

Trichotillomania

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What is Trichotillomania?

Trichotillomania is a compulsive hair pulling disorder characterized by repeated hair pulling from any part of the body. Trichotillomania can result in noticeable hair loss, other related physical impairments, and significant emotional distress. It is one of a group of “body-focused repetitive behaviors” that includes skin picking, nail biting, cheek or lip biting, and other related behaviors.

Hair pulling is actually one of many “self-grooming” behaviors that human beings and other primates engage in from an occasional to a regular basis. We grow, cut, color, bleach, curl, straighten, and pluck our hair from the head, eyebrows, and eyelashes, in addition to waxing, plucking, and shaving hair from other regions of the body. We also grow, cut, paint, and file our nails. We are constantly shaping and reshaping the appearance of our bodies. In other words, grooming behaviors are essentially normal for human beings. However, trichotillomania steps beyond normal grooming – it is repetitive, often self-destructive and extremely distressing to the sufferer.

With trichotillomania, hair can be pulled from any site on the body that has hair. According to one study (Christenson, 1995), pulling from the scalp is the most “popular” site, followed in decreasing order by the eyelashes, eyebrows, pubic area, arms and legs, and finally, armpits. In addition, pulling is usually not a haphazard, random act. Usually hairs are pulled out one-by-one. Often pullers pull hairs that are a particular color (e.g., gray) or that are deemed “out of place” (e.g., “That hair shouldn’t be there!”). In fact, more than 50% of pullers preferentially pull hairs possessing certain textural qualities, such as wiry, thin, coarse, stubby, or kinky (Christenson et al, 1991, Mansueto, 1990).

The complications stemming from trichotillomania are significant. In addition to the cosmetic loss of hair, there can be scarring or infection (especially if tools such as tweezers are used to pluck hair from under the skin). There is some evidence that pulling of long duration may lead to textural and color changes in the hair itself. Some individuals eat the hair that they pull, and this may lead to what are called trichobezoars (hairballs) in the intestinal tract. As we are not biologically equipped to handle the ingestion of hair, trichobezoars can necessitate surgery to remove them. Frequently, pullers complain of repetitive motion disorder of the hand, arm, or back due to the pulling behavior. Others complain of calluses on the fingers.

Yet, by far, the most serious negative consequence of trichotillomania is emotional. As noted above, individuals who pull often feel “freakish” or “crazy” because of their hair pulling behaviors, and their perceived lack of control over the urges to pull. Pulling has a dramatically negative impact on self-esteem and the sense of one’s own attractiveness. Pullers often feel that they are “less than” other people who do not pull. They often avoid social situations because they fear that others will notice their hair loss and judge them harshly. They frequently avoid dating because they fear being physically close to someone who might discover their bald patches through the touching or close scrutiny that romantic and sexual situations bring. To a lesser extent, this fear of scrutiny might also inhibit the formation of friendships. Thus, for individuals who pull, life can be quite lonely. Due to the same fear of scrutiny and discovery, pullers may also avoid opportunities to advance at work, especially if they involve being out in front of others. They may additionally avoid medical or dental visits, so that physical and dental health may be compromised.

Trichotillomania may manifest in a variety of different hair pulling and compensatory behaviors. Below are several examples of what an individual suffering from trichotillomania may experience:

Marie is a beautiful 14-year-old girl who has been pulling her eyelashes for two years. She often is teased by her classmates, who ask if she is a “cancer patient.” She tries to keep her distance from others and tries not to make eye contact in the hope that others will not focus on her eyes and the absence of lashes. She refused dental and orthodontia treatment because the thought of having the orthodontist peer closely at her face is intolerably shameful.

Janice is a 52-year-old woman who has pulled the hair on her head since puberty and has worn a wig since her early 20’s when she could no longer conceal the large hairless patches on her head with comb-overs and scalp coloring. A vivacious and accomplished professional woman, Janice has remained single as she fears rejection from males in situations of physical intimacy.

Frank is a 25-year-old male who pulls hair from his head, and has been doing so since his middle teens. He has had periods where he can stop pulling and his hair grows out fully. At other times his pulling increases to the point that he shaves his head to remove the temptation to pull. At other times, he wears caps to hide the damage. He says that he feels like a “freak.”

What are the symptoms of Trichotillomania?

