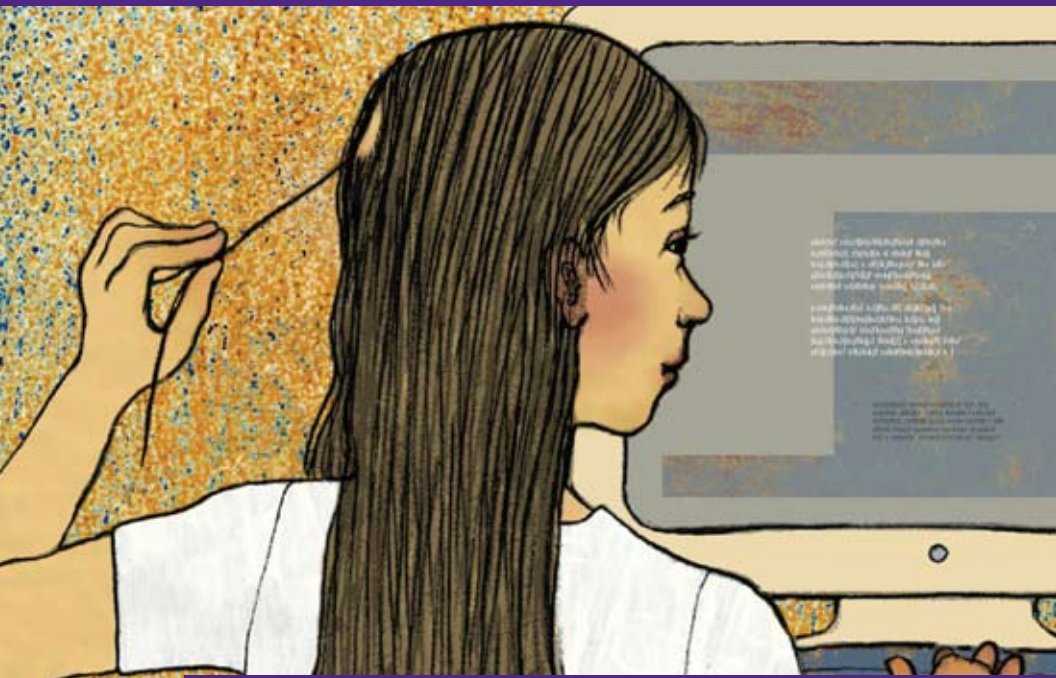

Expert Consensus

Treatment Guidelines for Trichotillomania, Skin Picking

And Other Body-Focused Repetitive Behaviors

A publication of the Scientific Advisory Board of the Trichotillomania Learning Center

TLC

bringing hope and healing since 1991

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The Trichotillomania Learning Center (TLC) is a non-profit organization devoted to ending the suffering caused by hair pulling disorder, skin picking disorder, and related body-focused repetitive behaviors (BFRBs).

TLC is advised by a Scientific Advisory Board comprised of leading researchers and clinicians in this field.

Authors

This pamphlet is a project of the
Trichotillomania Learning Center's Scientific Advisory Board.

Contributing Authors:
Ruth Golomb, LCPC
Martin Franklin, PhD
Jon E. Grant, JD, MD, MPH
Nancy J. Keuthen, PhD
Charles S. Mansueto, PhD
Suzanne Mouton-Odum, PhD
Carol Novak, MD
Douglas Woods, PhD

Illustrations for TLC by Maxine Lu.

The information in this booklet is not intended to provide treatment for Trichotillomania or Skin Picking. Appropriate treatment and advice should be obtained directly from a qualified and experienced doctor and/or mental health professional.

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Treatment Guidelines for Trichotillomania, Skin Picking

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Introduction

If you or someone you love is suffering from trichotillomania (TTM) or another **body-focused repetitive behavior** (BFRB), such as skin picking, you may feel alone, confused, frightened and in need of help. Many professionals have outdated or simply erroneous information regarding effective treatment options. Members of the Scientific Advisory Board of the Trichotillomania Learning Center (TLC) have reviewed the latest state-of-the-art treatments and provide these guidelines for individuals seeking treatment for these problems.

Until the past 20 years, BFRBs have received little attention in the psychological and dermatological literature. Despite the data showing that TTM and skin picking are quite widespread (2-5% of the general public suffer from TTM; 5% from skin picking), few professionals have current information about effective treatment for these conditions. Oftentimes clients or family members pursue treatment with more accurate information than the treatment provider. This paper will summarize information about the nature of BFRBs and provide treatment recommendations by acknowledged experts in the field. In addition, information is provided for families in which a member is exhibiting these behaviors.

What is Trichotillomania?

TTM, also known as Hair Pulling Disorder, is characterized by repetitive pulling out of one's hair (from the scalp, eyebrows, eyelashes or elsewhere on the body). According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition) of the American Psychiatric Association, TTM is defined as meeting the following five criteria:

1. Repetitive pulling of one's own hair that results in noticeable hair loss.

2. A feeling of tension prior to pulling or when trying to resist the behavior.

3. Pleasure, gratification, or relief while engaging in the behavior.

4. The behavior is not accounted for by another medical (dermatological) or psychiatric problem (such as schizophrenia).

5. Hair pulling leads to significant distress or impairment in one or more areas of the person's life (social, occupational, or work).

