



## Emotion regulation in individuals with and without trichotillomania



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### ABSTRACT

Emotion regulation difficulties in trichotillomania (TTM) have been documented in past studies. However, the potential conflation of relationships due to comorbid affective symptoms means that the relationship between TTM symptoms and emotion regulation constructs requires further investigation. In addition, the relationship between different hair pulling styles (focused vs. automatic) and emotion regulation constructs has received only limited empirical attention. This study investigated relationships between emotion regulation constructs and TTM, controlling for depression, in 20 adults with self-reported TTM symptoms compared to 43 non-symptomatic participants. All participants completed structured clinical interviews. The results revealed that individuals who endorsed TTM symptoms had significantly more difficulties regulating emotions and poorer distress tolerance compared to the non-symptomatic group, even after controlling for depression. While automatic hair-pulling was not associated with any emotion regulation constructs, focused hair-pulling yielded moderate-to-strong significant correlations with several emotion regulation facets. These findings support suggestions that emotion dysregulation is core to the phenomenology of TTM (specifically, the focused hair-pulling style) and is not simply a result of comorbid depression. Future research is required to examine the impact of comorbid depression on treatment outcomes, and to determine the clinical utility of differentiating between focused and automatic hair-pulling styles.

Trichotillomania (TTM) is an obsessive compulsive-related disorder characterized by persistent pulling of one's hair for non-cosmetic purposes, resulting in hair loss (American Psychiatric Association [APA], 2013). TTM is associated with considerable personal disability, high psychiatric co-morbidity, and with shame, isolation, and low self-esteem (Christenson, Mackenzie, & Mitchell, 1991; Stemberger, Thomas, Mansueto, & Carter, 2000). TTM is more common than previously believed, with the most recent lifetime prevalence estimates ranging from 2% to 4% (Ghisi, Bottesi, Sica, Ouimet, & Sanavio, 2013; Odlaug & Grant, 2003).

Once considered “non-functional”, hair-pulling and other body-focused repetitive behaviors (BFRBs) such as skin-picking and nail-biting are increasingly being suggested to serve an emotion regulation function (for a review, see Roberts, O'Connor, & Bélanger, 2013). Emotion regulation is a multi-faceted and adaptive process, which involves identifying and regulating the presence, intensity, timing, and expression of both positively- and negatively-valenced emotions (Gratz & Roemer, 2004). Early models of BFRBs proposed that hair-pulling and related behaviors initially begin as normal responses to stress (Azrin & Nunn, 1973), but become entrenched via negative reinforce-

ment (by minimising negative emotions such as anxiety, boredom, frustration, etc.) and by positive reinforcement (by enhancing a sense of relief, calmness, and happiness; Mansueto, Stemberger, Thomas, & Golomb, 1997). The fluctuation of these emotions across the hair-pulling cycle has been repeatedly demonstrated in retrospective self-report and experimental studies (Diefenbach, Mouton-Odum, & Stanley, 2002; Diefenbach, Tolin, Meunier, & Worhunsky, 2008; Duke, Bodzin, Tavares, Geffken, & Storch, 2009; Duke, Keeley, Ricketts, Geffken, & Storch, 2010; Ghisi et al., 2013; Roberts, O'Connor, Aardema, & Bélanger, 2015).

In their biopsychosocial model, Franklin and Tolin (2007) proposed that individuals with TTM are not only biologically predisposed to experiencing excessive grooming behaviors (e.g., Swedo & Rapoport, 1991), but also to experiencing difficulties with tolerating discomfort, such that individuals with this vulnerability are more likely to use hair-pulling to “control or eliminate their uncomfortable emotions or sensations” (Franklin & Tolin, 2007, p. 19). This is also the premise of the emotion regulation model for BFRBs, which proposed that individuals who develop BFRBs have a trait-like “general deficit in emotion regulation that promotes the adoption of maladaptive coping

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methods” (Roberts, O’Connor, & Bélanger, 2013, p. 750). Studies have supported the emotion dysregulation vulnerability hypothesis in TTM. Shusterman, Feld, Baer, and Keuthen (2009) found that, compared to non-pullers ( $n=175$ ), an internet-surveyed sample of participants with self-reported hair-pulling symptoms ( $n=1162$ ) endorsed significantly greater difficulty “snapping out” of nine emotions thought to be of particular relevance to TTM (e.g., boredom, frustration, shame, anxiety, anger, sadness). In a sample of 24 participants with BFRBs ( $n=6$  with hair-pulling), Roberts, O’Connor, Aardema, and Bélanger (2015) replicated Shusterman et al.’s findings using the Affective Regulation Scale (ARS; Shusterman et al., 2009) and the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). Additionally, Roberts et al. found that participants with BFRBs reported significantly greater behavioral urges than did 23 non-clinical control participants in response to mood-induction tasks for stress, frustration, and even during the relaxation condition. Overall, such findings suggest that adults with BFRBs, including TTM, have greater baseline difficulties with regulating emotions than do adults without BFRBs.

Treatment studies have also provided indirect support for the role of emotion regulation difficulties in TTM. McGuire et al.’s (2014) meta-analysis of behavioral therapies for TTM found that treatments such as dialectical behavior therapy (DBT; Keuthen et al., 2012) and acceptance and commitment therapy (ACT; Woods, Wetterneck, & Flessner, 2006) – both of which directly target emotion regulation processes – produced greater reductions in self-reported TTM severity than did core behavioral therapies. Emotion dysregulation and related processes (e.g., experiential avoidance, distress intolerance) have therefore been suggested as key maintaining mechanisms of TTM that should be targeted in treatment (Keuthen et al., 2010; Woods et al., 2006).

