Clarifying the relationship between Trichotillomania and anxiety


A R T I C L E   I N F O

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A B S T R A C T

Although research has consistently linked unidimensional anxiety with Trichotillomania (TTM) severity, the relationships between TTM severity and anxiety dimensions (e.g., cognitive and somatic anxiety) are unknown. This knowledge gap limits current TTM conceptualization and treatment. The present study examined these relationships with data collected from ninety-one adults who participated in a randomized clinical trial for TTM treatment. Based on prior research, it was hypothesized that TTM severity would be related to the cognitive anxiety dimension and that psychological inflexibility would mediate the association. Hypotheses were not made regarding the relationship between TTM severity and somatic anxiety. Regression analyses indicated that only cognitive dimensions of anxiety predicted TTM severity and that psychological inflexibility mediated this relationship. Implications for the conceptualization and treatment of TTM are discussed.

1. Clarifying the relationship between Trichotillomania and anxiety

Trichotillomania (TTM; also referred to as Hair Pulling Disorder) is a debilitating condition defined by recurrent hair pulling despite repeated attempts to stop (American Psychiatric Association [APA], 2013). Based on research suggesting that negative affect, particularly anxiety, contributes to disorder duration and severity (Christenson, Mackenzie, & Mitchell, 1991; Christenson & Mansueto, 1999; Hajcak, Franklin, Simons, & Keuthen, 2006; Mansueto, Stemberger, Thomas, & Golomb, 1997; Roberts, O’Connor, & Bélanger, 2013; Stanley, Borden, Bell, & Wagner, 1994), various TTM treatment models augment traditionally effective behavioral treatments (e.g., Habit Reversal Therapy; Azrin, Nunn, & Frantz, 1980) with anxiety-targeting techniques. However, different TTM treatment models target different anxiety components. For instance, comprehensive behavioral treatment models tend to target physiological symptoms of anxiety via techniques like deep breathing (Azrin, Nunn, & Frantz, 1980); cognitive-behavioral treatment (CBT) models target anxiogenic cognitions and feelings via techniques like cognitive restructuring (Lerner, Franklin, Meadows, Keuthen, & Foa, 1999); and third-wave behavioral treatment models target meta-cognitions about experiencing anxiety via techniques like mindfulness (Keuthen et al., 2010; Woods & Twohig, 2008). Unfortunately, there is currently little empirical basis for targeting any one component of anxiety over another, as the specific nature of the relationship between anxiety and TTM is unknown. Developing a better understanding of how the various components of anxiety relate to TTM is necessary for developing a better understanding of the disorder and its treatment.

TTM research has predominantly treated anxiety as a unidimensional construct (e.g., Diefenbach, Mouton-Odum, & Stanley, 2002; Diefenbach, Tolin, Hannan, Crocetto, & Worhunsky, 2005; Diefenbach, Tolin, Meunier, & Worhunsky, 2008; Duke, Bodzin, Tavers, Geffken, & Storch, 2009; Houghton et al., 2014; Shusterman, Feld, Baer, & Keuthen, 2009; Stanley et al., 1994). However, anxiety researchers recognize anxiety as a multidimensional construct consisting of cognitive (sometimes referred to as subjective anxiety; e.g., fear and worry) and somatic (e.g., physiological arousal and panic) dimensions (Clark & Watson, 1991; Nitschke, Heller, Imig, McDonald, & Miller, 2001; Ree, French, MacLeod, & Locke, 2008). Conceptualizing anxiety...
in such a way is clinically meaningful, as research suggests that cognitive and somatic anxiety symptoms may respond best to different treatments (Norton & Johnson, 1983; Ree et al., 2008; Schwartz, Davidson, & Goleman, 1978; Tamaren, Carney, & Allen, 1985). Specifically, some research suggests that cognitive anxiety may be most responsive to treatments like cognitive restructuring and meditation, while somatic anxiety may be most responsive to diaphragmatic breathing exercises and progressive muscle relaxation (Norton & Johnson, 1983; Ree et al., 2008; Schwartz et al., 1978; Tamaren et al., 1985). Accordingly, to develop treatments that effectively target anxiety associated with TTM, it is important to understand the relationships between the different dimensions of anxiety and TTM severity.

The few studies that have examined the relationships between TTM severity and the cognitive and somatic anxiety dimensions have not been conclusive. Some evidence suggests that TTM severity is related to aspects of cognitive anxiety, such as worry (Hajcak et al., 2006), and other evidence suggests TTM is related to fear of negative evaluation (Norberg, Wetterneck, Woods, & Conelea, 2007). Still, other evidence suggests that while TTM-affect individuals demonstrate higher levels of cognitive and somatic anxiety than unaffected persons, TTM severity may not be related to either anxiety dimension (Wetterneck, Lee, Flessner, Leonard, & Woods, 2016). However, this study was limited by a small sample size that may have precluded power to detect such relationships. Overall, research appears to suggest that TTM severity may be related to cognitive aspects of anxiety, but it is unclear whether TTM severity is related to somatic anxiety.