Although these criteria have been very useful for describing the problem, there are concerns among the clinical and scientific communities about whether they all are present in every case. It has been acknowledged that many people suffering from hair pulling do not meet all of these criteria. For example, many hair pullers do not experience tension prior to pulling hair or pleasure, gratification, or relief while engaging in the pulling. Also, some people pull hair from areas of the body that are not visible, such as the pubic or chest areas, yet they still experience significant distress.

A very common experience reported by people with TTM is isolation. Because people with TTM often feel ashamed of their behavior, they don't talk about it and may try to hide the problem. As a result, many sufferers feel isolated, confused and reluctant to seek advice or treatment from professionals. Unfortunately, this secrecy contributes to a general misperception that the behavior is less common than it actually is.

What are BFRBs?

BFRBs, *a term that may be new to you and new to many professionals,* **are repetitive self-grooming behaviors in which pulling, picking, biting or scraping of the hair, skin or nails result in damage to the body.** Common BFRB behaviors include skin picking (of scabs, acne, or other skin imperfections, for example), cuticle or nail biting or picking, and lip or cheek biting. These behaviors share similar characteristics, which are described below, and are all considered BFRBs for that reason.

What are the symptoms of BFRBs?

Many people who engage in TTM or other BFRBs find that these behaviors often occur during sedentary activities. These activities include, but are not limited to, lying in bed, reading, listening to a lecture (in class), riding in or driving a car, using the bathroom, talking on the phone, using the computer or sitting at a desk at work. However, there are some individuals who find that these behaviors take place during more active times (walking or putting on make-up, for example).

In addition, there are times when a sufferer might engage in the BFRB behavior in a fully focused way, for example, planning to go home and pick a scab or pull hair. However, there are other times when the same individual might engage in the behavior in a less focused manner, only realizing it when he/she discovers a pile of hair, scratches on the skin, open scabs or bleeding fingers.

For some, there is a sensation that draws the fingers to the site of picking or pulling. These sensations can be itching, tingling,

pain or other such experiences. For others, there is no sensation prior to engaging in the picking or pulling behaviors, the fingers simply find their way to the site and the behavior begins. Many people report that they are searching for a particular irregularity of the hair (thicker, coarser, bumpier) or skin (rough, jagged, bumpy) in order to remove or fix the perceived problem.

Many people will also find that searching behaviors are part of the process, such as rubbing the fingers over the skin, in the hair, on the eyebrows, etc., to find a hair or skin irregularity on which to focus. Picking or pulling will ensue, and some individuals will examine the product of their pulling or picking by looking at it closely, rubbing it on their skin, face or lips, smelling it, chewing or swallowing it, or rolling it between their fingers.

The severity of these behaviors varies greatly. Hair pulling can result in small areas of thinning hair, bald patches or, in some cases, extensive baldness that is difficult to conceal. Many people who pick at their skin develop scabs or sores that do not heal because of repeated picking. Sometimes skin can become infected or scar, resulting in an appearance at the picking site that can exacerbate feelings of shame.

Although pulling hair and picking skin may seem to some to be harmless habits, when they are done in excess they can cause serious medical problems. For those individuals who swallow pulled hairs, gastrointestinal distress or even digestive blockage caused by a trichobezoar, or "hair ball," can occur and may even require surgical removal. It is critically important therefore to see a doctor if you or your child eats the hair. Regarding skin picking, it is important to keep wounds clean and treat them with antibiotic cream to prevent infection. In some cases, the behaviors may result in repetitive motion injuries.

In addition to these physical and medical problems, most people who engage in BFRBs also experience some degree of shame, secrecy, isolation, interference with intimate relationships, avoidance of activities that they would otherwise pursue, and possibly interference with work or study.

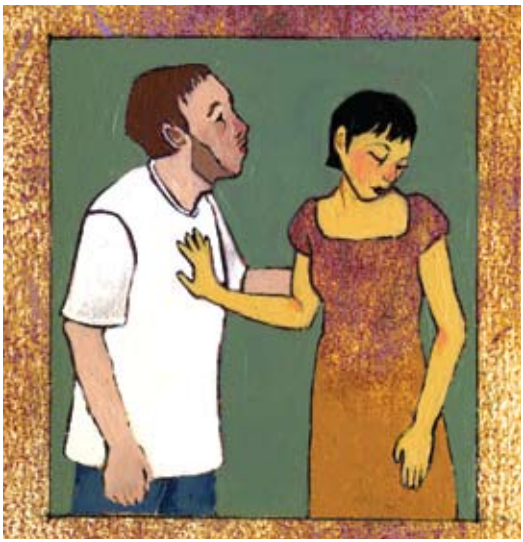
When do BFRBs begin?