Symptoms of trichotillomania may include:

- Compulsive hair pulling from any part of the body
- Significant areas of hair loss that can be located on any part of the body.
- Significant emotional and social suffering, as a result of the hair pulling, often worse than any actual physical damage of the pulling itself.
- Shame about pulling behaviors.
- Fearing that others will judge you as “freakish” or “crazy” if your pulling behaviors are discovered.
- Elaborate cover-up strategies using make-up, wigs, scarves, and/or hats.
- Withdrawal from social situations, including romantic relationships and work promotions, etc.

How is Trichotillomania diagnosed?

According to the DSM-IV, the diagnostic criteria widely used in the mental health field, in order to be officially diagnosed with trichotillomania, there must be the presence of the following:

- 1) Repetitive hair pulling that results in noticeable hair loss*
- 2) Increased tension prior to pulling or when the individual is resisting the behavior*
- 3) Pleasure, gratification, or relief during pulling*
- 4) Significant distress or impairment in social or occupational functioning due to the pulling and/or its consequences*

However, the official criteria may be too stringent to adequately capture trichotillomania as it is actually lived by many individuals. A study by Christenson and others (1991) suggested that from 17-23% of individuals claim they do not meet criteria (2) or (3) (i.e., they do not feel increased tension before a pull, nor pleasure or gratification from pulling), yet still engage in significant hair pulling resulting in hair loss.

How common is Trichotillomania?

The few studies that have attempted to assess the number of individuals suffering from trichotillomania in the United States have suggested a range from 0.6 – 3.4% of the general population. This percentage suggests that there are millions, or even tens of millions of people suffering from this disorder. The sex ratio of those with trichotillomania is also somewhat unclear. Of those who come in for help, the vast majority is female (70-93% across studies). However, in accounts of pulling very early in life and in some of the general population studies of those with trichotillomania, it appears that males and females are more on par. For most people pulling seems to start in the early teen years (average age is 13 years old); however, pulling can start at any age.

What will Cognitive Behavior Therapy treatment for Trichotillomania be like?

Many treatment approaches for trichotillomania have been tried, including a variety of medications and many psychotherapies. The therapeutic approach that has the most research support is a type of Cognitive Behavior Therapy called *Habit Reversal Training*. Habit Reversal Training (HRT) was developed by Nathan Azrin in 1973 to help a variety of people with self-destructive habit disorders (trichotillomania was one of them). Over the years Dr. Azrin's original HRT has undergone additions and subtractions. The following is a version of HRT that I have adapted for use in my practice:

1) Self-Monitoring: The first task in HRT is to get an accurate “map” of the pulling behavior. When people have pulled for some time, pulling can become a habit that is done with little consciousness. To the degree that pulling is nonconscious, it is to that same degree, immune to being changed. Accordingly, the individual is asked to carry around a log and to make notes each time s/he pulls. The log usually consists of space to note time of day, place or activity within which the pulling occurs (e.g., “on phone” or “reading”, etc.), emotional state “before,” “during,” and “following” a pulling episode, as well as how many hairs were pulled in the particular episode. The log serves as “awareness training,” to bring the pulling back into consciousness, as well as to educate both the puller and the therapist about the features of the pulling behavior. The log helps the puller and therapist to determine “high risk” situations that seem to trigger pulling episodes, as well as develop hypotheses about the “function” of the pull (e.g. what need the pull fulfills).

2) Identifying & Responding to High-Risk Situations: The puller and therapist use information from the log to specify situations that seem to trigger the urge to pull. These often include being on the phone, watching television, driving the car, reading, looking into mirrors, etc. Pullers are taught to temporarily avoid these situations, if possible, until they are better able to handle their pulling urges. For example, if magnifying mirrors are a stimulus to pull eyelashes, then the therapist would probably suggest that the puller avoid using such mirrors. If sitting in a particular chair while watching TV reliably leads to pulling, then the therapist might suggest that the patient experiment with sitting in a different chair. When the situation cannot be avoided, stimulus-control techniques can be utilized to maintain awareness and impede pulling behavior.

For example:

Janice, who tends to pull absentmindedly while driving, now puts tape around her thumb as she gets into the car so that if while driving her hand moves automatically to her hair, she will be signaled by the “something’s not right” sensation of touching her hair with her taped thumb. This sensation allows her to “wake up” out of her driving reverie and gives her a chance to decide whether or not to pull.

Other stimulus-control measures that can be utilized include squeezing Koosh balls or manipulating smooth stones in order to occupy the hands, wearing caps or scarves to serve as physical barriers to pulling, and applying hair gel to make the hair slippery and less tactilely attractive to the puller. These methods are designed to interrupt the habitual aspect of pulling and to raise the consciousness of the person so that s/he has the opportunity to choose not to pull.

