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Behaviour Research and Therapy 44 (2006) 359–370
BEHAVIOUR RESEARCH AND THERAPY
www.elsevier.com/locate/brat

Behavioural treatment of trichotillomania: Two-year follow-up results

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Received 19 October 2004; received in revised form 8 March 2005; accepted 15 March 2005

Abstract

Post-treatment evaluation studies of behaviour therapy (BT) for trichotillomania (TTM) have shown that BT is successful in reducing symptoms in this impulse-control disorder. The present study was aimed at investigating gain maintenance at long-term follow-up. TTM-related symptoms and other symptom characteristics were evaluated in 28 patients suffering from TTM before and after brief BT and at a 3-month and 2-year follow-up. The manual-based BT consisted of self-control procedures offered in six sessions. Pre-post effect sizes for TTM symptoms at post-treatment evaluation and at the two follow-ups were 2.91, 1.47, and .87. Compared to the post-treatment effects, the 3-month and 2-year follow-up effect sizes had decreased by 49% and 70%, respectively. Better 2-year follow-up results were associated with lower pre-treatment levels of depressive symptoms and with complete abstinence from hairpulling immediately after treatment.

Keywords: Impulse control disorders; Hairpulling; Self-control; Behavior therapy; Post-treatment follow-up

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doi:10.1016/j.brat.2005.03.004

Introduction

Brief behaviour therapy (BT) and serotonin re-uptake inhibitors (SRIs) have both been reported to be effective in the treatment of trichotillomania (TTM). However, better post-treatment outcomes were found for brief BT in the two randomized controlled studies that directly compared the effects of the two treatments (Minnen, Van Hoogduin, Keijsers, Hendriks, & Hellenbrand, 2003; Ninan, Rothbaum, Marsteller, Knight, & Eccard, 1993). Brief BT, therefore, seems to be the treatment of choice for TTM. Nevertheless, the findings of studies that investigated whether the positive treatment responses of BT are maintained in the long run have been inconsistent. Azrin, Nunn, and Frantz (1980) reported an excellent gain maintenance at 4 and 22 months for 19 TTM patients treated with habit reversal training. Rosenbaum and Ayllon (1981) found similar positive effects for their follow-up assessments at 6 and 12 months in 4 patients treated with the same procedure. In contrast, Mouton and Stanley (1996) obtained considerable relapses after 4 weeks and 6-months in 5 patients treated with habit reversal, as did Lerner, Franklin, Meadows, Hembree, and Foa (1998) in their 3.7-year follow-up assessment of 13 patients. These findings suggest that in TTM initial positive responses may be difficult to maintain after treatment (Diefenbach, Reitman, & Williamson, 2000; Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999).

Adequate insight into the factors that foster or impede treatment gain maintenance is lacking. So research is aimed at identifying relapse-prone patients prior to treatment which would allow therapists to tailor treatments to the patient's needs in such a way as to reduce the risk of relapse. Based on the literature and clinical observations, the present study focuses on three pre-treatment symptom characteristics and two treatment process issues in relation to long-term treatment outcome.

TTM symptom duration and age at onset were previously found to be unrelated to long-term treatment outcome (Keuthen, O'Sullivan, Goodchild, et al., 1998; Lerner et al., 1998) and they were currently not investigated. Lerner et al. reported that pre-treatment levels of TTM symptom severity and depression were positively related to higher levels of TTM symptoms at their long-term follow-up. In contrast, Keuthen, O'Sullivan, Goodchild, et al., (1998) and Keuthen, Fraim, Deckersbach et al. (2001) reported higher levels of pre-treatment depression in treatment responders than non-responders 6 years after BT and/or SRI treatment. Neuroticism has frequently been related to poorer gain maintenance in relapse-prone disorders such as pathological gambling (e.g., Echeburua, Fernandez-Montalvo, & Beaz, 2001), substance abuse (e.g., Fisher, Elias, & Ritz, 1998; McCormick, Dowd, Quirk, & Zegarra, 1998) and recurrent depression (e.g., Angst, 1999; Gormley, O'Leary, & Costello, 1999; Scott, 1988; Surtees, & Wainwright, 1996). Since negative affectivity triggers hairpulling in TTM patients (Christenson, Ristveldt, & Mackenzie, 1993), neuroticism may also be a predictor of relapse after initial successful treatment of TTM.

In our investigation, we addressed the potential role of two-treatment process issues in long-term BT treatment outcome. Lerner et al. (1998) reported on two patients who had achieved total abstinence from hairpulling at treatment completion. Both patients showed little recurrence of symptoms at the long-term follow-up. Complete abstinence following treatment may thus be associated with better long-term effects than partial symptom reduction.