The majority of individuals start engaging in hair pulling or other BFRBs between the ages of 11 and 13. Over time, the problem may wax and wane in severity. Some children begin pulling earlier than age 13. For this group, the numbers of males and females who pull hair is about equal. However, among adult hair pullers, females outnumber males. The current research indicates that many more females than males begin pulling around the time of puberty, although the reason for this is not known. It is possible, however, that adult males are not as willing to seek treatment for their symptoms as females, and that the male-to-female ratio may actually be somewhat higher than it seems. There are some individuals who

start engaging in BFRB behavior well before adolescence. Some parents have reported observing their child engaging in hair pulling behaviors as early as 9 months old. When children of pre-school age or younger engage in hair pulling, the behavior is sometimes known as "baby trich." This behavior is often, but not always, accompanied by thumb sucking. It is thought by some experts to be less likely to develop into a long-term behavior than hair pulling that begins at a later age.

What causes BFRBs?

Why do some people engage in these behaviors while others do not? Research indicates that some people may have an inherited predisposition to skin picking or hair pulling. Several studies have shown a higher number of BFRBs in immediate family members of persons with skin picking or hair pulling than would be expected in the general population. A recent study examined hair pulling in identical and fraternal twins and produced results consistent with a significant inherited component in TTM. Given the possibility that some or all BFRBs have a genetic origin, researchers are currently studying the genes of people suffering from TTM in an effort to isolate gene markers that may clarify the origins of these problems.



Even if a predisposition toward BFRBs is inherited, there are certainly other factors involved as well, including; temperament, environment, age of onset, and family stress factors. One interesting point is that other species engage in similar behaviors. Primates, such as the great apes or certain types of monkeys, will pull hair, overgroom and pick at nits and other insects on their own fur and the fur of others. Birds will pull out their feathers, mice will pull fur or "barber" themselves and their cage mates, dogs and cats may lick their skin or bite at an area, removing fur until there are bald spots. Researchers interested in animal models of BFRBs are trying to understand these behaviors in animals in order to shed some light on the complex neurobiology that underlies the human experience of BFRBs.

What other problems are sometimes confused with TTM and other BFRBs?

Some professionals have speculated that TTM is a form of obsessive compulsive disorder. Over the last fifteen years, this view has fallen out of favor. Although individuals with BFRBs engage in repetitive, seemingly compulsive behaviors, there are enough differences to suggest that these are quite different disorders.

Before BFRBs had received much scientific attention, it was common for professionals to assume that hair pulling and skin picking were symptoms of other "deeper" disorders or even the result of early trauma. Current evidence suggests, however, that these behaviors are not generally an indication of deeper issues or unresolved trauma. Furthermore, BFRBs do not appear to be associated with problems such as self-mutilation or eating disorders, as some writers have suggested. As such, BFRBs are separate and distinct disorders. However, it is not unusual for many individuals who struggle with BFRBs to experience anxiety and/or depression, thus adding to their difficulties in coping with the BFRB.

How are TTM and other BFRBs treated?

The most important thing that a person can do to address a BFRB is to first become knowledgeable about the problem and its treatment. The Trichotillomania Learning Center (www.trich.org) provides up-to-date information regarding TTM and other BFRBs, with guidance from its Scientific Advisory Board, comprised of expert clinicians and researchers working in this field. Books, lectures, videos and articles are all available through TLC, as well as educational events that are regularly held around the country for interested therapists and for individuals and families whose lives have been affected by TTM and other BFRBs. The Internet can be a valuable source of information; however, caution must be taken as there are BFRB-related websites, chat rooms, and products available online which can provide questionable advice. A list of resources approved by TLC's SAB will be available at the end of this booklet. Being an informed consumer is the first step to success.

What can families and friends do to help?

As a family member of someone with a BFRB, it is also important to be well informed. Well-meaning friends and family members often wish to be helpful, yet at times their efforts can actually be hurtful and may even contribute to the problem. Maintaining a supportive role and making efforts to communicate directly but in a sensitive manner with the person you are trying to help can be beneficial. In addition to effective communication, patience and flexibility can be very important for family members who are attempting to help an individual with a BFRB.

It can be extremely difficult to be a loved one of someone who is suffering with a BFRB, and it is very important to take care of yourself also as you try to support and assist your family member. Books, self-help groups and other resources are

available to family members, as they may need extra support. In order to be a supportive, helpful, fully invested resource, you must be as strong, informed, empathic and as calm as possible when helping your loved one.

Psychotherapy

An approach to psychotherapy, called cognitive behavior therapy (CBT), is the treatment of choice for treating BFRBs. This approach lends itself to individualized treatment, allowing the techniques to uniquely match each individual's symptoms.

What is CBT?

CBT is a therapeutic approach that focuses on a person's thoughts, feelings and behaviors. Individuals learn how to change their thoughts, feelings and behaviors by employing techniques that have been shown to be effective for helping individuals reach their goals. There are a number of different treatment approaches for BFRBs that fall under the umbrella of CBT: habit reversal training, comprehensive behavioral treatment, acceptance and commitment therapy, and dialectic behavior therapy.

Habit Reversal Training

Habit Reversal Training (HRT) is an early treatment for TTM and similar problems, developed in the 1970s by Nathan Azrin and Gregory Nunn. HRT is the method that has been examined the most in research studies to date. HRT has a varying number of components in its treatment package. The three components that are considered most critical are awareness training, competing response training, and social support.

