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Acceptance and Commitment Therapy and Habit Reversal Training for the Treatment of Trichotillomania

Jesse M. Crosby, John P. Dehlin, P. R. Mitchell, Michael P. Twohig, *Utah State University*

Trichotillomania is a behavioral problem, and is often referred to as a habit disorder, but it is important to consider the cognitive and emotional components of the behavior. Current treatment recommendations include a traditional behavioral approach (Habit Reversal Training; HRT) combined with an approach that addresses the cognitive and emotional components of the behavior (Acceptance and Commitment Therapy [ACT] or Dialectical Behavior Therapy [DBT]). Current evidence indicates a combination of ACT and HRT is an effective treatment for trichotillomania. The goal of this article is to replicate the effectiveness of the ACT/HRT treatment package for trichotillomania and to provide practical clinical guidance on how to deliver the treatment. This guidance is presented in the context of an empirical study in which 5 participants demonstrating high levels of pulling at pretreatment were treated with 8 sessions of a combination of ACT and HRT. Treatment resulted in an 88.87% reduction in pulling across participants from pretreatment to posttreatment, and all 5 responded to the treatment. At 3-month follow-up, 2 participants maintained the treatment gains, 2 lost half of the treatment gains, and 1 was at pretreatment levels. A discussion of the results is presented along with implications for clinical practice and future directions for research.

TRICHOTILLOMANIA (TTM) is a psychological disorder that involves repetitive pulling of hair to the point of noticeable loss (American Psychiatric Association, 2000). Lifetime prevalence rates of TTM have been estimated to be from 0.6% to 1.0% (Duke, Keeley, Geffken, & Storch, 2010), and TTM has been tied to a number of negative effects, including feelings of isolation, shame, embarrassment, and low self-esteem, along with avoidance of important activities such as medical exams, haircuts, social relationships, and sexual intimacy (Diefenbach, Tolin, Hannan, Crocetto, & Worhunsky, 2005; Woods, Flessner, Franklin, Keuthen, et al., 2006). In extreme cases when the hair is ingested, trichobezoars (masses of hair in the stomach and intestine) can result in digestive problems and require surgery (Duke et al., 2010; Woods, Flessner, Franklin, Wetterneck, et al., 2006). Pulling is generally preceded by a feeling of tension that is relieved by the action. While some individuals pull indiscriminately, it is common to search for hairs with a particular texture, feel, or appearance. It is also common for the hair to be played

with, manipulated, broken, bitten off, saved, or used as dental floss, while some will simply discard the hair.

While TTM is highly behavioral and is often referred to as a habit disorder, it is important to consider the cognitive and emotional components of the behavior as it now appears it may be a coping response with an emotion-regulation function similar to binge eating, substance abuse, or self-harm. This is supported by work showing that TTM can be strongly influenced by inner experiences such as urges, cravings, and thoughts (Teng, Woods, Twohig, & Marcks, 2002), and that the pulling is often performed to regulate an aversive internal experience or to induce an appetitive internal experience (Diefenbach, Tolin, Meunier, & Worhunsky, 2008; Grant, Odlaug, & Potenza, 2007; Shusterman, Feld, Baer, & Keuthen, 2009).

TTM is often conceptualized as having two primary subtypes: *automatic* pulling, which occurs outside of awareness during activities such as driving or watching television, and *focused* pulling, which is the more conscious pulling of hair to neutralize anxiety or other internal experiences (Christenson & Crow, 1996; Flessner, Woods, Franklin, Cashin & Keuthen, 2008). Research with 47 individuals with TTM showed that 34% reported primarily “focused” pulling, 47% primarily “automatic,” and 19% showing equal amounts of both (du Toit, van Kradenburg, Niehaus, & Stein, 2001). These results show individuals with TTM exhibit varying levels of both automatic and focused pulling. The Milwaukee Inventory for Subtypes of

¹ Video patients/clients are portrayed by actors.

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Trichotillomania–Adult Version (MIST-A) was developed to aid in the detection and assessment of these subtypes (Flessner, Woods, et al., 2008), and recent research shows that this measure differentiates pulling severity and psychological and functional impairment for high and low levels of each pulling type (Flessner, Conelea, et al., 2008).

