Trichotillomania Manual Based Treatment:
An ACT-enhanced Behavior Therapy Approach

Lindsey M. Muller, M.S.
Carlos Albizu University
Abstract

The purpose of this paper is to present a detailed description of a manual based treatment for trichotillomania using empirically supported techniques. The manual utilizes an acceptance and commitment therapy enhanced behavior therapy approach. The components of this approach include acceptance and commitment therapy and behavior therapy elements of habit reversal and stimulus control, and each are broken down in detail with applicative in-session examples. Due to the evidence based nature of this therapeutic approach for trichotillomania, research results are presented to highlight the proven efficacy. Assessment tools, structure of the manual, content of the sessions, and therapeutic techniques are explained. Then, limitations, application of the manual, and recommendations for use in clinical setting are mentioned.

Keywords: Trichotillomania treatment, Behavior therapy, ACT, Treatment manual
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The diagnosable mental disorder of trichotillomania (TTM) is defined as the irresistible recurrent pulling of one’s own hair resulting in noticeable hair loss, and causing significant impairment and distress (American Psychiatric Association, 2000). In adult TTM, there are more reported cases in females than males, and among Caucasians (Woods & Twohig, 2008). For the majority diagnosed, hairpulling occurs in multiple contexts. Mature TTM has high comorbidity with many psychiatric conditions including mood disorders, ADHD, anxiety, substance abuse, and personality disorders (American Psychiatric Association, 2000). Although it may appear as though the disorder has a low prevalence rate in the general population due to hesitancy to seek treatment out of embarrassment and shame, the estimated prevalence rate is 1 to 3% across the developmental lifespan. Further, the disorder has been around for years but there has been a growing awareness among parents, psychologists, and researchers, especially within the last 15 years, of how this disorder may impair everyday living by causing distress; academic, occupational, and financial difficulties; physical discomfort; and psychosocial and interpersonal challenges.

The magnitude of effects of the disorder is significant and severe irrespective of the pulling site, the individual’s age, duration of pulling, education, and/or other variables. Research on the etiology, pattern, and treatment of the disorder is limited at the present time. As a result, it is rare that two clinicians who are not specialized in the treatment of the disorder would know or understand which treatment approach to base therapy. Some view TTM as a habit and would be most likely to employ behavioral theory to conceptualizing and treating the disorder as a pure behavior devoid of emotion and cognition influences. Other clinicians may conceptualize the disorder as falling among the obsessive compulsive spectrum and therefore creating a treatment plan around the dissipation of anxiety. The most common intervention for TTM is medication
(Woods & Twohig, 2008), despite the fact that hairpulling is largely unresponsive to any type of medication whether it be a stimulant, MAOI or SSRI. Medication may be effective in treating comorbid disorders which are secondary to, and exacerbate, TTM. Clearly, there are various conflicting methods in working with individuals who present with TTM. The reality is that the manifestation and maintenance of hairpulling includes the interface of behavior, thought, and emotion within the context of the individual. As aforestated, the number of clinicians who are familiar and comfortable with TTM and its treatment is less rather than more. Therefore, the development and utilization of an evidence-based treatment manual containing step by step procedures to guide therapy may be beneficial.

**Evidence Base for Treatment Manual**

At this time, there has been one treatment manual, *Treatments that work: Trichotillomania-An ACT-enhanced behavior therapy approach therapist guide* by Woods and Twohig (2008), which has been developed and revised on the basis of empirical research to specifically treat TTM. Originally, TTM was understood from a behavioral model (Mansueto, Townsley-Stemberger, Thomas & Golomb, 1997), which delineated the disorder as comprising of primary environmental triggers and secondary emotional and cognitive factors. Prior to Mansueto’s model, treatment consisted of habit reversal, as the pulling behavior viewed as a solitary habit. Subsequent to 1997, attention was drawn to dealing with individuals private experiences (thoughts, emotions, and urges) in addition to finding ways to prevent pulling.