- ***Awareness training*** consists of helping the person focus on the circumstances during which pulling or picking is most likely to occur. This enables individuals to become more aware of the likelihood that the behavior will occur, and therefore provides opportunities for employing therapeutic techniques designed to discourage performance of problem behaviors.

- ***Competing response training*** teaches the individual to substitute another response for the pulling or picking behavior that is incompatible with the undesired behavior. For example, when an individual experiences an urge to pull or pick, he/she would ball up their hands into fists and tighten their arm muscles and "lock" their arms so as to make pulling or picking impossible at that moment. This response is to be repeated each time that individual experiences an urge to pull or pick or when faced with a situation where pulling or picking is likely to occur.

- ***Social Support*** involves bringing loved ones and family members into the therapy process in order to provide positive feedback when the individual engages in competing responses. They may also cue the person to employ these strategies and provide encouragement and reminders when the individual is in a "trigger"situation."

The research literature is encouraging using this method for short term improvement; however, professionals and sufferers have found that when used by itself, achieving long term improvement in symptoms is much more difficult.

Comprehensive Behavioral Treatment

Using some of the techniques employed by HRT and incorporating other CBT techniques has been clinically found to be more successful and lends itself to better maintenance of improvement. The Comprehensive Behavioral (ComB) Model, developed by Dr. Charles Mansueto and his colleagues, uses the existing treatment options, expands on them and individualizes the treatment to include a wide range of behaviors. The ComB Model consists of four components: Assessment, Identify and Target Modalities, Identify and Choose Strategies, and Evaluation. There are five modalities to consider and they are: Sensory, Cognitive, Affective, Motor, and Place (SCAMP). Although the ComB Model needs to be the focus of empirical research, expert clinicians in the field believe it to be a more viable option than HRT alone.

Assessment/Self Monitoring

Using the ComB Model, the therapist and client complete a thorough assessment of the problematic behaviors, including thoughts, feelings and behaviors prior to picking and pulling, during picking and pulling and post picking and pulling. This allows the therapist and the client to learn a lot about the function of the many behaviors that comprise a BFRB. The client is also asked to monitor his/her behavior for one week in order to determine a baseline (what does a typical week look like with regard to the picking or pulling behaviors.)

Techniques Chosen That Directly Relate to Behavior

Once this initial baseline assessment is complete, the therapist will explore the behavior itself. One major difference with the ComB Model and HRT is that rather than simply employing an incompatible response, the therapist helps the client explore the use of ***sensory substitutes*** at the site of picking or pulling to help the individual meet the body's needs in a different way (and therefore not engage in the picking or pulling behavior). For example, if itching is a trigger and scratching starts or leads to pulling, the individual would be encouraged to use a ***wide tooth comb as a sensory substitute***, not only to provide relief for itching, but also to discourage the fingertips from making contact with the scalp. Further, the individual might be directed to find ***some items that achieve the sensation that is desired when engaging in the BFRB behavior.*** For example, an individual who searches for coarse hairs to roll between their fingers might be instructed to ***roll yarn, twine, floss, or to stimulate the fingers and hand with a nail brush or baby brush, again as a sensory substitute.*** These are not simply idle suggestions; each intervention is designed to address the unique sensations that are achieved by picking or pulling. As a result, therapy addresses the nervous system's need for sensory input while removing the problematic picking or pulling.

Addressing the Environments

The therapist and client are not done yet! They will also look at the environment where picking or pulling occurs and alter it to make it less conducive to engaging in those behaviors. For example, for those individuals who engage in picking or pulling in front of a mirror, it might be recommended that the mirror be removed or covered for a period of time. Another approach might be a treatment called Acceptance and Commitment Therapy (ACT) which has been shown to be quite promising when used with individuals who have "focused" behaviors. (See ACT section below).

Many people also pick or pull without even noticing that the behavior has started. For this type of "unfocused" or "automatic" behavior, barriers such as gloves, Band Aids, medical tape or hats are employed to raise awareness and eliminate the automatic nature of the behavior.

Handling Feelings in a Productive Way

People experience a variety of emotions prior to, during and after engaging in BFRB behaviors. It is common for people to feel bored, tired or tense prior to pulling or picking, then angry or guilty following an episode. Identifying these emotions, and then using techniques designed to directly address them, is also part of this comprehensive approach. For example, relaxation may be used when agitation or anxiety is present or assertiveness techniques may used when individuals feel impotent due to an inability to assert oneself on the job or with interpersonal relationships. This names just a few of the techniques available depending upon the individual's unique experience with his/her BFRB.

Dealing With Thoughts That Are Not Helpful

For some people, thoughts contribute the picking or pulling behavior. In this case, the therapist would use cognitive techniques to address unhelpful thought patterns. Restructuring, gaining perspective and correcting faulty thinking are all techniques used when thoughts not only challenge progress, but even support the behavior that has been targeted for change.

The Complex Behaviors in BFRBs

During the assessment phase of treatment, people learn that their behavior is multi-dimensional and very complex. Using the ComB Model allows the therapist and client to intervene on a variety of different levels to control this very difficult and tenacious set of behaviors.