Based on this conceptualization of TTM, current treatment research has introduced the idea of implementing both behavioral and cognitive intervention strategies to address automatic and focused pulling. Habit reversal training (HRT) has been the traditional behavioral approach, and is generally accepted as a suitable treatment for the habitual nature of automatic pulling (van Minnen, Hoogduin, Keijsers, Hellenbrand, & Hendriks, 2003). To be clear, HRT was developed long before there were recognized subtypes of pulling, but current research suggests it is particularly effective for automatic pulling. HRT involves three main components: *awareness training*, to help alert clients to common triggers; *competing response training*, which is the development of alternative behaviors to pulling; and *social support training*, to gain assistance in maintaining the treatment program (Azrin, Nunn, & Frantz, 1980). From this conceptualization, HRT targets the automatic pulling that is subject to minimal influence by inner experiences.

Focused pulling appears to have strong emotional and cognitive components, thus the addition of a cognitive approach to the traditional behavioral treatment. To date, two cognitive therapies have been utilized in conjunction with the traditional behavioral approach: Acceptance and Commitment Therapy (ACT; Twohig & Woods, 2004; Woods, Wetterneck, & Flessner, 2006) and Dialectical Behavior Therapy (DBT; Keuthen et al., 2010), both of which specifically address maladaptive emotion regulation as a central target. This article will address the combination of ACT with traditional HRT. The specific components of ACT are covered in the introductory paper of this special series (Twohig, 2012–this issue), but generally, ACT addresses the role of acceptance and mindfulness processes to decrease maladaptive emotion regulation and produce behavior change in the service of client values. The goal of the acceptance and mindfulness processes, as applied to the treatment of TTM, is to create a context where urges to pull can be experienced and not followed, contextualizing the functional behavioral regulation of urges to pull hair.

Current treatment research is supportive of the ACT/HRT packaged approach with the subtypes of TTM. In a multiple baseline design with 6 participants, it was found that a combination of ACT and HRT in 7 sessions was successful in decreasing hairs pulled to near-zero levels for 4 of 6 participants, with 3 of 4 participants maintaining results at 3-month follow-up (Twohig & Woods, 2004). These findings were supported in a randomized trial of 25

participants comparing a 10-session ACT/HRT treatment to a waitlist control (Woods, Wetterneck, et al., 2006). Results showed that 66% of the treatment group responded to the treatment compared to 8% in the control group, with results generally maintained at 3-month follow-up. Additional support for the ACT/HRT combination was found in multiple baseline investigations for TTM and chronic skin picking (Flessner, Busch, Heideman, & Woods, 2008) and ACT alone for skin picking (Twohig, Hayes, & Masuda, 2006). Finally, in an open clinical trial with a related cognitive behavioral intervention, 10 participants were offered DBT-enhanced HRT for TTM, resulting in significant improvement in hair-pulling severity, emotion regulation, hair-pulling impairment, and anxiety and depressive symptoms, with outcomes maintained at 3-month follow up (Keuthen et al., 2010).

Accounting for cognitive or emotional regulation in TTM in addition to the traditional behavioral strategies is an important step in the treatment literature. The goal of this article is to replicate the effectiveness of the ACT/HRT treatment package for TTM and to provide more detailed clinical guidance on how to present the packaged approach, including the order of presentation, the total number of sessions, a rationale for clinical decision making, and how the two approaches work together. These considerations are presented and illustrated in the context of an empirical study in which five participants demonstrating levels of focused and automatic pulling at pretreatment were treated with a combination of ACT and HRT. Particular care has been given to provide a detailed description of the treatment approach and any unique considerations that arose in the practical application of current evidence-based practice for TTM. Using self-report of hairs pulled as the dependent variable, a multiple baseline across participants design was employed to track treatment progress and provide an empirical indication of the effectiveness of the approach. Additionally, a weekly process measure tracked changes in ACT processes and standardized pretreatment, posttreatment, and 3-month follow-up assessments of TTM severity. A discussion of the results, with a focus on how they inform implementation of this treatment, is also presented.

Method

Participants

No formal recruiting procedures occurred; participants all located the research facility via their own efforts through the trich.org website. Three female and two male adults contacted the treatment facility and met criteria for TTM, established with a semistructured interview based on the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). Four of the five participants in this study traveled 60 to 120 miles to receive treatment. Additional participant characteristics are provided in Table 1.

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