CASE REPORT

Year : 2014
Issue : 1
Number : 1
Doi Number : 10.5455/JNBS.1394035079

Article history:
Received 08 January 2014
Received in revised form 12 February 2014
Accepted 30 January 2014

HABIT REVERSAL TRAINING IN TRICHOTILLOMANIA

TRİKOTİLLOMANİDE ALIŞKANLIĞI TERSİNE ÇEVİRME EĞİTİMİ

Gökben Hızlı Sayar[1*], Gaye Kağan[2]

Abstract

Trichotillomania is a psychiatric disorder that involves repetitive hair pulling to the point of apparent loss. No approved treatment algorithm is available for trichotillomania. We present a case report of a 28-year-old female diagnosed as trichotillomania, with complaints of recurrent hair pulling resulting in noticeable hair loss. She was treated with Habit Reversal Training and a selective serotonin reuptake inhibitor (sertraline) over a period of 6 weeks. Habit reversal training includes self-monitoring, awareness training, competing response training, and homework assignments. The aim of this case report is to provide a brief description of habit reversal training, which is unfamiliar to many professionals.

Keywords: habit reversal training, hair pulling, trichotillomania

Özet

Trikotillomani, tekrarlayan saç yolmalar sonucu belirgin saç kaybı ile sonuçlanan bir psikiyatrik bozukluktur. Kabul görmüş bir tedavi algoritması bulunmamaktadır. Bu yazıda tekrarlayan saç koparmaları sonucu belirgin saç kaybı olan trikotillomani tanılı, 28 yaşında bir kadın olgu sunulacaktır. Olgu alışkanlığı tersine çevirme eğitimi ve seçici serototnin gerialım inhibitörübir ilaç (sertralin) ile 6 hafta boyunca izlenmiştir. Alışkanlığı tersine çevirme eğitimi, kendini izleme, farkındalık eğitimi, karşıt cevap eğitimi ve ev ödevlerini kapsayan bir tekniktir. Bu olgu sunumunun amacı birçok profesyonelin aşine olmadığı alışkanlığı tersine çevirme eğitiminin kısa bir tanımını yapmaktır.

Anahtar Kelimeler: alışkanlığı tersine çevirme eğitimi, saç koparma, trikotillomani

1. Introduction

Trichotillomania (TTM) is characterized as a psychiatric disorder in which individuals fail to resist urges to pull out their own hair, and is associated with significant functional impairment and psychiatric comorbidity across the developmental spectrum. Lifetime prevalence rates of TTM have been estimated to be from 0.6% to 1.0% (Duke et al., 2010). TTM has been found to be related with feelings of isolation, shame, embarrassment, and low confidence, along with avoidance of activities such as medical exams, haircuts, swimming, social relationships, and intimate interpersonal relationships to hide their symptoms (Diefenbach et al., 2005). Individuals may pull their hair for up to several hours a day or require extraordinary attempts to conceal hair loss, either of which can significantly interfere with daily living.

The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hairpulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5 (APA, 2013). After pulling hair, more than half of the patients use the hair in an odd manner (biting the hair, touching the hair to the lips and even swallowing the hair). Swallowing of hair may lead to the formation of hairballs in the intestine known as trichobezoars which can lead to intestinal ulceration, obstruction and even perforation (Walsh & McDougle, 2001). Management of trichotillomania is challenging. A number of treatment modalities have been used including psychotherapy, hypnotherapy, and pharmacotherapy; though treatment response is variable and relapses are frequent (Chawla et al.2013; Franklin et al., 2011).

In 1973, Azrin and Nunn developed Habit Reversal Therapy (HRT) to treat various habits (Azrin & Nunn, 1973). HRT is commonly used to treat disorders involving repetitive, body-focused, unwanted behaviors, such as Tourette's Syndrome (Woods & Miltenberger, 1995), trichotillomania, nail biting, temporomandibular disorder, thumb sucking, finger and lip biting (Roberts et al., 2013). These disorders all characterized the variety of

[1]Uskudar University, Neuropsychiatry Istanbul Hospital, Department of Psychiatry, Istanbul, Turkey [2]Uskudar University, Neuropsychiatry Istanbul Hospital, Department of Psychology, Istanbul, Turkey Correspondance: Gökben Hızlı Sayar Neuropsychiatry Istanbul Hospital, Ümraniye, Istanbul
gokben.hizlisayar@uskudar.edu.tr

problems as habit behaviors, each with clear potential for development of a competing muscle movement (Bate et al., 2011). Studies on the pharmacotherapy of trichotillomania remain inconsistent with no particular drug or group of drugs found to be clinically effective constantly (Stewart & Nejtek, 2003; Voth, 2006). Behavior therapy in the form of HRT has been found to be an effective treatment in several reports (Bloch et al., 2007; Crosby et al., 2012; Woods et al., 2006). HRT has some key components like awareness training, stimulus control, competing response training and social support which are delivered on several therapy sessions (Kar & Kumar, 2012; Mouton & Stanley, 1996).