The Toll of BFRBs

People who experience BFRBs often have other important issues to discuss in therapy. Many sufferers experience ***shame, isolation and low self-esteem as a result of coping with their BFRB for years.*** Many individuals have been reticent to establish close interpersonal relationships or have not pursued vocational interests. These problems do not simply disappear once the behavior is being addressed. ***The therapist must assist individuals to develop skills in these areas as well.*** If too much attention is paid to the picking or pulling and none to these life issues, the individual has a much higher chance of relapse. However, if too much attention is paid to these life issues and little to the picking or pulling behavior, the individual will likely not experience improvement in their BFRB. Finding a therapist who can balance the important needs of individuals with BFRBs is critically important.

Other Treatment Approaches to Augment CBT Treatment for BFRBs

Acceptance and Commitment Therapy

Another promising treatment approach is called acceptance and commitment therapy (ACT) developed by Steven Hayes. Through the therapy process, individuals are asked to experience urges to pick or pull, and accept the urge without acting on it. They are also asked to experience negative emotions that come before or after pulling as events to be observed without judgment rather than as events that must be acted upon. Understanding, feeling and experiencing that one does not **have to** respond to an urge or emotion can be quite freeing. With the assistance of a trained therapist the individual can devise a treatment plan.

This plan would include:

- ***Understanding a Patient's Values.*** A key part of treatment is to understand what the patient wants to be about. What do they want to be remembered for? The rest of treatment will be set in this context. Patients will need to ask themselves throughout treatment if what they are doing in the BFRB process is moving them in a way that is consistent or inconsistent with their stated values.

- ***HRT and Stimulus Control.*** Assuming the patient's values do not involve pulling or getting rid of urges or negative emotion from their life, HRT and stimulus control strategies are taught to help the patient refrain from pulling/picking so they can engage in valued behavior.

- ***Understanding How Patients Relate to Urges and Negative Experiences.*** Part of the therapy process involves discussing how the patient uses pulling/picking and other methods to reduce or eliminate urges, anxiety, or sensations that they experience as unpleasant. Through this process, it is often the case that patients have not found an effective and healthy strategy to control these experiences that does not also prevent them from doing things that they value.

- ***Seeing Internal Experiences for What They Are***. A large part of ACT involves teaching patients about what private experiences like urges, thoughts, and emotions are, and what they are not. Often, people treat their private experiences as if they must cause pulling to occur, or must cause people to react. However, through various exercises, patients are taught to understand what urges, thoughts and emotions are—events that a patient can choose to react to or not react to—and that these events are temporary. Often, people have a tendency to try to eliminate unpleasant experiences. In ACT, mindfulness-based strategies are used to teach patients to openly accept (not necessarily enjoy or like) any internal experience they have without trying to reduce, modify, or eliminate them.

- ***Commit to the Process.*** The individual will need to commit to working on their difficulties by experiencing and tolerating these thoughts and emotions instead of attempting to avoid them.

Rigorous research has documented that the use of ACT-enhanced habit reversal treatment is more effective than a control condition in reducing pulling symptoms. Importantly, short-term treatment benefits were also maintained several months after treatment termination.

Dialectic Behavior Therapy

Dialectic behavior therapy (DBT), a treatment developed by Marsha Linehan, is another treatment currently being researched. Pilot studies show that this intervention has some promising results when used in conjunction with more traditional habit reversal and stimulus control approaches. Maintenance of treatment benefit months after treatment termination has been demonstrated. Its utility includes enhancing awareness of pulling triggers and motor behaviors, and teaching pullers how to tolerate uncomfortable emotions and urges related to pulling.

DBT has four modules including:

- ***Mindfulness.*** This module borrows from Buddhism in its focus on living in the moment, experiencing feelings and senses fully, but with a nonjudgmental perspective. In this way individuals are helped to accept and tolerate powerful emotions without acting on them.

- ***Interpersonal Effectiveness.*** This module teaches important skills such as assertiveness and interpersonal problem solving.

- ***Emotion Regulation.*** This module instructs individuals in how to better manage their emotions using the follow techniques:
    - *Identify and label emotions*
    - *Identify obstacles to changing emotions*
    - *Reduce vulnerability to emotions*
    - *Increase positive emotional events*
    - *Increase mindfulness to current emotions*
    - *Take opposite action*
    - *Experience uncomfortable emotions without acting on them*

- ***Distress Tolerance.*** This module is designed to instruct the individual in different ways to tolerate or "get through" a crisis situation in the short-term without making it worse.

Note: The types of cognitive behavior therapy described above are not mutually exclusive. Elements derived from several approaches may be helpful for an individual striving to manage a BFRB.

Treating Children with BFRBs

Children can be treated quite effectively using the same cognitive behavioral approach used for treating adults. However, when working with children there are some special considerations. When children are experiencing difficulty with BFRBs it becomes a challenge for the entire family. Treatment should include parents for some portion of the time. Each developmental stage has its own unique challenges that also need to be addressed during the treatment process. Motivation for children can be a considerable obstacle at times. Therapists experienced in working with children can assist in constructing a well-developed reward system to help initiate behavior change and work with the child and parents to develop techniques to successfully sustain new behaviors. Each child and every family have different and unique needs though certain ages and stages of development have some things in common.

