assert that only one or two of the above antecedents play a role for some individuals. All of the above antecedents are applicable to other clients. Associated with the above antecedents, behavior components exist. For example, for the environmental modality, going to a particular setting is the behavior. For the motoric realm, choosing a particular body site to remove hair is a behavior component. Behaviors associated with the sensation antecedent range from tactile search of hair to examining the hair or root after pulling. A plethora of behaviors are possible for each modality, and counselors must record their observations in detail to decide which antecedent component is applicable. Finally, Stemberger et al. (2003) are convinced that the consequences of trichotillomania serve the function of maintaining the overall cycle and influencing the likelihood of occurring again in the future. Depending on the behavior associated with a particular antecedent modality, the individual may interpret that hair pulling experience as reinforcing or punishing. For example, punishing stimuli for the environmental realm would be criticism or disapproval. A reinforcer for the affect domain could be relief from stress or distraction from obligations. The idea of regaining self-control could be a punishment for the cognitive modality. Counselors can employ the ABC model prior to identifying specific interventions. The ABC model is a widespread behavior analysis technique that can be implemented with other assessment methods. Once function is determined, it can be linked to specific interventions, for example if the function is sensory, an enriched environment, reprimands or redirection could all be employed. If the function is attention, reprimands and redirection should be avoided and the client should be taught in alternative ways to get attention and counseled in ways to activate those alternative methods through homework and contracting those alternative methods.

Behavioral Treatments and Interventions

The information obtained in the clinical interview and assessment offers an avenue through which interventions can be tailored to address problem behaviors (Mansueto et al., 1999). Behavioral interventions and treatment approaches of Trichotillomania have been referenced among the most effective treatment techniques and have proven to be promising in producing positive results (Diefenbach et al., 2000; Enos & Plante, 2001; Keuthen, O'Sullivan, & Sprich-Buckminster, 1998; Stemberger et al., 2003).

Treatment should be individually tailored and focused, as one treatment is not solely effective in the treatment of all those diagnosed with Trichotillomania (Mansueto et al., 1999; Stemberger et al., 2003). A diverse spectrum of behavioral techniques and interventions are useful in the treatment of trichotillomania (Diefenbach et al., 2000; Mansueto et al., 1999). Behavioral procedures have led to long-term constructive changes in hair pulling (Nelson, 1982). Several techniques are outlined below that may be incorporated into traditional counseling approaches or implemented as part of a structured behavioral program of intervention.

Nelson (1982) recommended that the clinician collect a baseline prior to implementing interventions. Any attempts to stop hair pulling should be directed at the beginning of the response chain (i.e., prior to the individual lifting a hand to pull hair; Taylor, 1963, as cited in Nelson, 1982). It may be helpful for client's to label statements that reinforce hair-pulling behaviors (e.g., pulling my hair makes me feel calmer; Yeh, Taylor, Thordarson, & Cocoran, 2003). The consequences that follow hair-pulling influence whether or not the behavior will continue (Stemberger et al., 2003).

The client may be asked to self-monitor his or her hair pulling (Deifenbach et al., 2000; Lerner, Franklin, Meadows, Hembree, & Foa, 1998). Self-monitoring requires that clients record their urges to pull their hair, including the frequency, duration and situations in which the urges occur (Bordnick, 1997; Stein et al., 1999). It is appropriate to request that the client monitor emotions that are experienced in relation to the behavior, as well as triggers that influence hair pulling. Clients can be encouraged to engage in response product measures; such as, saving and counting hairs that have been pulled (Deifenbach et al., 2000; Diefenbach et al., 2005). Recording the pattern of hair pulling through self-monitoring can add insight to the treatment of hair pulling (Deifenbach, 2005).

Researchers have suggested that clients label hair pulling behaviors as compulsions and identify associated triggers (i.e., being alone, reading, talking on the phone). Subsequently, efforts should be made to engage in competing behaviors or refocus themselves to continue engaging in the current behavior (i.e., being with others, taking a walk; Yeh et al., 2003). Competing reaction training teaches clients to use a behavior that is incompatible with hair pulling (Bordnick, 1997; Diefenbach et al., 2000; Enos & Plante, 2001; Lerner et al., 1998; Twohig & Woods, 2004). For example, a client may be asked to make a fist for one-minute when he/she experiences the urge to pull or asked to play with clay (Lerner et al., 1998; Twohig & Woods, 2004). A goal is to inverse the value placed on hair pulling and alternative behaviors resulting is increased time spent on alternative behaviors and decreased time spent hair pulling (Yeh et al., 2003). Clients can be instructed to wear bandages on their fingers, wear gloves, put weights on wrists, clench their fists, put hair in a ponytail or engage in activities that require use of their hands to prevent pulling (Mansueto et al., 1999; Rupp et al., 2000).

Response interruption coupled with differential reinforcement has been effective in eliminating hair-pulling in initial stages of treatment removal (Rupp et al., 2000). Response interruption is a technique employed with the intention of blocking attempts made to engage in hair pulling behaviors (Holttium, Lubetsky, & Eastman, 1994; Rupp et al., 2000). Differential reinforcement is used as a technique to increase client's engagement in alternative behaviors or in the absence of the behavior (Rupp et al., 2000). The client can be redirected to engage in more appropriate use of his or her hands (Holttium et al., 1994).

The rationale for the aforementioned techniques is seen in the notion that hair pulling behavior has been reinforced, thus alternatives to pulling can also be reinforced (Rupp et al., 2000; Stemberger et al., 2003).

Habit-reversal training is an empirically supported behavioral approach that is directed at increasing awareness of the target behavior (hair pulling), teach alternative coping skills (i.e., knitting), maintain motivation, and increase generalization (Bordnick, 1997; Diefenbach et al., 2000; Elliott & Fuqua, 2000; Enos & Plante, 2001; Himle, Flessner, & Woods, 2004; Lerner et al., 1998; Mouton & Stanley, 1996; Stein et al., 1999). The time spent on alternative behaviors should increase; hence, decreasing time spent pulling hair (Yeh et al., 2003). Strategies should be employed that are aimed at decreasing the number of conditions where hair pulling is favorable and increase conditions that make hair pulling difficult (Stemberger et al., 2003).

Elliott and Fuqua (2000) suggested that punishment is effective in decreasing behaviors associated with Trichotillomania. Some examples of successful punishment techniques are electric shock, topical agents that produce pain and snapping a rubber band. The authors emphasized that punishment is especially helpful in treating individuals with developmental disabilities. Another behavioral approach is the implementation of relaxation training culminating in reduced stress that indirectly reduces the urge to pull hair (Lerner et al., 1998).

Unique approaches to the implementation of behavioral intervention strategies have been offered. Behavioral interventions can be employed via telephone or group setting. Telephone administered behavior therapy has been an effective approach for the treatment of trichotillomania (Yeh et al., 2003). Group therapy has been shown to increase awareness of clients' internal and external cues associated with the urges to pull their hair, interrupt the sequence of their hair pulling, and introduce alternative behavioral responses to their urges (Diefenbach et al., 2000; Stein et al., 1999). Additional considerations include modifications, generalization and client empowerment. Giving clients the opportunity to review treatment options may aid in client empowerment and motivation (Mansueto et al., 1999). The ability to generalize learned skills to real world situations should be taken into consideration at termination (Gluhoski, 1995). Treatment should be evaluated for needed modifications (Mansueto et al., 1999).

Trichotillomania is a mental and emotional disorder of increasing prevalence. Clinicians have a responsibility to effectively treat individuals struggling with this condition. Behavioral interventions have proven to be effective methods to employ and are worthy of consideration in the development of treatment plans.

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