We present a case report detailing clinical data taken during the course of outpatient treatment of a patient with a diagnosis of TTM. The patient was resistant to a range of drugs and was started on treatment with HRT. Informed consent was obtained from the patient by using a written form.

2. Case

Ms E, twenty-eight years old, high school graduated, divorced, a saleswoman, admitted to psychiatric interview with complaints of hair pulling and apparent hair loss. She has been pulling her hair since she was 13 years old. She used to do it when alone or under stress. There was significant hair loss on her scalp, which was more marked in the left side, due to repeated pulling. After pulling the hair, she used to chew the ends of her hair and even swallow it. She used to develop both an urge and a sense of tension immediately before pulling out the hair, or when attempting to resist the behavior on which she felt relieved while pulling out the hair. Hair pulling was not only localized to the scalp but also to the eyebrows. She totally lost her whole eyebrows, so she drew an artificial eyebrow with a make-up pencil. The patient started using a scarf, which she was wearing throughout the day, because of the baldness arising due to her hair pulling. She developed decreased confidence owing to her problems and started avoiding social gatherings. She was diagnosed as TTM. Her treatment history revealed various antidepressants including fluoxetine, escitalopram, clomipramine, risperidone, sulpiride, with no significant improvement. There was no relevant family history of any psychiatric illness. Physical examination revealed patchy baldness all over the scalp. Hair loss was also observed on her eyebrows. Laboratory tests revealed normal hemogram, liver function and thyroid functions and abdominal ultrasoundography.

She was started on sertraline 50mg/day which was then gradually escalated to 100mg/day over a period of 6 weeks, along with risperidone 1 mg/day. Behavior therapy in the form of HRT was planned. The therapy was structured as six sessions, each lasting for 40 to 45 minutes on a weekly basis.

In the first session, she was educated about the diagnosis of trichotillomania, its prevalence, etiology, and course. The concept of HRT was explained. She completed a focused questionnaire related to her hair-pulling behaviors, antecedents, and consequences. A self-monitoring form was given, and she agreed to fill it on a daily basis and maintain it throughout the therapy period.

In the second session, awareness training was given by making the patient realize that the behavior of hair pulling was abnormal, and by identifying different situations during which she used to pull her hair. Environmental, sensory, cognitive, and effective cues that have been conditioned to trigger hair-pulling are identified through self-monitoring. She concluded that she pulled it when she was feeling bored or relaxed, therefore, she needed something to do with her hands.

In the third session, feedback of the last session was taken, and self-monitoring form was assessed. She had developed an awareness of habit and often resisted pulling. Skin sensations provided significant cues for pulling. Efforts then are aimed at breaking or interrupting these conditioned sequences and replacing the hair-pulling behavior with more adaptive responses. The patient was taught progressive muscular relaxation and diaphragmatic breathing and was asked to do both on a daily basis. She was advised to replace her behaviors including cue for hair pulling with other postures, such as placing her hands behind her back while working or putting her hand under the pillow while sleeping. Imaginal exposure techniques were used during the session to encourage patient in practicing the relaxation techniques in high-risk situations. She was asked to close her eyes and imagine herself in a high-risk situation and notice the urge to pull hair become stronger until she wanted to pull her hair acutely. Afterwards, she was asked to use relaxation strategies to restrict the hair-pulling urge by both breathing and postural adjustment.

The fourth session constituted of teaching the "competing response" which is acquiring of a muscle tensing activity which is opposite to, and incompatible with hair pulling. She was taught to make a clenched fist with the hand she uses to pull hair, to bend the arm at the elbow 90, and to press the arm and hand firmly against her side at her back. She was then instructed that whenever and wherever she would get the urge to pull, she was to (in order) relax herself, do diaphragmatic breathing for 60 seconds, and the competing response for 60 seconds. She was encouraged to perform these techniques in front of the therapist, thereafter her family members and then in different social situations. She was asked to do rehearsal of these techniques at home.

In the fifth session, she reported that the deep breathing and doing competing muscle exercises almost entirely eliminated her urge to pull. The patient's parents were instructed to help her to practice the competing responses and appreciate her efforts. Review of the rationale and types of replacement or competing behaviors that would help reduce her symptoms were done with the patient and her family.

In the concluding session, the patient's improvement after HRT sessions was analyzed. She reflected upon her experiences and progress over the 6-week period. Despite some hesitancy at treatment onset, she concluded that increasing awareness of behavior was the key to change hair pulling behavior.

With the combination of pharmacotherapy and HRT technique, there was a significant improvement. During follow-ups, over a period of six months, her hair pulling habit was reduced from several times in a day to 1 – 2 times in a week and hair started growing on the scalp and she stopped using her scarf to cover her head.

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3. Conclusion

HRT is a highly effective, well-structured and simple behavioral therapy approach for patients with TTM. Although HRT appears to be an effective method of treatment for TTM, conducting is not enough due to the possibility of non-adherence to the strategic approach after the end of psychotherapeutic sessions. Therefore, it is required to follow the case and review the HRT technique and hair pulling symptoms in regular intervals.

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