3) Assessing the Function of the Pull: As mentioned above, not all pulling is done through nonconscious “habit.” Initially, pulling probably starts as a way of fulfilling a mood-regulation function, perhaps soothing the person during stressful childhood or adolescent situations. This functional aspect of pulling often persists over time. Logs frequently show that people pull in response to a particular mood state and that the pulling “works” to give pullers temporary relief from their emotional states. Moods that are frequent triggers for pulling are anxiety, nervousness, boredom, and anger. However, for some people, pulling is not utilized to manage just the negative emotions like anger or anxiety, but even the positive emotions, such as joy or excitement.

For example:

Frank, in logging, notices that he not only pulls when nervous and anxious at work, but when he returns home from a social situation happy and energized from meeting with friends. He says he realizes that he uses the pulling to calm himself down.

Logging helps the puller and therapist to develop some ideas about the function of the pull. The therapist can then help the puller experiment with alternative ways of dealing with emotion beyond simply pulling. The puller would expand his or her range of options in managing moods and body states so not to be dependent on pulling.

For example, the puller might learn alternative means of handling anxiety by utilizing and mastering anxiety-management techniques such as deep breathing or muscle relaxation. Furthermore, the puller can be helped to recognize and challenge his/her beliefs about situations that cause anxiety, and to try to change the perception of threat that makes him/her react with anxiety in the situation.

The same process of assessing reactions and developing alternate responses might be implemented with pullers who pull when in mood states of anger, irritability, sadness or melancholy. Traditional cognitive techniques might be extremely helpful in these situations.

4) Competing Response Training: Research and clinical experience suggest that the use of a “competing response” can be helpful in the treatment of trichotillomania. The idea behind competing response (CR) training is to utilize the same muscles involved in pulling but to use them in a way that is incompatible with actual pulling. A common CR is to ball the fingers into a fist and draw them into the body, holding the fist (or fists, if the person pulls with both hands) there for one minute whenever the individual experiences the urge to pull. This is often coupled with a relaxation technique, such as deep breathing. The CR is frequently first introduced in the therapist’s office — the person closes his/her eyes, imagines that s/he is in a typical pulling situation, and tries to apply the CR in response. The individual’s homework is then to try to apply the CR whenever s/he feels the desire to pull throughout the following weeks. The puller and therapist keep track of the puller’s attempts through his/her logging.

For example:

During the course of therapy, Marie gradually used her fist-clenching CR with more consistency whenever she had the urge to pull her eye lashes. Initially, she only used the CR to interrupt her pulling after she had started, but little by little, Marie found that she could

implement the fist-clenching prior to starting to pull, and use it until the urge to pull diminished.

5. Confronting Rationalizations: Those suffering from trichotillomania also need to address their own thoughts and beliefs about the act of pulling. Our thoughts, in the form of rationalizations and “bargains” that we make with the urges to pull, play a major role in the maintenance of the pulling behavior, and can foil our efforts to stop pulling.

For example:

Janice has always considered gray hair as “OK” to pull because “gray hair makes you look old!” Even as a young woman, when her pulling was minimal and much of her hair had grown in again, Janice had steadily pulled the gray hairs, and thus had kept the pulling behavior active. As the years went by, and as her hair gradually turned more completely gray, she naturally found greater and greater numbers of “target” hairs to pull. The pulling escalated, leaving her with significant bald patches. In work with her therapist, Janice began for the first time to challenge her beliefs about the “ugliness” of gray hair and gradually began to value all of her hair, rather than just the non-gray hair.

The following is a sample list of frequently occurring rationalizations for pulling:

I’ve had a hard day, I deserve to pull...

I’ll stop tomorrow...

That gray (kinky, coarse, etc.) hair doesn’t belong there...

My boss (spouse, mother, etc.) makes me pull...

I’ll stop after I pull just one more...

This hair is out of place – it doesn’t deserve to remain...

I’ll only pull one...

*It’s compulsive, I **can’t** stop...*

In therapy, it can be critical to work on capturing and challenging beliefs related to the pulling behavior as illustrated above. Critical pulling-related thoughts and beliefs can be “captured” by logging thoughts that accompany pulling episodes, and bringing them back into therapy where the client and the therapist work together to challenge them. Thoughts can be challenged by systematically evaluating the evidence both for and against the pulling-related belief. When the evidence is carefully examined, frequently one is able to modify the belief in a more rational direction.