0-5 years old

When pulling hair occurs at this stage (0 to 5 years old) it is often referred to as "baby trich." When treating these youngsters, the parents must be primarily involved. Children at this age are quite used to having their parents guide, direct, pace and structure their behavior and their environments. Since these children are so dependent on their parents for most of their needs, having the parents structure, guide, and pace the treatment at home is very consistent with this developmental stage. Very young children often respond very well to treatment. At this stage it is completely up to the parents to oversee, monitor and manage the entire treatment process with the guidance of a therapist experienced with treating TTM in very young children.

6-9 years old

When children 6 to 9 years old engage in BFRB behavior, the treatment is similar to that of younger children; however, the children are more able to engage in treatment. At this stage, children are able to be more articulate and are often interested in the world around them. To assist in engaging the child at this age, introducing a well-developed reward system where the focus is on successfully

using strategies (and not on the act of pulling/picking) can be most helpful. Effective reward systems can be challenging to create and are often misunderstood. A therapist trained to work with cognitive behavioral approaches with children will be very helpful.

10-13 years old

Pre-adolescent children are certainly more independent; however, they still need some guidance, support and structure from the family. A reward system at this age often continues to work well to help focus and motivate the child. Allowing the children to fully participate in their own treatment and engage in developing the strategies and structure will be most successful. Often the family will need support and guidance themselves regarding their own involvement at this stage. Many parents need regular feedback with respect to how much help they should be giving and what they should do if they see their child pulling. During treatment the parental role will evolve and change, depending upon the child's temperament, needs, and stage of treatment.

14-18 years old

Children at this stage are often appropriately involved in establishing some form of independence. In the best of circumstances, the teenage years are a challenging time. When a teen has the added burden of experiencing a BFRB, this stage of life can be extremely difficult. At this point, the teenager will need to feel a sense of privacy while working on their picking or pulling behaviors in treatment. Thus, parental contact with the therapist will need to be limited. Parents may wonder what is taking place in therapy and observe no progress. Teenagers often need time to process information in their own way. Sometimes teens need this processing time in order to be able to fully participate in their treatment. At these times therapy might consist of helping the teen become ready to engage in therapy. Other times, the teen may simply not be ready or able to start treatment, but the parent is more than ready. Many times, parents will need a lot of support themselves to help navigate this uncertain time. For these circumstances, the parent may want to get some support and guidance in addressing their own concerns in order to relieve the pressure at home.

Medications for BFRBs

While the main treatment for trichotillomania and skin picking is behavior therapy, medications often can be helpful. No one medication helps everyone with skin picking or hair pulling, though a few have been found to reduce symptoms in some individuals.

Medications are often used to lessen feelings or sensations that can increase picking or pulling rather than treat the disorder itself. Some research has suggested that taking medications temporarily may be enough, possibly by allowing individuals to make use of behavioral techniques they would otherwise not have been comfortable with. Some medications work only if taken every day; while others may help if taken as needed for certain times of the day or stressful situations.

Unlike with other psychiatric disorders such as OCD, we don't know yet which neurologic system or chemical messengers are involved in BFRBs. Therefore experts don't have a clear model for choosing which medications to try. Glutamate, GABA, serotonin, acetylcholine and dopamine are some chemical messengers or "neurotransmitters" thought to be involved in BFRBs.

Skin picking and hair pulling have improved to some extent for some people with a variety of medications. **As of the printing of this pamphlet, there has not yet been any single medication or combination of medications approved by the Food and Drug Administration (FDA) for the treatment of trichotillomania (Hair Pulling Disorder).**

Over the past 15 years, many of the medications used for OCD and other anxiety disorders have been tested, with limited success overall. This said, there are still a certain percentage of people who do benefit, especially those with additional psychiatric conditions (such as depression).

Much of the choice in medication treatments is based on the doctor's clinical experience. If a medication is what would be helpful for other current symptoms, then it should be tried first. Safe treatment should be given priority, such as when using medications in children and pregnant women, and the risks must always be weighed against the benefits.

As there are too many types of medications to discuss individually in this booklet, they are categorized here as either taken every day, only when needed, or applied to the skin ("topical" medications).

Daily Medications

Psychoactive medications usually need to be taken on a regular basis to be helpful, and often take weeks to start working. Prescription medications taken every day should not be stopped suddenly or without a doctor's guidance. N-acetylcysteine is an amino acid that has been tested in a controlled study for trichotillomania, and was proven effective for over half the participants. There have been promising open trials of N-acetylcysteine for skin picking. Selective Serotonin-Reuptake Inhibitors(SSRIs) are prescribed for anxiety and depression. Scientific studies using SSRIs for TTM and skin picking show mixed results though positive to a mild degree or for small numbers of people. Many individuals report that their effects seem to wear off over time. Other medications of interest have included opioid antagonists (pain blockers), mood stabilizers, and dopamine blockers.

