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DBT-Enhanced Cognitive Behavioral Therapy for Adolescent Trichotillomania: An Adolescent Case Study

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Results and a case study for a DBT-enhanced habit reversal treatment (HRT) for adult trichotillomania (TTM) (Keuthen & Sprich, 2012) is adapted for use with adolescents. Trichotillomania in adolescence is a very important but understudied problem. Onset often occurs in adolescence, and yet very little treatment research exists. DBT-enhanced habit reversal has shown promise in adult samples (Keuthen et al., 2008) and may prove useful as a model for further study in adolescents. Here, we provide a case study using DBT-enhanced HRT with an adolescent girl. The treatment emphasizes traditional CBT for TTM and also includes a focus on emotion regulation, mindfulness, and distress tolerance to help manage both focused and automatic pulling.

Results and a case study for a dialectical behavior therapy (DBT)–enhanced CBT treatment for adult trichotillomania (TTM) (Keuthen & Sprich, 2012) is applied here to the treatment of adolescents. DBT-enhanced CBT is aimed at improving outcomes and maintenance of gains beyond those typically found to date for TTM sufferers. In adult studies of CBT, complete abstinence from hair pulling is rarely achieved and relapse following treatment is a significant clinical problem (Diefenbach, Tolin, Hannan, Maltby, & Crocetto, 2006; Lerner, Franklin, Meadows, Hembree, & Foa, 1998; Mouton & Stanley, 1996). While the adult TTM literature is certainly in need of more attention, the child and adolescent treatment literature is almost nonexistent. This gap in the treatment literature is quite concerning given the potential importance of this developmental period to the onset, maintenance, and chronicity of TTM. Given the pressing need and lack of data, innovation is sorely needed. The encouraging results from Keuthen et al. (2010) inspired an adaptation of the protocol for use with adolescents. This case study describes the protocol as used to treat an adolescent presenting with TTM who was treated by the first author.

[1] Video patients/clients are portrayed by actors.

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Trichotillomania in Adolescence

Adolescence is a time characterized by rapid developmental change and many psychiatric disorders have their onset during this phase of life. This is true for TTM, which usually develops in late childhood or adolescence. The mean age of onset of cases reported in the literature is 8 years for males and 12 years for females; median age is 6 for males and 12 for females (Graber & Arndt, 1993). The lifetime prevalence of the disorder in adolescents has been estimated to be 1% (Hanna, 1997). The majority of studies find a much higher percentage of females than males in samples of children and adolescents (Hanna, 1997; Mancini, Van Ameringen, Patterson, Simpson, & Truong, 2009). However, at least one epidemiological study found a higher percentage of males. King, Scahill, et al. (1995) conducted a study with a sample of 794 consecutive 17-year-old Jewish Israeli adolescents (369 male, 425 female). The subjects were screened using a questionnaire and interview for current and past hair-pulling and comorbid psychopathology. The study found that males slightly outnumbered females in prevalence, by 5 to 3.

Adapting TTM Treatment for Adolescents: Can We Adapt From Adult Models?

Given the almost total lack of data on treatment for adolescents with TTM, clinicians are faced with a difficult situation when teenagers and their families present for help with this problem. Adapting a treatment that has been researched with adults, as we have done here, assumes that at least some basic elements of TTM in adolescents are similar to those in adults. Though data are

limited, the available findings suggest that there are significant similarities and overlap between adult and adolescent TTM. There appear to be enough similarities in how people pull and the function of their pulling to justify an adaptation of the basic principles of adult treatment models for evaluation of their effectiveness with youth.

The topography of TTM appears to be similar in adolescents and adults. Although studies of children tend to show less endorsement of the pattern of "rising tension/relief" associated with hair pulling, older children/teens endorse this symptom more similarly to adults (Hanna, 1997; King, Zohar, et al., 1995; Reeve, Bernstein, & Christenson, 1992). Pulling sites are also similar between adolescents and adults (see Franklin & Tolin, 2007, for a review of studies). Adolescents tend to pull primarily from the scalp, followed by eyelashes and eyebrows, and then hair from other areas of the body (e.g., pubic hair). Many pull from multiple areas (Hanna). Routines associated with the hair once it is pulled are also common (eating it, stroking the lip or mouth, inspecting it, lining it up, biting or popping the root, etc.). Additionally, pulling severity appears similar across age groups (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2009).

