



# Emotional regulation cycles in trichotillomania (hair-pulling disorder) across subtypes



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## ABSTRACT

The patterns of emotional regulation involved in trichotillomania (hair-pulling disorder; HPD) were studied across various subtypes of hair pulling. Using the Milwaukee Inventory for Subtypes of Trichotillomania-Adult Version (MIST-A), this is the first study to address the regulation of emotions across four specific subtypes of hair pulling. For this study, 427 participants completed an online questionnaire around their hair pulling subtype, severity, and emotions experienced by hair pulling. Participants were divided as either high- or low-focused and either high- or low-automatic. Significant differences between subtypes and severity were reported. Subtypes differed in the severity of the emotions they experienced; individuals with high-focused pulling reported more intense negative emotions, and a greater number of emotions regulated by pulling. Positive emotions—happiness, relief, and calm—were also found to play a significant role in reinforcing hair pulling. For high-focused subtypes, negative emotions before, and after, pulling were associated with greater severity, indicating that altering negative emotions via pulling plays an important role for high-focused subtypes. Clinical and treatment implications, study limitations, and areas of future research are discussed.

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## 1. Introduction

Trichotillomania (Hair-Pulling Disorder; HPD) is characterized by the recurrent pulling of one's own hair from any part of one's own body, resulting in hair loss (American Psychiatric Association, 2013). In HPD, hair can be pulled from any area of the body, although the scalp, eyebrows, eyelashes, and pubic hair have been identified as the most frequent sites (Christenson, Mackenzie, & Mitchell, 1991; Lochner, Seedat, & Stein, 2010). A range of social, academic, occupational, physical, and psychological impairments is also experienced by people with HPD. Secrecy, self-stigmatization, shame, and avoidance or impairment of enjoyable social and occupational activities are all routinely reported by people with HPD (Marcks, Woods, & Ridosko, 2005; Soriano et al., 1996; Wetterneck, Woods, Norberg, & Begotka, 2006).

Studies using different degrees of strictness in defining HPD have made a precise prevalence rate difficult to settle upon (Duke, Keeley, Geffken et al., 2010). Early studies found the prevalence ranged from 0.6% to 2.5% (Christenson et al., 1991), while larger and more recent community samples endorse a prevalence of 1.2% (Duke, Bodzin, Tavares, Geffken, & Storch, 2009), often with a

higher female presence for the disorder (Chamberlain, Menzies, Sahakian, & Fineberg, 2007; Wetterneck et al., 2006).

## 2. Pulling styles

Over the course of HPD research, a heterogeneous conceptualization of HPD emerged, with individuals reporting two distinct pulling styles. *Focused* pulling is intentional, goal directed (e.g., looking for a specific hair), or pulling to regulate a negative affective state (e.g., anxiety, stress, etc.). *Automatic* pulling is defined as pulling that occurs outside of awareness and can occur in the presence of affective states such as boredom (Christenson, Mackenzie, & Mitchell, 1994). Originally it was reported that pure automatic hair pulling occurred in 5–32% of the HPD population, with 15–25% displaying focused-only hair pulling, and 43–80% of individuals displaying a mix of both patterns (Christenson et al., 1994, 1991; du Toit, van Kradenburg, Niehaus, & Stein, 2001). Flessner, Woods, Franklin, Cashin, and Keuthen (2008) who developed the Milwaukee Inventory for Subtypes of Trichotillomania-Adult Version (MIST-A), a self-report measure to identify and analyze the unique behaviours of focused and automatic pulling, found pure-automatic and pure-focused hair pulling occurred in less than 0.01% of the HPD population (Flessner & Conelea, 2008; Flessner et al., 2008). Because of this mixed presentation, and the unique characteristics distinguishing focused and automatic

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pulling, it is meaningful understand how these two styles are expressed within the individual and to arrange treatment specifically to address the emotional regulation and awareness deficits of the individual depending on their composite pulling style. Flessner, Busch et al. (2008) reported that an understanding the focused and automatic presentation of individuals may help aid in the response to treatment –improving the decision of the type of therapy to administer and the order the therapy protocol is provided.

