

Acceptance-Enhanced Behavior Therapy for Trichotillomania in Adolescents

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Although several studies have examined the efficacy of Acceptance Enhanced Behavior Therapy (AEBT) for the treatment of trichotillomania (TTM) in adults, data are limited with respect to the treatment of adolescents. Our case series illustrates the use of AEBT for TTM in the treatment of two adolescents. The AEBT protocol (Woods & Twohig, 2008) is a structured treatment manual that was adapted to the individual clients' needs and clinical progress. Both clients reported clinically significant gains in treatment as determined by at least 2 weeks of abstinence from pulling, and subjective reports of decreased distress and impairment, although one required a booster session due to relapse. AEBT is worth further exploration as a treatment for adolescents with TTM.

TRICHOTILLOMANIA (TTM) is characterized by the repeated pulling out of one's hair, resulting in noticeable hair loss (American Psychiatric Association, 2000). Other diagnostic criteria include a rising sense of tension or urge preceding the pulling episode and a sense of relief following a pulling episode, although children and adolescents may not readily report these symptoms (Franklin et al., 2008; Hanna, 1997; Tolin et al., 2008). TTM predominantly occurs in women by a ratio of approximately 8:1 (Christenson, Mackenzie, & Mitchell, 1991; Cohen et al., 1995; Woods et al., 2006), although this gender discrepancy may be less pronounced in children (Chang, Lee, Chiang, & Lü, 1991; Muller, 1987).

Individuals with TTM may pull from any site on the body, but the most common include the scalp, eyebrows, and eyelashes (Cohen et al., 1995; Santhanam, Fairley, & Rogers, 2008). Patients with TTM may engage in pre-pulling behaviors such as hair stroking or twirling, as well as post-pulling behaviors (i.e., hair ingestion, stroking hair strands across the lips, and chewing, biting, or examining the hair root; du Toit, van Kradenburg, Niehaus, & Stein, 2001).

Several studies have examined the efficacy of pharmacological and nonpharmacological interventions for TTM. Research on various selective serotonin reuptake inhibitors (SSRIs) has been mixed, with open trials showing a positive

effect on pulling (Koran, Ringold, & Hewlett, 1992; Stanley, Bowers, Swann, & Taylor, 1991; Winchel, Jones, Stanley, Molcho, & Stanley, 1992) but placebo-controlled double-blind crossover studies suggesting SSRIs produce no benefit over placebo (Bloch et al., 2007; Christenson, Mackenzie, Mitchell, & Callies, 1991; Streichenwein & Thornby, 1995).

Another antidepressant, clomipramine, has shown greater efficacy than SSRIs (Bloch et al., 2007). More recently, N-acetylcysteine (Grant, Odlaug & Kim, 2009) and olanzapine (Van Ameringen, Mancini, Patterson, Bennett & Oakman, 2010) have been shown to be more efficacious than pill placebo in double-blind randomized controlled studies. Unfortunately, controlled studies of medication for TTM have been conducted primarily with adults, leaving the efficacy of medications for children with TTM untested.

Nonpharmacological treatments typically involve some form of behavior therapy. Various behavioral techniques have been used, either as stand-alone interventions or in combination with each other. These include relaxation training, self-monitoring, reinforcement programs, and stimulus control (Diefenbach, Tolin, Hannan, Maltby, & Crocetto, 2006; Salama & Salama, 1999; van Minnen, Hoogduin, Keijsers, Hellenbrand, & Hendriks, 2003). The behavioral intervention with the strongest empirical support as a treatment for TTM is Habit Reversal Training (HRT). HRT consists of three primary techniques, including awareness, competing response, and social support training (Azrin & Nunn, 1973). HRT or HRT-based treatment packages have demonstrated efficacy in single-subject studies (Mouton & Stanley, 1996; Rapp, Miltenberger, Long, Elliot, & Lumley, 1998; Rosenbaum, 1982; Tarnowski, Rosen, McGrath, & Drabman, 1987) and

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in group studies utilizing waitlist (van Minnen, et al; Woods, Wetterneck, & Flessner, 2006), alternate treatment (Azrin, Nunn, & Frantz, 1980), and pill placebo (Ninan, Rothbaum, Marsteller, Knight & Eccard, 2000) control conditions. Across these studies, HRT has been found to be more efficacious than the control conditions (Bloch et al., 2007).