Prior to understanding the sessions of the treatment manual and why different exercises are included as they are, the clinician needs a better understanding of the two subtypes of hairpulling: focused and automatic. Through research, it was determined that two types of pulling exist in each individual diagnosed with the disorder. As such, any developed, effective
treatment would have to target both subtypes. Focused pulling is pulling done via conscious awareness and in response to an unpleasant private experience (urge, negative feeling, or specific thought). Automatic pulling is done unconsciously, usually during times of boredom or sedentary activities, without any identifiable trigger, or antecedent. The described treatment manual expanded the original behavioral model of treatment to include interventions for both focused and automatic pulling (Woods & Twohig, 2008).

The first version of the manual, authored in 2004, included habit reversal therapy (HRT) and stimulus control (SC) to target the automatic pulling, and acceptance and commitment therapy (ACT) to target the focused pulling (Twohig & Woods, 2004). The manual consisted of seven sessions that were applied to six adults. A multiple baseline across subjects design was used. The first four sessions were ACT and the fifth was HRT which was reviewed in sessions six and seven. According to Woods & Twohig (2008), “…intervention resulted in decreases to zero levels of pulling for four of the six subjects, and the results were maintained for three of the four subjects at 3-month follow-up” (p.10).

The manual was later revised to its current format, which includes 10 sessions. The revisions made included adding relapse prevention strategies and adding more structure and organization to the ACT part of treatment. To determine the effectiveness of the revisions, the treatment manual was applied to 14 randomly assigned participants who were compared to a 14 participant wait list control group (Woods, Wetterneck & Flessner, 2006). Assessments pre- and post-treatment, and at a 3-month followup were completed. The assessment included depression, anxiety, experiential avoidance, and pulling severity. “Results showed that pulling severity across the two primary outcome measures decreased for the AEBT group, but not for the WL group. Likewise, after the WL group received treatment, they also showed significant decreases
in all indicators of pulling severity…depression and anxiety scores also decreased for the AEBT group but not for the WL group” (Woods & Twohig, 2008, p. 11). A measure of experiential avoidance was analyzed pre- and post- treatment and found that decreases in the measure of experiential avoidance were moderately and significantly correlated with hair pulling decreases pre- versus post-treatment (Woods & Twohig, 2008). In generalizing to other disorders, ACT has been shown to be more effective than progressive muscle relaxation in treating Obsessive Compulsive Disorder (Twohig et al., 2010), a disorder which has a high comorbidity with TTM. Three randomized controlled trials evaluating the efficacy of HRT for TTM have all evidenced positive outcomes of pulling decreases (Azrin, Nunn, & Frantz, 1980; Ninan et al., 2000; van Minnen et al., 2003). However, evidence of the necessity and benefit of both ACT and HRT treatment component in treating TTM was found in a study by Flessner et al. (2008) in which two participants received 7 sessions of ACT then HRT added, and one received HRT then ACT. Results found that the greatest benefit did not occur until both parts of treatment had been completed. Conclusively, while each treatment component individually contributes to reduction in hair pulling, the combination of both components achieves larger benefits warranting the present treatment manual one of efficacy and effectiveness.

**Assessment**

The manual include an entire chapter on assessment of initial intake information, pre-treatment measures, and ongoing assessment to determine changes made as treatment progresses. An outline of information that should be initially gathered is described in detail and includes history of pulling, prior attempts at treatment, current symptoms and severity, functional behavioral assessment, comorbid conditions, and global assessment of functioning. The manual includes accompanying self-report measures: *Milwaukee Inventory of Subtypes of*
Trichotillomania Scale-Adult (MIST-A) to determine which subtype of pulling is more prevalent, and Acceptance and Action Questionnaire.

Manual Structure

The treatment manual is comprised of ten sessions for adolescents through adults with TTM. Each session has a similar structure in that at the start of each session the patient should complete the self-report assessment measure, which is found in either the appendix of the Therapist Guide or the separate published Workbook (Woods & Twohig, 2008). Next, the patient and clinician are to review the previous session’s material and note any accompanied thoughts or reactions. Then homework is reviews which was assigned in the previous session, the techniques and for the present session are completed with the patient and clarified by example vignettes offered in the Therapist Guide, and then homework is assigned as listed (i.e. bullet form) in the Guide. The first session is slightly different than as described due its introductory nature.