Medications Used as Needed

While medications for depression and other disorders must be taken every day for them to work, this may not be true for all drugs helpful for BFRBs. Tranquilizers can be used at times of stress or anxiety to prevent a flurry of pulling or picking. SSRIs or tranquilizers used cyclically can diminish premenstrual tension. Antihistamines may be taken to reduce itching. As trying to fall asleep can be a difficult time, sleeping pills can be used to facilitate sleep onset.

Skin Medications

Often skin sensations are the cause of picking or pulling and medication applied to skin can aid in reducing them. Itching can be reduced using topical steroids or antihistamine cream. "Bumpiness" of the skin or pimples may be prevented or treated with acne medications or other treatments. Tingling is often described as a trigger for hair pulling and may be modified by astringents, topical anesthetics, or creams causing a mild burning sensation (often containing capsaicin).

Maintenance Treatment

Even with successful treatment of BFRBs, slips are often a part of the landscape. Hair and skin are ever present. Since individuals must face these difficult temptations on a daily basis, slips are often inevitable. Slips, however, need not equal relapse. When slips are handled well, there is often no need for further treatment.

To prevent a recurrence of the problem behavior, it is essential to remain vigilant. Once a predisposition to pick skin and pull hair has developed, it is important to be aware that the problem may return. In the event of the return of the BFRB behavior itself, or of strong urges, techniques and strategies that worked best in active treatment can be reemployed during vulnerable phases. Some individuals find it especially useful to check in with their therapist for added support. In some situations, the formerly useful techniques may no longer be as effective as they once were. This would present a good opportunity to see a therapist and explore some more strategies.

Some individuals do not handle slips well and are at risk for relapse. These individuals may feel as though they were "cured" of the problem and therefore view a recurrence as a sign of failure. For others, the pulling or picking episode is viewed as "just a phase." Often, such individuals take a wait-and-see attitude and do not employ problem-solving or effective management techniques. In both of these circumstances, relapse is highly likely.

Effective maintenance includes:

- Acceptance of the lapse and a willingness to reengage in problem-solving and using effective strategies for a short time.

- Assumption of a nonjudgmental perspective in which the likelihood that the BFRB or urge may come back from time to time is acknowledged and accepted.

- Willingness to contact a therapist to enlist appropriate support when necessary.Willingness to reemploy previously effective self-management techniques and to add new ones if necessary.

When the individual acknowledges the possibility of a slip and is willing to use appropriate and effective resources, maintenance can be quite successful and manageable.

Treatments That May NOT Work

When choosing a treatment or treatment provider, there are some important ideas to take into consideration. There are some treatments that may have worked for a few people, yet no scientifically valid studies support their efficacy and therefore they are not typically recommended by expert clinicians. Diets, electric stimulation, massage, acupuncture and hypnosis are all approaches which lack adequate research to be recommended by expert clinicians. Some of these approaches might prove useful as an adjunctive or additional treatment to use with cognitive behavioral treatment. However, currently they cannot be recommended as stand- alone treatments. Other approaches, such as miracle cures, secret remedies, or simple solutions promised by some lesser-known websites are also unsupported and thus not recommended by the scientific community or by the Trichotillomania Learning Center. Remember, any treatment might work for one person, but may not work for most or all people. The treatment approaches that we endorse are derived from cognitive behavioral principles, which are evidence-based. The saying "if it sounds too good to be true, then it probably is" certainly applies here.

About TLC

The Trichotillomania Learning Center (TLC) is a non-profit organization devoted to ending the suffering caused by hair pulling disorder, skin picking disorder, and related body-focused repetitive behaviors (BFRBs).

TLC is advised by a Scientific Advisory Board comprised of leading researchers and clinicians in this field.

TLC offers a wide range of services for adults, children and families suffering with BFRBs, as well as for treatment professionals and researchers.

We provide:

- **treatment referrals**
- **support groups**
- **information and advice by phone and email**
- **educational events, online communities**
- **training programs for treatment professionals**
- **Books, DVDs, and fiddle toys**

TLC also supports a small research grant program to advance understanding and treatment of BFRB disorders. For more information, visit www.trich.org or call 831-457-1004.

Selected Books & Videos Available at www.trich.org

DVDs

Bad Hair Life is an award-winning, one-hour documentary presenting intimate portraits of adults and children coping with hair pulling disorder. The director shares her own history with hair pulling and expert researchers and clinicians discuss the disorder's causes and treatment. Broadcast nationally on Public Television in 2005.

The Virtual Professional Training Institute:
Practical Training in the Treatment of Trichotillomania, Skin Picking and Related Body-Focused Repetitive Behaviors. Instructors Charles Mansueto, PhD, Fred Penzel, PhD, and Ruth Goldfinger Golomb, MEd, LCPC, have designed this DVD-based program to provide health care professionals with practical training in current cognitive-behavioral treatment approaches for trichotillomania, skin picking, and related body-focused repetitive behaviors (BFRBs). Each Training Set includes 3 DVDs of instruction and 1 CD with supplemental reading materials. CE Credits available.

