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Of all the disorders belonging to the OCD family, Trichotillomania is probably one of the least understood by both sufferers and practioners alike. It has also been, for many years, among the most frustrating and difficult to treat for all parties concerned.

The name Trichotillomania (TTM) coined in 1889 by Hallopeau, is in itself an unfortunate and misleading one. It seems to pigeonhole the disorder with other unrelated problems such as kleptomania, pyromania, etc. In addition, it seems to imply an enjoyment and attraction on the part of sufferers to pursue their hair pulling activities. Those who have the disorder understand that this obviously is not true. The term "mania" itself seems to suggest a serious mental illness.

Given what we now understand about TTM, it appears to be a disorder that has both biological and behavioural components. The fact that antidepressant medications such as Anafranil and Prozac seem to relieve much of the urge to pull, is strong evidence of an underlying neurochemical basis. To those who would go the route of medications alone, I would say that while medications are extremely helpful in treating TTM, I have rarely seen them eliminate 100% of the problem. I strongly believe in combining behavioural treatment with drug therapy. As in other obsessive-compulsive disorders, both appear to work better together than either one alone. Medications may also be imperfect for some in terms of the side effects they produce. Sometimes these side effects prevent individuals from taking high enough doses to lower their symptoms substantially. One other situation where medications cannot help is in the case of women who wish to become pregnant and need to be drug free.

The gap between what the drugs can and cannot do can be bridged by behavioural therapy. Over the years, many assorted techniques for treating TTM have been tried, with little or no success. These would include psychoanalysis, hypnosis, relaxation training, aversion therapy, etc. I have heard a few isolated reports of the successful use of biofeedback, but no data or studies are available on it's effectiveness. Although more formal studies of the use of behavioural therapy for TTM remain to be done, it appears that it is the most effective treatment we possess.

The technique which is at the heart of behavioural therapy for TTM is known as Habit Reversal Training (HRT). HRT was pioneered by Dr. Nathan Azrin in 1973 for the treatment of tics and nervous habits. Unfortunately, as TTM was not known to be widespread at the time (we now believe that there are possibly several million sufferers in the U.S. alone - one estimate claims 8 million) and because there were practically no practitioners involved in it's treatment, this technique remained relatively unknown - except to a handful of specialists around the country. This obscurity is confirmed by a quick scan of the literature, which revealed that since 1973 it has been mentioned in only about 8 studies involving the treatment of around 44 individuals with TTM. Studies of this technique show good results though. One study, done in 1980 by Azrin, Nunn and Frantz showed decreases in hair pulling of over 90%.

Let us now briefly examine just what principles are involved in HRT. Generally speaking, there are three steps. Each step is practiced separately and then all three are finally integrated into a unified program. The first step involves the development of an awareness of the habit itself. While many with TTM feel an urge or tension prior to pulling, many also pull at times when their attention is focused on some other activity, such as watching TV, talking on the phone, reading,

driving the car, etc.. They seem to go into what can best be described as something like a trance. They do not realize what they have been doing until the bout of hair pulling has stopped. Those who do notice it, tend to quickly forget recent incidents as they are unpleasant to think about or remember. Getting those with TTM to pay attention to hair pulling is not always easy for this last reason. In any case, it is easier to control a habit when you are aware of the circumstances surrounding it.

We accomplish our first step by giving patients special self-monitoring sheets to fill out in between weekly sessions. They are instructed to keep track of when hair pulling episodes occur, how long they last, how many hairs were pulled, how strong the urge was, what they were doing at the time, and what their emotional state was. Interestingly enough, even those with TTM who seem to be aware of the circumstances surrounding their pulling, are often surprised at what they discover about their own patterns. This recording continues throughout the full treatment period.

Generally, we begin the second step about a week after the recording in the first step has begun. This involves learning progressive muscle relaxation and diaphragmatic breathing via taped instruction. This exercise is done once a day and takes about 15 - 20 minutes. The purpose of it is to focus oneself and to try to reduce some of the tension. After about two weeks most people become fairly proficient at relaxing their bodies and regulating their breathing. At this point, they are given and abbreviated relaxation tape in which they compress their relaxation skills into a 60 second period. This is then practiced several times a day while learning the third step.

The third step is the acquiring of a muscle tensing activity which is somewhat opposite to, and incompatible with hair pulling. It is known as a "competing response". In this step, patients are taught to make a clenched fist and to press their arm and hand firmly against their side at about waist level. This position is then held for one minute. This is practiced in the office, and then at home over the following week. I usually recommend around three practice periods a day, of ten repetitions each.

Finally, all three steps are assembled into a complete habit reversal response. Patients are instructed that as a first priority, whenever and wherever they get the urge to pull, they are to
(1) relax themselves and simultaneously
(2) breathe from the diaphragm for 60 seconds, and when this is done,
(3) clench their fist and press their arm to their side for 60 seconds. If they find themselves already in a hair-pulling episode, they are, as a second priority, to interrupt the episode while it is in progress with their habit reversal response. As a third and lowest level priority, they are to practice the response even if they have already stopped pulling and the episode has just ceased.