The ten sessions sum to make the Acceptance and Commitment Therapy Enhanced Behavior Therapy approach, which is a combination of habit reversal training (HRT) and stimulus control procedures (SC) to target automatic pulling, and acceptance and commitment therapy (ACT) to target focused pulling. According to the manual:

- The purpose of the treatment is to educate the client about TTM and teach her to (a) be aware of her pulling and its antecedents, (b) use self-management strategies to prevent or stop the pulling, (c) stop fighting against private experiences that lead to pulling, through learning skills such as defusion and acceptance, and (d) work consistently toward increasing her quality of life (Woods & Twohig, 2008, p. 12).

HRT is made up of awareness training and competing response which brings pulling into awareness and then provides a competing behavior that cannot be done while pulling at the same
time, thereby making the pulling difficult to achieve. SC is providing and reinforcing the use of strategies in ones environment to make the pulling more difficult. ACT’s goal is not to try to change the patient’s private experience (urge, thought, feeling) but to view these as things to be observed and accepted as they come instead of being fought against or acted upon. Underlying ACT is the concept of having a choice to experience without acting or experience and act by pulling. This is achieved through the application of experiential exercise and metaphors in the manual utilized in the sessions.

**Manual Sessions**

In session one, the clinician educates the patient on TTM; a review of situations that may increase pulling are discussed; self-monitoring homework assignments are introduced which requires the use of the *Self-Monitoring* form and *Monitor Your Urge* form found in the *Workbook* (i.e. recording of time spent pulling each day, situations where pulling occurred, and thoughts/emotions/urges had before and after the pulling); therapy expectations are discussed; and HRT/SC is introduced (Woods & Twohig, 2008).

In session two, the clinician should review last week’s session. The *Self-Monitoring* form and *Monitor Your Urge* form is collected. Awareness training and competing response are implemented which together make up HRT. According to Woods and Twohig (2008), “Awareness training involves describing the pulling, describing the sensations and behavior preceding the pulling, acknowledging therapist-simulated pulling, and acknowledging real or simulated pulling exhibited by the client” (p. 39). Next, the competing response behavioral strategy is explained and the patient is asked to select a competing response behavior that works for her, and that will be used outside of the therapy sessions (Woods & Twohig, 2008). The competing response is taught and practiced. Last, the clinician identifies, through
discussion, situations where the pulling or urges are most likely to occur for the patient. A list of interventions is provided for the patient and ways to use the interventions in the real world are discussed. The patient is then given homework.

Session three is the identification of what is valuable or important for the patient and a discussion is centered around bringing the patient to realize how fighting urges up to this point has interfered with the identified valuable or important parts of the patient’s life (Woods & Twohig, 2008). An oral summary is provided at the end for the patient. The patient is also to continue monitoring by completing the Self-Monitoring form and Monitor Your Urge form found in the Workbook.

Session four addresses the issue of control and pointing out to the patient how he has been struggling to control urges but has been largely unsuccessful. Through this form of cognitive challenge and cognitive restructuring, it is the hope that the patient will, according to Woods and Twohig (2008), “see how damaging the control agenda can become….pulling one’s hair reduces aversive private events or increases feelings of pleasure in the short term, but is generally ineffective and costly in the long term” (p. 57). The Manual provides a case vignette to aid the clinician in how the patient-clinician interaction may go. Two experiential exercises are conducted: Two-Games Metaphor and Paper in the Shoe (Woods & Twohig, 2008). The first involves guiding the patient to see that she has a choice in continuing to live in the same struggle or to walk away and do something new. The second is addressed more specifically in session five but the patient is asked to place a piece of paper in her shoe with an event written down that is attempted to be controlled.