Psychiatric comorbidity tends to be high among adults with TTM, especially mood and anxiety disorders (Christenson, Ristvedt, & Mackenzie, 1993; Franklin et al., 2008; Reeve et al., 1992). Though data are more limited, the same appears to be true for adolescents, with around half to two-thirds meeting criteria for a comorbid psychiatric disorder, most typically anxiety and/or depression (Hanna, 1997; Lewin et al., 2009). The recent Child and Adolescent Trichotillomania Impact Project (CA-TIP), an Internet-based study, found high rates of comorbidity with depression and anxiety in a sample of 113 youth with TTM ages 10–17. Adolescents reported more of these symptoms than children (close to half of the teens in the sample compared to 17% of children). Depressive symptoms appeared to partly mediate the relationship between TTM symptoms and functional impairment (socially, academically, and interpersonally), and this was not related to duration of illness. The authors concluded that, "taken together, development of TTM during adolescence, a common age of onset, appears to be particularly devastating" (Lewin et al., p. 525).

Automatic and Focused Pulling in Adolescence

A major research finding in the TTM field in the early 1990s was that there may be two primary types of hair pulling behavior with different cues and reinforcers: automatic/habitual pulling and pulling that functions to regulate emotions (Christenson & Mackenzie, 1994). For instance, approximately 75% of adults with TTM endorse "*automatic*" pulling (i.e., pulling out of awareness), often accompanying sedentary, contemplative activities (Christenson & Mackenzie, 1994). Others pull in a more "*focused*" manner associated with a more compulsive quality. Here, pulling is often cued by negative emotions, intense thoughts or urges, or attempts to create symmetry (Diefenbach, Mouton-Odum, & Stanley, 2002; Flessner et al., 2009). Focused pulling appears to function more as emotion regulation behavior. It appears that many TTM sufferers have both patterns, though different patterns may accompany different episodes. A recent survey found this pattern in both adults and children/-adolescents (Flessner et al., 2007) as have other smaller studies (Hanna, 1997).

Of particular relevance to the treatment of adolescents are the results of a recent large cross-sectional study of 1,471 females with TTM ages 10–69 (Flessner et al., 2008). Results indicated a dramatic rise in the incidence of focused pulling at age 13, corresponding to the age of the beginning of puberty. This study also found increases in focused pulling in women of perimenopausal age, followed by a decrease postmenopause. Both developmental epochs are characterized by well-known exacerbations in mood and anxiety related to hormonal changes. Additionally, the Flessner study documented increases in functional impairment that increased over time. Younger children showed mild to moderate social and interpersonal impairment related to their TTM, which steadily increased into late adulthood, when impairment was moderate to severe. Less than 1% of the variance was related to duration of illness. These findings underscore the importance of developing effective treatments for teenagers living with TTM.

Treatments for Adolescents With TTM

Tolin, Franklin, Diefenbach, Anderson, and Meunier (2007) published an open trial for youth with TTM and have recently completed the first randomized controlled trial for TTM in youth (Franklin et al., 2007). Their open trial included eight biweekly meetings after active treatment concluded for the purpose of helping prevent relapse. Data from the open trial indicated significant reductions in hair pulling as rated by clinicians on the CGI; 77% were classified as "treatment responders" and 32% as "excellent responders." At 6-month follow-up these ratings were 63% and 32%. Self-report of depression and anxiety showed decreases during treatment as well. Interestingly, none of the patients who achieved an excellent response relapsed. If the strength of initial treatment response/achievement of abstinence predicts future maintenance of gains, this may be an important finding and would be similar to findings in other disorders, such as depression and OCD (Frank et al., 1990; Hiss et al., 1994; Vittengl et al., 2009). The results are an extremely important first step in developing