However, there are complicating factors that preclude a clear understanding of the role of emotion regulation processes in the development and maintenance of problematic hair-pulling behaviors. Comorbidity in TTM is the norm rather than the exception; in clinical and treatment-seeking samples, rates of depressive and anxiety disorders exceed 50% and 25%, respectively (Christenson et al., 1991; Lochner, Simeon, Niehaus, & Stein, 2002; Woods et al., 2006). Shusterman et al. (2009) found that ARS scores accounted for less than 1% of the variance in TTM symptom severity. Including measures of worry, perceived stress, experiential avoidance, and perfectionism in the analysis increased the proportion of explained variance to 10%. Similarly, in their sample of DBT completers, Keuthen et al. (2010, 2012) reported no significant baseline relationships between TTM severity and several emotion regulation measures, including the DERS and a modified version of the ARS. Nevertheless, participants in both trials experienced significant improvements to both TTM symptoms and in emotion regulation processes (Keuthen et al., 2010, 2012). Keuthen et al. (2012) suggested that the “limited affective comorbidity” in their sample may have weakened the potential to find such relationships. This last possibility could suggest that emotion dysregulation is not related to TTM, but to the psychiatric disorders that are so commonly comorbid with it. The inter-relationships between affective comorbidity, TTM, and emotion regulation constructs remain under-studied.

A second question is whether emotion regulation constructs relate differently to the specific hair-pulling styles shown by individuals with TTM; namely, automatic and focused hair-pulling (Flessner, Woods, et al., 2008). Automatic hair-pulling typically occurs with limited-to-no awareness and without an identifiable internal antecedent, whereas focused hair-pulling is performed intentionally in order to reduce the intensity of unpleasant urges, cognitions or emotions (Flessner et al., 2008; Wetterneck & Woods, 2007). As such, focused hair-pulling is conceptualized as a specific emotion regulation strategy aimed at reducing or avoiding the experience of negative internal states (i.e., experiential avoidance; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). To our knowledge, only a single empirical study has reported on

the relationships between experiential avoidance and hair-pulling styles. In a treatment-seeking sample of 90 adults with TTM, Houghton et al. (2014) identified that higher levels of focused hair-pulling were significantly and negatively correlated with psychological flexibility (the opposite of experiential avoidance;  $r = -.46, p < .001$ ), as measured by their newly developed scale designed to assess this construct specifically in TTM samples. There was no relationship between automatic hair-pulling and psychological flexibility (Houghton et al., 2014). Contrasting with the lack of a relationship reported in the treatment-seeking samples of Keuthen et al. (2010, 2012), Houghton et al. (2014) did find significant baseline relationships between TTM severity and experiential avoidance.

Findings that suggest that the focused and automatic hair-pulling styles are each associated with unique clinical characteristics (du Toit, van Kradenburg, Niehaus, & Stein, 2001; Flessner, Conelea et al., 2008) have fueled suggestions that treatments specifically addressing emotion dysregulation (and related processes) could be most suitable for individuals whose hair-pulling style is predominantly focused (Flessner, Woods, et al., 2008; Woods, Flessner et al., 2006). However, there is a paucity of research that has examined the relationships between specific hair-pulling styles and emotion regulation constructs. Additionally, the potential conflation of relationships between TTM severity and emotion regulation constructs due to comorbid affective symptoms needs to be investigated. The aim of this study was to investigate the relationships between hair-pulling behaviors and emotion regulation constructs after controlling for the influence of depressive symptoms. A secondary aim was to explore the relationships between emotion regulation constructs and higher levels of focused versus automatic hair-pulling styles. It was hypothesized that individuals with TTM symptoms would report significantly higher levels of emotion dysregulation, distress intolerance, and experiential avoidance relative to participants without TTM symptoms. Given the lack of previous research examining the relationships between emotion regulation constructs and TTM symptoms after controlling for depression symptoms, no *a-priori* hypotheses were proposed with regards to whether relationships between TTM symptoms and emotion regulation constructs would hold after controlling for depression. It was also hypothesized that emotion dysregulation, distress intolerance, and experiential avoidance would be correlated with higher levels of focused hair-pulling, but not with higher levels of automatic hair-pulling. Finally, relationships between TTM symptoms, hair-pulling styles, and facets of emotion dysregulation were also explored.

## 1. Method

### 1.1. Participants

Participants were eligible if they were aged 18 years or older, proficient in the English language, and willing and able to participate in a clinical interview either in-person or via teleconferencing software (Skype). Participants were ineligible if they experienced current high suicide risk, past or current psychotic illness or current substance and/or alcohol dependence. Of the 74 participants who consented to take part in the study, five participants were excluded due to current cannabis or alcohol dependence. One participant did not complete any study measures following the clinical interview. These participants were followed-up and offered support services. This resulted in a total of 68 participants; 20 participants recruited through TTM-specific organisations and support groups, and 48 student and community-recruited participants. All but one participant were Australian residents; the other was a resident of the United Kingdom.

Of the 20 participants who self-identified as having TTM, the symptoms of four participants were assessed as meeting subthreshold *DSM-5* criteria for TTM, defined as meeting criterion A (repetitive hair-pulling resulting in hair loss) and at least two of the four remaining

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