The HRT is fairly discreet and can be practiced in most situations without attracting attention. This does not turn out to be a serious problem, as most with TTM seem to do the majority of their pulling when they are alone. The one main exception to the above instruction concerns handling urges to pull when driving a car. In such a case, patients are instructed to just do the diaphragmatic breathing and to clench their hands on the wheel instead. This can obviously be adapted to other situations where HRT is not possible or advisable. HRT appears to be adaptable to treating all types of hair pulling from different areas of the body.

It is vitally important from the beginning to explain the need for patience and persistence in working to develop HRT skills. Some will practice it for a few days and pessimistically conclude that it won't work and that they will never recover. I like to point out that they have probably practiced hair pulling hundreds or thousands of times, versus the few dozen times they have used their HRT. It is also important to remember that those with TTM can get easily discouraged at first. They have probably tried to stop many times in the past, without success, and have gotten into the habit of visualizing themselves as failures and people who cannot control themselves. They have often had to face the ridicule and criticism of others. Trichotillomania seems to them to be more powerful than they are.
There are two other techniques we often employ along with HRT. One is the use of covert self-statements in which patients are encouraged to practice telling themselves things which will help them resist or cope. Examples to help someone cope would include "Pulling doesn't help - it just makes things worse", "I CAN control my pulling if I just keep trying", or "I don't have to give myself permission to pull". Self-instruction statements to help in carrying out treatment could be "You're getting close to a risky situation - keep your hands down", or "Get ready to use HRT - you have a choice". The other technique which is more of short-term help is the use of physical aids such as plastic finger splints or rubber finger covers sold in business supply stores. When self-awareness problems remain strong, these act as reminders to interrupt pulling, and also can prevent it. As self-management improves, they are usually outgrown.

One of the major misconceptions about behaviour therapy is that it doesn't take feelings into account, but any behaviour therapist who doesn't take the feelings that patients with TTM have into account will face many treatment failures. Coaching and encouragement is very important. The procedure is really not a difficult one to learn but practicing it like a discipline takes stubborn persistence. I have seen the time it takes to master HRT range from a few weeks to a few months. It varies with how strong the urges are and how persistent the person is in facing their symptoms.

One of the greatest stumbling blocks can be seen with the TTM sufferer who says, "What is the point of my practicing so hard and letting my hair grow back if in one slip-up I pull it all out again? I feel like such a failure when this happens." My answer to them goes something like, "Look, I know difficult it must be in sticking with a treatment where hours of effort can seem to be undone in a few minutes. I am sure you are feeling very disappointed with yourself at the moment. Remember, though, it's more important to take the long-term view, rather than just concentrating on where you are at this moment. Your hours of practice haven't been wasted. Eventually, if you keep picking yourself up each time you fall down, the accumulated force of all your practice will add up to behavioural change. Focus instead on crediting yourself with not pulling all those other times you usually would have. Don't measure your progress right now in terms of hairs you have or haven't pulled. Concentrate on learning the HRT and you'll reach your goal. It isn't possible to learn a new goal without some setbacks here and there. If you simply quit, then we can be sure you won't make any progress. As long as you keep trying, you're making progress.

I also believe in integrating cognitive therapy with the behavioural. This centres around teaching TTM sufferers that disturbed emotions are the result of illogical beliefs and distorted reasoning - that they cause their own upsets, but can also control them by learning to spot these errors and vigorously challenge them and change them. Beliefs such as "I must get the result I desire without discomfort or frustration", or "Getting over TTM should be easy", or "I shouldn't have TTM. It's unfair and therefore I shouldn't have to work hard to recover from it". I like to use tapes and reading material to help my patients learn to challenge these ideas and to learn to think

more sensibly in ways that will help them. One of the chief goals is to teach patients to quit rating themselves as human beings (which is impossible) and to stick to rating their behaviour (which IS something they CAN rate and change) - that doing badly, at times, does not mean that they themselves are bad or worthless.

Even when HRT has been mastered and logical thinking is established, the work has not ended. I tell people that getting well is 50% of the job - staying well is the other 50%. TTM is best viewed as a chronic problem that you can recover from, but never be cured of. Long-term maintenance is the key to keeping gains. We do this via a program called " relapse prevention". There are four steps to this. They are:

Know your high risk situations,
Be prepared for slip-ups - take immediate action,
Accept that slip-ups do occur and are only temporary - don't down your efforts, and
Live a balanced life to reduce the role of stress, both physical and psychological.

Does everyone maintain their recovery and stay free of TTM following therapy? The answer is of course no. Because people aren't perfect, because life can be stressful, and because we are talking about recovery versus cure, a certain number of people will run into trouble from time to time. We expect this. Using their relapse prevention steps, however, or even returning for a few booster sessions of therapy, most can get back on the track in a short term.

To conclude, there are many useful techniques for treating TTM - no one must suffer needlessly anymore. Be a wise consumer in seeking proper therapy from a trained and competent therapist. This rest is up to you.