In addition to understanding how particular aspects of anxiety are related to TTM symptoms, researchers have also examined how anxiety symptoms are perceived and acted upon by persons with TTM. To this end, a growing body of research focuses on the role of psychological inflexibility in TTM. Psychological inflexibility refers to the propensity to prioritize the mitigation of undesirable private experiences over the pursuit of adaptive goals (Bond et al., 2011). Generally, the most frequently discussed form of psychological inflexibility is experiential avoidance, which refers to the propensity to engage in behaviors that facilitate disengagement from undesirable experiences (Bond et al., 2011). Studies that have examined the role of psychological inflexibility in TTM have found that psychological inflexibility mediates the relationships between hair pulling severity and unidimensional measures of anxiety (Houghton et al., 2014) as well as between hair pulling severity and certain cognitive aspects of anxiety (i.e., apprehension/ anxious thoughts about being negatively evaluated by others; Norberg et al., 2007). However, it is unclear whether psychological inflexibility mediates the relationship between TTM severity and the broader cognitive anxiety dimension. Further, no study has examined whether psychological inflexibility mediates the relationship between TTM severity and somatic aspects of anxiety.

Since the introduction of “psychological inflexibility” as a construct, it has been implied that different psychiatric disorders are characterized by different manifestations of psychological inflexibility. That is, the manner in which psychological inflexibility manifests in social anxiety disorder may differ from the manner in which psychological inflexibility manifests in TTM. Accordingly, it has been proposed that using disorder-specific measures of psychological inflexibility may yield more precise information about the manner in which psychological inflexibility is involved in that disorder (Houghton et al., 2014; MacKenzie & Kocovski, 2010; Sandoz, Wilson, Merwin, & Kellum, 2013). Although such a measure has been created to measure psychological inflexibility descriptive of TTM, the Acceptance and Action Questionnaire-Trichotillomania (AAQ-TTM; Houghton et al., 2014), no study has examined whether TTM-specific psychological inflexibility mediates the relationships between TTM severity and the cognitive and somatic dimensions of anxiety.

The current study was intended to explore the anxiety-PTM relationship. Using the same data set utilized by Houghton et al. (2014), the current study examined whether TTM severity (assessed via self-report and clinician rating) is differentially related to different anxiety dimensions (i.e., cognitive and somatic). In addition, the current study examined whether TTM-specific psychological inflexibility mediated the relationship between these anxiety dimensions and TTM severity.

Based on the findings of Hajcak et al. (2006) and Norberg et al. (2007), we hypothesized that the cognitive domain of anxiety would be significantly related to TTM severity. In addition, consistent with findings from Norberg et al. (2007), we hypothesized that TTM-specific psychological inflexibility would mediate the relationship between cognitive anxiety and TTM severity. Based on prior research showing no relationship between somatic forms of anxiety and TTM (Wetterneck et al., 2016), we did not anticipate finding an association between TTM severity and the somatic dimension of anxiety in the current study.

2. Method

2.1. Participants

Data were collected as part of a randomized clinical trial for TTM treatment. Information about the sample and recruitment can be found in Houghton et al. (2016).

Ninety-one participants (92% female; 8% male) were included in the current study. Seventy-six participants identified as European American (84%), eleven identified as African American (12%), one identified as Asian American (1%), and three identified as multiracial or did not disclose their race (3%). In addition, one participant identified as Hispanic or Latino (1%). Participants had a mean age of 35.04 years (SD = 12.68).

2.2. Measures

2.2.1. Cognitive and somatic anxiety

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1985) is a 21-item self-report measure of clinical anxiety that assesses both somatic and cognitive symptoms of anxiety. Each item on the BAI is ranked on a 0–3 scale. Thus, raw scores range from 0–63, with higher scores indicating higher levels of anxiety. Although the BAI total score is frequently used in research, several studies suggest that the BAI consists of multiple factors. Two studies (Beck & Steer, 1991; Steer, Ranieri, Beck, & Clark, 1993) exploring the factor structure of the BAI in clinically anxious samples concluded that the BAI consists of four factors: subjective anxiety, neurophysiological anxiety, autonomic anxiety, and panic anxiety. These same researchers hypothesized that raw scores on the subjective anxiety factor assessed cognitive anxiety and raw scores on the neurophysiological, autonomic, and panic anxiety factors assessed somatic anxiety (Steer, Rissmiller, Ranieri, & Beck, 1993).

We calculated all four of the BAI factors observed by Steer, Ranieri et al. (1993) using data from the current sample. To examine whether the Steer, Ranieri et al. (1993) BAI factors were adequate in the current sample, we analyzed these factors clinically anxious samples concluded that the BAI consists of four: subjective anxiety, neurophysiological anxiety, autonomic anxiety, and panic anxiety. These same researchers hypothesized that raw scores on the subjective anxiety factor assessed cognitive anxiety and raw scores on the neurophysiological, autonomic, and panic anxiety factors assessed somatic anxiety (Steer, Rissmiller, Ranieri, & Beck, 1993).

We calculated all four of the BAI factors observed by Steer, Ranieri et al. (1993) using data from the current sample. To examine whether the Steer, Ranieri et al. (1993) BAI factors were adequate in the current sample, we analyzed these factors’ internal consistencies. This analysis indicated that the subjective anxiety (α = .86), neurophysiological anxiety (α = .88), and autonomic anxiety (α = .80) factors each demonstrated acceptable internal consistency. The panic anxiety factor demonstrated poor internal consistency (α = .54). Therefore, only the Steer, Ranieri et al.’s (1993) subjective, neurophysiological, and autonomic anxiety factors were analyzed in the current study. As proposed by Steer, Rissmiller et al. (1993), the subjective anxiety factor measured cognitive anxiety and the neurophysiological and autonomic anxiety factors measured somatic anxiety. Correlations between cognitive anxiety and the two forms of somatic anxiety (i.e., neurophysiological and autonomic) are presented in Table 1.

2.2.2. TTM severity

The Massachusetts General Hospital Hairpulling Scale (MGH-HS;
دریافت فوری
متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات