

A Preliminary Investigation of Acceptance and Commitment Therapy and Habit Reversal as a Treatment for Trichotillomania

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In this study, the combination of Acceptance and Commitment Therapy and Habit Reversal (ACT/HR) was evaluated as a treatment for trichotillomania with 6 adults. The effectiveness of ACT/HR was assessed within two separate multiple baseline designs. Self-monitoring data showed that treatment was successful in decreasing the numbers of hairs pulled to near-0 levels for 4 of the 6 participants, with results being maintained for 3 of the 4 participants at the 3-month follow-up. These findings were confirmed with ancillary measures. The treatment was found to be acceptable by all participants.

Trichotillomania (TTM) involves the chronic pulling and removal of hair from one's own body that results in noticeable hair loss. Additional diagnostic criteria require that (a) feelings of tension that exist prior to pulling are relieved by pulling, (b) the pulling cannot be accounted for by another mental or medical condition, and (c) the pulling must cause significant distress or impairment (American Psychiatric Association, 2000). Prevalence estimates for TTM range between 1% and 4% and TTM is believed to be more prevalent in adult females than in adult males (Miltenberger, Rapp, & Long, 2001).

The physical effects of TTM include hair loss, follicle damage, structural changes in regrown hair, scalp irritation, and trichobezoars, which are gastrointestinal blockages that develop when an individual ingests the pulled hair (Christenson & Mansueto, 1999). Persons with TTM also commonly

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A copy of the complete treatment manual is available from the corresponding author.

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suffer from social and emotional problems such as low self-esteem, shame, irritability, depression, and feelings of unattractiveness (Soriano, O'Sullivan, & Baer, 1996; Townsley-Stemberger, Thomas, Mansueto, & Carter, 2000). In addition, over 60% of adults with TTM avoid haircuts and swimming, over 30% are uncomfortable in windy weather, playing sports, and engaging in physical intimacy, and over 20% avoid activities in public areas (Townsley-Stemberger et al., 2000).

Phenomenological descriptions suggest persons with TTM demonstrate two separate patterns of pulling and may exhibit predominantly one pattern or varying degrees of both. Nonfocused pulling has no identifiable function, is habitual, and often occurs outside of awareness. In contrast, "focused" pulling is a consciously initiated behavior and appears to serve the purpose of regulating one's internal experiences of tension, urges, thoughts, emotions, and other private events. A descriptive survey of people with a chronic hair-pulling problem found that 31% of hair pullers appeared to engage primarily in a nonfocused pattern of pulling, whereas the remaining sample either demonstrated a primarily focused pattern of pulling or a mixed pattern (du Toit, Kradenburg, Niehaus, & Stein, 2001). Although the distinctions between focused and nonfocused pulling are relatively recent and await further empirical confirmation, it would seem that different treatments would be required for the different patterns.

Habit reversal (HR; Azrin & Nunn, 1973) is a treatment that appears tailor-made for reducing nonfocused pulling. The procedure approaches pulling as a habitual motor pattern that needs to be brought into awareness and interrupted by a behavior that competes with the pulling. This is accomplished through the techniques of awareness training, the practice of a competing response done contingent on the pulling or its antecedents, and social support to facilitate treatment compliance (Azrin & Nunn, 1977). To date, HR is the most common and effective nonpharmacological treatment for TTM, although its effectiveness is not universal (Elliot & Fuqua, 2000).

The reasons for HR's limitations are not clear, but perhaps the procedure has been less effective with some TTM patients because it does not appear to address the variables responsible for focused pulling. To address these variables, cognitive therapy has been added to standard HR treatments and there is growing evidence that the combined intervention (i.e., CBT) is effective for TTM, although it has never been directly compared to HR alone (Lerner, Franklin, Meadows, Hembree, & Foa, 1998; Mouton & Stanley, 1996; Rothbaum, 1992), and has only been evaluated in one controlled study (i.e., Ninan, Rothbaum, Marsteller, Knight, & Eccard, 2000). Nevertheless, these preliminary findings suggest that up to 85% of those receiving CBT show decreases in pulling (Lerner et al., 1998), although maintenance of treatment gains appears more difficult, with only 30% to 40% of patients retaining their treatment gains at 6 to 38 months (Lerner et al., 1998; Mouton & Stanley, 1996).

Cognitive therapy techniques are designed to control, change, or otherwise alter the content or form of the private experiences that may contribute to the

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