TLC also offers DVDs of various lectures and presentations from TLC events. Topics range from overviews of treatment to medication to self-help therapies. Visit the TLC website for a current listing of available DVDs.

Books

Help for Hair Pullers: Understanding and Coping With Trichotillomania
Nancy J. Keuthen, PhD, Dan J. Stein, PhD, and Gary A. Christensen, MD
New Harbinger Press, Mar. 30, 2001
This book is a basic primer on trichotillomania that can be helpful for both individuals with the disorder and medical professionals. It provides general information about the disorder and an overview of cognitive-behavioral treatment and medication interventions.

The Hair Pulling "Habit" and You:
How to Solve the Trichotillomania Puzzle, Revised Edition
Ruth Goldfinger Golomb, MEd, LCPC, Sherrie Mansfield Vavrichek, LCSW-C,
Emily Condon-Douglas, and Uri Yokel
Writers' Cooperative, Nov. 15, 2000
This workbook is designed to help children and their families outline cognitive behavioral treatment for trichotillomania, based on the Comprehensive Behavior Model (ComB). Children, adults and therapists have found the assessment tools, strategies, and worksheets in the book to be useful to help guide treatment.

The Hair-Pulling Problem: A Complete Guide to Trichotillomania
Fred Penzel, PhD
Oxford University Press, Mar 2003
This comprehensive handbook provides a detailed discussion of the causes and treatment options for trichotillomania, with particular emphasis upon cognitive and behavioral therapies, and effective medications and their side effects. It shows patients how to design a self-help program and gain control of their behavior, how to prevent relapse, describes trichotillomania and its treatment in children, and suggests coping strategies for families at home and in public situations.

Pearls: Meditations on Recovery from Hair Pulling and Skin Picking
Christina Sophia Pearson
April 2010
This is a simple - yet profound - collection of meditations and contemplations that provide specific insight into skin picking and hair pulling recovery. In an easy-to-understand language, Christina shares the internal process that helped her overcome the colossal challenge of becoming aware of, reducing and eventually moving beyond unwanted body-focused repetitive behaviors. This quote from a long-time sufferer says it all: *"You've blazed a path I can follow. Every step may be my own but your courage is my guiding light." M.C., California*

Stay Out of My Hair! Parenting Your Child with Trichotillomania
Ruth Goldfinger Golomb, LCPC , Suzanne Mouton-Odum, PhD
Goldum Publishing, Feb 6, 2009
Designed to help parents with the unique challenges of raising a child who struggles with hair pulling, *Stay Out of My Hair!* provides strategies for managing parent emotions and reactions to a child's hairpulling as well as techniques for helping children understand and successfully manage hairpulling behavior. The authors describe what treatment typically entails, appropriate treatment expectations, and a parent's role in treatment.

Treating Trichotillomania:
Cognitive-Behavioral Therapy for Hairpulling and Related Problems
(Series in Anxiety and Related Disorders)
Martin E. Franklin and David F. Tolin
Springer, Sep. 27, 2007
Treating Trichotillomania is intended primarily for clinicians who are actively treating TTM in their practices or who wish to further develop their expertise in this subspecialty area. Sample dialogue is used frequently to explicate how therapists might interact with patients and families about key aspects of treatment. The section on Adjunctive Modules is an acknowledgement of the complexity of the condition and the nuanced approach needed to conduct successful treatment.

Trichotillomania: An ACT-enhanced Behavior Therapy Approach
Therapist Guide and Workbook (sold seperately)
(Treatments That Work)
Douglas W Woods and Michael P Twohig
Oxford University Press, Mar 31, 2008
In this book, Drs. Twohig and Woods provide a step by step description of a 10-session behavioral treatment program for trichotillomania This book leads therapists through the treatment components of educating the patients about TTM, doing habit reversal and stimulus control, and teaching patients to be more accepting of their internal experiences as they learn to engage in behaviors that are more consistent with the kind of person they really want to become.

Additional Resources:

Skin Deep: A Mind-Body Program for Healthy Skin
Ted Grossbart, PhD, and Carl Sherman, PhD
Available as a free e-book from http://grossbart.com, **Skin Deep** has become an indispensable resource for readers dealing with persistent skin problems who are looking to better understand their causes and become active agents in their own treatment and recovery.

Stoppulling.com is a website that provides state-of-the-art interactive self-help for people who pull their hair. This website is based on cognitive behavioral principles using the ComB Model (Comprehensive Behavior treatment model for hair pulling) and has been found to be effective when used daily.

Stoppicking.com is an interactive self-help website for skin picking behaviors such as acne excoriation, nail biting, nail picking , lip/cheek biting, and other picking behaviors. Stoppicking.com has also demonstrated clinical success among users around the world.

TLC trichotillomania LEARNING CENTER

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Minneapolis, MN

Charles S. Mansueto, PhD
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Department of Psychiatry
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Neuropsychiatry & Behavioral Science
University of South Carolina School of Medicine

trichotillomania
LEARNING CENTER

For additional information on trichotillomania and skin picking:

Trichotillomania Learning Center (TLC)
207 McPherson Street, Suite H
Santa Cruz, CA 95060
831-457-1004

www.trich.org