### 3. Emotion regulation

Research into therapies for HPD first approached the condition using cognitive behavioural therapy (CBT) and habit reversal training (HRT), which emphasize awareness, self-monitoring, and developing competing responses (Azrin & Nunn, 1973). More recently, studies on therapies for HPD have shifted towards more acceptance and emotion regulation models (Crosby, Dehlin, Mitchell, & Twohig, 2012; Keuthen & Sprich, 2012). This move follows studies that demonstrate HPD serves as a way for individuals to regulate their emotional states (Diefenbach, Tolin, Meunier, & Worhunsky, 2008; Shusterman, Feld, Baer, & Keuthen, 2009). The emotion regulation (ER) model proposes that HPD is initiated by negative emotions and negatively reinforced by the alleviation from these negative affective states. (Roberts, O'Connor, & Bélanger, 2013). In support of this model, Shusterman et al. (2009) found that individuals with HPD had a greater difficulty regulating emotions than did controls. People with HPD have been found to use pulling to regulate a variety of negative affective states including anger, anxiousness, boredom, embarrassment, frustration, guilt, sadness, and tension (Diefenbach, Mouton-Odum, & Stanley, 2002; Diefenbach et al., 2008; Duke, Keeley, & Ricketts, 2010; Stanley, Borden, Mouton, & Breckenridge, 1995; Shusterman et al., 2009). In light of findings showing individuals having distinct pulling styles, research is beginning to look at whether some individuals respond more favourably to the behavioural protocols of HRT or the emotional regulation strategies of ER therapies depending on the degree to which individuals pull to avoid, escape, or regulate internal experiences (Crosby et al., 2012; Flessner, Busch et al., 2008).

Researchers have yet to explore the relationship between hair pulling style and the role of emotion regulation in HPD. Shusterman et al. (2009) found that individuals differ in what emotional cues they use for pulling, but did not administer the MIST-A to map these emotional patterns onto the degree of focused and automatic pulling that manifests in the individual. Accordingly, the study being reported on proposed three specific research hypotheses to address this unexplored area of research. First, by establishing how the severity of hair pulling maps onto each hair pulling profile. This study hypothesized that the degree to which people use pulling to control how they feel, pull in response to anxiety or sadness, and in the degree of dissociation that occurs – items measured on the MIST-A; will reflect on the MGH-HPS as greater intensity, lower perceived control, greater distress, and overall increased hair pulling severity. Second, people with more focused hair pulling would experience a higher degree of emotional regulation by pulling, expressed as the intensity of change emotional states underwent during the before-during-after pulling cycle. Third, regulating emotions by pulling was hypothesized to create additional negative experiences that reinforced the behaviour. The intention was that by mapping the emotion clusters across hair pulling styles, more intentional and deliberate treatment planning could be developed to be more responsive to the individual.

## 4. Methods

### 4.1. Subtypes of trichotillomania affect questionnaire (STAQ)

A large-scale web survey, the STAQ, composed of two demographics forms and four inventories was compiled to address the research goals. The study sought to reach out to a community sample of nonreferred, self-reported individuals who hair pull. The intention was to capture a large, representative sample size and obtain a comprehensive spectrum of individuals that could not be captured through inpatient clinical research.

### 4.2. Participants

Recruitment and advertising was done through The TLC Foundation for Body-Focused Repetitive Behaviours (TLC). TLC distributed the survey on their online research page, through an email distributed to thousands of TLC members, and through recurrent posting on the TLC Facebook and Twitter social media pages.

### 4.3. Inclusion criteria

To be included in the study, participants needed to (a) indicate that their hair pulling has resulted in noticeable hair loss or the thinning of hair; (b) report this action causes them mild distress in at least one or more personal, interpersonal, occupational, or academic domains; and (c) indicate that they were at least 18 years of age. To ensure uniformity of inclusion criteria across studies, these criteria were adapted with permission from Dr. Douglas Woods, the main author of the largest trichotillomania study to date—the Trichotillomania Impact Survey (see Woods et al., 2006). Participants were excluded from participation if they endorsed pulling in response to any drug abuse or untreated psychotic condition, or if their pulling was secondary to another medical condition (e.g., dry or itchy skin).

### 4.4. Survey administration and informed consent

The survey was administered online through the Internet survey platform Qualtrics. Surveys were saved anonymously and downloaded by the authors for analysis. Responses were collected between December 2012 and January 2013.

Participants accessing the study were provided with the study's rationale and informed both of the voluntary nature of participation and of the ethical approvals for the study granted by the Scientific Advisory Board of the TLC and the Human Research Subjects Committee of the University of Lethbridge. Participants who indicated that they had read and agreed to the terms of consent for participation were provided access to the survey. Upon completing the survey, participants were thanked, debriefed, provided resources to treatment providers, and given a link that later hosted a summary of the findings.

## 5. Assessments

### 5.1. Basic demographic form

Participants were requested to answer six general demographic questions, including gender, age, ethnicity, and marital status. These questions were asked to gain an understanding of the demographics of participants entering the survey.

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