Although HRT has been found to be effective in reducing TTM symptoms, there are limitations. First, treatment research has rarely included children and adolescents, although the one published open trial in children suggests that HRT in conjunction with stimulus control (i.e., a group of techniques designed to prevent pulling and provide alternative tactile reinforcement) can be effective in this population (Tolin, Franklin, Diefenbach, Anderson, & Meunier, 2007). Second, there is little evidence to suggest that complete elimination of pulling is a standard outcome. Reasons are unclear, but may have to do with the different styles of pulling believed to be present in many with TTM. One style, automatic pulling, is a habitual pattern that often occurs out of awareness and is likely maintained by the sensory consequences of the hair pulling act itself. HRT plus stimulus control has been suggested as particularly well-suited to treat this style of pulling (Walther, Ricketts, Conelea, & Woods, 2010). Focused pulling, on the other hand, appears more purposeful and is believed to serve an emotional regulatory function. Unfortunately, there is evidence suggesting HRT does not significantly impact negative emotions (Teng, Woods, & Twohig, 2006), and thus may be less effective in treating the focused style of pulling. Because both styles of pulling are believed to be present in most adolescents and adults who pull (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2009), when only HRT and stimulus control are used, our clinical experience indicates that treatment gains may be incomplete if a person also engages in focused pulling.

To address this concern in adults, a combined Acceptance and Commitment Therapy (ACT) and HRT approach, labeled Acceptance Enhanced Behavior Therapy (AEBT) for TTM was developed. ACT is based on the assumption that psychological problems are brought about, in large part, by experiential avoidance (Hayes, Strosahl, & Wilson, 1999), or the person's tendency to avoid, control, or escape from unwanted private experiences such as thoughts, urges, or emotions. In TTM, it is believed that the act of pulling regulates these internal experiences and as such, the pulling itself is used to avoid or escape from unwanted private events (Wetterneck & Woods, 2007). Indeed, data exist showing a link between TTM severity and experiential avoidance (Begotka, Woods, & Wetterneck, 2004), and other evidence suggests that experiential avoidance mediates the relationship between thoughts and emotions and pulling severity (Norberg, Wetterneck, Woods, Conelea, 2007).

Researchers have begun to examine the efficacy of this combined approach in adult samples with TTM. A preliminary investigation of AEBT using a multiple baseline design showed that treatment was effective in reducing the number of hairs pulled to rates approaching zero in 80% of the participants (Twohig & Woods, 2004). In a follow-up study comparing AEBT to a waitlist control, AEBT was found to be effective in decreasing hair-pulling severity, number of hairs pulled, overall impairment, experiential avoidance, and symptoms of anxiety and depression (Woods, Wetterneck, et al., 2006). Evidence was provided for the differential impact of the ACT and HRT components on TTM symptoms in a study by Flessner, Busch, Heideman, and Woods (2008).

Although several studies have examined the efficacy of AEBT for the treatment of TTM in adults, data are limited with respect to the treatment of adolescents, despite the fact that both focused and automatic pulling occur commonly in adolescents with TTM. Our case series illustrates the use of AEBT for TTM in the treatment of two adolescents with TTM. These cases were selected from a larger set to illustrate varying presentations of TTM. Protocol adaptations for the adolescents were made throughout treatment based on the specific needs of each adolescent.

Assessment

Patients seeking treatment in the Trichotillomania/Body Focused Repetitive Behavior Disorders Specialty Clinic (TTM/BFRB) at the University of Wisconsin-Milwaukee are administered a standard assessment battery prior to the commencement of therapy. Potential psychiatric disorders are evaluated using a structured clinical interview, which is a computerized version of the National Institutes of Mental Health Diagnostic Interview Schedule for Children (NIMH-DISC-IV; Columbia (C-DISC) Development Group, 1999) and IQ estimates are obtained by using the 2 subtest version of the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999). To better characterize the patients and evaluate treatment response, relative strengths of focused and automatic pulling styles are assessed using the Milwaukee Inventory for Styles of Trichotillomania-Child Version (MIST-C; Flessner et al., 2007). The MIST-C is a 25-item scale designed to assess the strength of both focused (21 items—possible scores ranging from 0–189) and automatic (4 items—possible scores ranging from 0–36) pulling styles. In a community sample of adolescents with TTM, the mean MIST-C Focused pulling score was 95.9 ($SD=35.5$) and the mean automatic pulling score was 13.3 ($SD=8.7$). The Trichotillomania Scale for Children (TSC; Tolin et al., 2008) is completed by the patient at the start of each session to assess pulling severity. The TSC is a 12-item measure assessing both pulling severity and pulling-related distress/impairment. Total scores range

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