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Behaviour Research and Therapy 44 (2006) 639–656

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A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania

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Received 2 February 2005; received in revised form 6 May 2005; accepted 16 May 2005

Abstract

This randomized trial compared a combined Acceptance and Commitment Therapy/Habit Reversal Training (ACT/HRT) to a waitlist control in the treatment of adults with trichotillomania (TTM). Twenty-five participants (12 treatment and 13 waitlist) completed the trial. Results demonstrated a significant reduction in hair pulling severity, impairment ratings, and hairs pulled, along with significant reductions in experiential avoidance and both anxiety and depressive symptoms in the ACT/HRT group compared to the waitlist control. Reductions generally were maintained at a 3-month follow-up. Decreases in experiential avoidance and greater treatment compliance were significantly correlated with reductions in TTM severity, implying that targeting experiential avoidance may be useful in the treatment of TTM. Other implications and suggestions for future research are noted.

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Keywords: Trichotillomania; Acceptance; Habit reversal; ACT; Hair pulling

Introduction

Trichotillomania (TTM) is defined by the repetitive pulling of one's own hair resulting in notable hair loss and significant life impairment. In addition to these criteria, the person with TTM must experience tension prior to pulling that is relieved after the pulling episode or must experience an

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increasing sense of tension during attempts to refrain from pulling (American Psychiatric Association, 2001). Prevalence estimates suggest that TTM (as defined in DSM-IV) occurs in approximately .6% of the population (APA, 2001) and is much more common in women (Graber & Arndt, 1993). Nevertheless, when the tension buildup/tension reduction criteria are eliminated, prevalence estimates increase to 2.5% of young adults (Christenson, Pyle, & Mitchell, 1991).

Existing animal models (e.g., Bordnick, Thyer, & Ritchie, 1994; Greer & Capecchi, 2002) and neuroimaging studies (e.g., Stein et al., 2002; Swedo et al., 1991; Vythilingum et al., 2002) suggest an underlying pathogenesis involving a disrupted motor habit system and poor inhibitory control. These findings seem consistent with phenomenological reports made by persons with TTM who note that episodes of pulling often seem “automatic,” and occur with little apparent control or awareness (Christenson, Mackenzie, & Mitchell, 1991). Still, not all episodes of pulling are consistent with such reports. Some with TTM also report full awareness of their pulling, exhibit volitional control over the behavior, and may pull their hair as a method of coping with or reducing aversive private experiences. Christenson, Mackenzie, et al. (1991) called this pattern of behavior “focused pulling” (i.e., more volitional pulling used to control emotional (e.g., urges, tension, anxiety) or cognitive experiences (e.g., need to pull a specific hair). Christenson and colleagues reported that about 5% of their TTM sample reported being entirely automatic in their style of pulling, 15% reported being entirely focused, and 80% reported a mix of the two types of pulling.

Additional evidence for a more “focused” or emotion-controlling type of pulling comes from Diefenbach, Mouton-Odum, and Stanley (2002), who found that people with TTM report significant decreases in anxiety, tension, and boredom, and significant increases in sadness, anger, guilt, and relief from before to after the pulling episode. These findings suggest that affective experiences such as reductions in anxiety or tension negatively reinforce the pulling, and other emotional consequences, including sadness, anger, and guilt create a vicious cycle which then leads to later pulling (Diefenbach et al., 2002).

In summary, the limited extant research suggests that TTM in adults may derive from two separate processes, the first involving a dysregulated habitual motor pattern, and a second involving an effective, yet potentially counterproductive method for coping with aversive private events. As such, it may be useful to consider both processes when developing interventions for the disorder.

Cognitive-behavioral interventions have long been considered a viable treatment for TTM, despite the relative dearth of well-controlled outcome studies (Elliott & Fuqua, 2000). At the center of most cognitive-behavioral interventions for TTM is habit reversal training (HRT; Azrin & Nunn, 1973), which generally includes awareness training (AT), competing response (CR) training, and social support (Rapp, Miltenberger, Long, Elliott, & Lumley, 1998).

Azrin, Nunn, and Frantz (1980) first evaluated HRT for TTM by comparing it to massed negative practice in 34 persons with “hair-pulling.” Relying on self-monitoring of hairs pulled per day, Azrin et al. showed HRT to be far superior than massed negative practice for the reduction of hair pulling in adults. Unfortunately, it was not clear that either intervention was superior to simple passage of time, assessments were not conducted by blinded evaluators, and a diagnosis of TTM was not established. Other studies utilizing single-subject or uncontrolled group designs, have generally supported the findings of Azrin et al. in both adults (e.g., Mouton & Stanley, 1996; Rosenbaum & Ayllon, 1981; Stoylen, 1996) and children (Rapp et al., 1998; Tarnowski, Rosen, McGrath, & Drabman, 1987).

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