For example:

In logging her pulling episodes, Marie found that she often told herself, “I’ll only pull one lash, and then I’ll stop.” This thought allowed her to start pulling “because one doesn’t matter – what’s just one? It won’t show.” She noted that many of her eyelash-pulling binges started with this rationalization. The therapist helped her to isolate two thoughts implied in the above statement: that it is “easy” to just stop pulling at one, and that one hair does not matter. Marie found that, when she carefully thought about it, especially in light of her prior experience, that it was exceptionally difficult to stop pulling at just one. She noted that pulling one eyelash rarely satisfied her urge to pull and, in fact, often increased the strength of her urges, so it became even more difficult to stop. She was also able to recognize that each of her lashes were important, that she had a finite number of eyelashes and that every lash left untouched helped to build a full set. Being able to challenge her rationalizations helped Marie begin to more successfully resist her urges to pull.

Challenging core beliefs about the self as puller is just as critical as challenging the above rationalizations. As noted at the beginning of this article, in addition to causing cosmetic damage, trichotillomania also injures one's sense of self.

For example:

Frank believed that because he pulled out his hair, others would consider him a “freak” if they knew about the pulling. Consequently, he was very socially isolated, afraid that others would reject him. When out in public he would hide any current hair damage by wearing hats or caps, or at other times, shaving his head. With the therapist's help, Frank began to challenge the idea that he was any different in any fundamental way than anyone else by virtue of his pulling. He learned about how universal private grooming habits were. He began to rank human values in order of importance, and began to acknowledge that strength, integrity, compassion, intelligence, trustworthiness, etc. were as important, if not more, than the absence of hair or the fact that he pulls hair. He began to perform some behavioral experiments to “test” the idea that others would reject him. He began to go out in public without his hat and carefully noted his interactions with others, and discovered that people were a lot less critical and rejecting than he had believed.

6) Developing Mindfulness: One of the more recent innovations in the treatment of trichotillomania has been to add a “mindfulness” aspect to the standard treatment package illustrated above. When people are aware of the urge to pull, they often think that they *have* to pull, i.e., that they can't resist the urge, that if they don't pull when they have the urge, the urge will go on forever or rise to an unbearable crescendo. People say, “It's like an itch – if I don't scratch it, I'll go crazy!” However, remarkably few people have thoroughly experimented with their beliefs about resisting an urge to itch or an urge to pull. They may believe that resisting an urge would be unbearable, without ever having really tried it.

Here is a useful experiment to try: whenever you get an itch, instead of immediately reaching to scratch it, allow yourself to observe the experience of the itch. What does it actually feel like? What happens to the itch over time? Does it really rise to an unbearable state or does it have a lifecycle where it comes, stays awhile, then fades? Is the experience of the itch really unbearable? By not rushing to scratch an itch, people often realize that the actual experience of an itch may not be as intolerable as they previously believed.

The same experiment could be made with the urge to pull. You might want to set up the experiment in the following manner: Set aside a time when you will be alone, sit in a comfortable chair, and try to stimulate an urge to pull. You might think certain stressful thoughts, look in the mirror, or gently start to play with your hair – whatever would serve to fire up the pulling urge. Once you feel the urge, rather than trying to quench it through pulling, just become mindful of the urge and observe the urge over a period of time. It would be best to make the observation period at least 15-30 minutes so you can track the changes that occur in the strength of the pulling urge over time. What does it really feel like and what happens to these feelings over time? Many people discover that the urge to pull has a limited lifespan and diminishes on its own when just observed and not pulled. If you do this experiment or experiments (it's best to do this at least a few times) you can learn a tremendous amount about the urge to pull that will help you in your quest to learn how to give up pulling.

This act of observing experiences without judgment is called “mindfulness”. The use of mindfulness in psychotherapy is currently being intensively studied. There are early studies indicating that adding this approach to the treatment package for trichotillomania might be very helpful.

What does research say about Cognitive Behavior Therapy for Trichotillomania?

A number of research studies have shown that the form of Cognitive Behavior Therapy known as Habit Reversal Training (HRT) is an effective treatment for trichotillomania. Studies indicate that HRT is probably more effective than treatment with antidepressant medication, the usual medication of choice for trichotillomania.

In Conclusion

In ending, it needs to be said that, though it is difficult to stop pulling your hair, it is completely possible to learn to do so. So don't stop trying!

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