Session five is titled Acceptance. Three vignettes are outlined to demonstrate a potential or likely clinician-patient interaction where the goal is to guide the patient toward acceptance of
her experiences, see the difficulty in suppressing or controlling private events and consider possibility of willingness to accept private events, all through cognitive therapy (Woods & Twohig, 2008). The Elephant in the Room metaphor is used and the Paper in the Shoe metaphor which was started in session four is explained and processed by the patient. At the end of the session, the patient is taken through making a behavioral commitment. This is a contract that, as part of homework, the patient is to practice every day over the next week, until the next session, for an agreed-upon amount of time. A detailed description of what behavioral commitments are is explained in the Therapist Guide and should be covered in the session with the patient until she understands the definition and purpose of this part of treatment. As explained by Woods & Twohig (2008):

...behavioral commitment exercises should be presented as opportunities to follow her values instead of controlling her urges to pull… Success is determined by whether the prescribed task is completed… Third, completing these exercises is not about tolerating or toughing out the urges to pull for a specified period of time… help reorient the client to the overall function of behavioral commitment exercises: to do what is important to her rather than alter her urge to pull” (p. 71).

Sessions six and seven are together where the patient learns that thoughts, feelings, and urges can be observed for what they are and that urges are separate from the individual. This is called cognitive defusion (Woods & Twohig, 2008). There are ten exercises that are described with case vignettes and sample dialogues. All the exercises have the same goal in mind. Session eight provides the patient the opportunity to practice what has been learned from the previous sessions, and the patient is exposed to situations or cues that are likely to trigger the urge to pull as a form of sensitization and “embracing of the urge”. Issues relating to patient avoidance,
fusion, and lack of motivation to participate are noted with possible responses if they are to occur in the sessions. Session nine is another session for practice and review of what has been learned. The patient should still be completing ongoing self-report assessments and monitoring to determine progress and change. Additionally, the patient should still be using the chosen competing response, stimulus control interventions, behavioral commitments, and practicing acceptance and defusion (Woods & Twohig, 2008). Session ten is the final session. In this session, a final assessment is to be completed to determine progress to be pointed out to the patient, allow for debriefing, review relapse prevention strategies, educate the patient in the common long-term pattern for TTM maintenance, and terminate. It is important to also inform the patient that she may return for booster sessions as the predetermined time or when she feels it is warranted.

Limitations and Applicability

Irrespective of the empirically-validated nature of a treatment manual, there does not exist a perfect manual with the absence of limitations. This explains why many clinicians do not like to use manuals when treating patients as he or she may feel as though it creates restriction, does not allow for the artistic influence of the therapeutic process, and does not truly address the issues of the individual (since two patient with the same diagnosis will never present the same). From experience with this manual in practice, the following differences have been noted by the author of this paper. Age plays a large part in treatment outcome although the manual states treatment is appropriate for adolescents through adult. The onset of puberty (i.e. hormonal changes) is a strong factor in emotional expression, vulnerability, self-confidence, self-identity, perception, impulsivity, and emotional regulation, all of which may influence the maintenance or etiology of a disorder and the way treatment interacts and acts upon the individual and the
diagnosis. Second, the behavioral component of treatment may interfere with cultural differences if the individual is part of a culture where he engages in repetitive hand movement rituals. This can be counter-therapeutic or decrease the impact that the competing response has for TTM treatment. Additionally, the Therapist Guide is devoid of any mention of cultural or gender differences that may present in therapy. Third, the patient needs to be functioning at an acceptable cognitive/intellectual level in order to successfully identify his own private experiences and be able to express these. This requires a degree of insight and judgment. Next, some homework worksheets and the weekly assessment questionnaire are hard to understand due to vague wording, specifically on the Acceptance and Action Questionnaire for Trichotillomania (AAQ-4TTM). Fourth, those with a comorbid mood disorder may have difficulty with treatment if anxiety, depression, or manic symptomatology is severe and causes interference and distraction from the TTM treatment sequence. As a result, it is important for the clinician to determine which disorder, in the case of comorbidity, is more salient causing more impairment and distress, and this should be addressed first. The Therapist Guide does not address this issue. Finally, all patients who have completed ten sessions, which have been implemented with fidelity, have required additional sessions with an interwoven therapeutic approach. It therefore seems as though there are details of the treatment approach that are absent from the Therapist Guide but were present in the empirically validated research studies which resulted in a high degree of success.
References


