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Exposure and Ritual Prevention Therapy for Trichotillomania: Two Case Reports

To the Editor: Trichotillomania is an often debilitating psychiatric condition characterized by recurrent pulling out of one’s own hair, leading to hair loss and marked functional impairment.¹ Current behavioral therapies do not help everyone with trichotillomania, and relapse is frequent^{2,3}; thus, more treatment options are needed.

We report 2 cases of trichotillomania responding to a brief, 4-component approach based on the conceptualization that hair-pulling is maintained by negative reinforcement similar to compulsions associated with obsessive-compulsive disorder (OCD). The first component examines the individual’s hair-pulling pattern, including specific hair-pulling behaviors, environmental triggers, and emotional vulnerabilities. The second component involves the generation of a hair-pulling hierarchy, similar to that used in OCD. In this hierarchy, the ratings of hair-pulling are based on the intensity of the premonitory urge in various scenarios. The third component uses exposures based on the individual’s hierarchy. Individuals are encouraged to select a hair that would typically be pulled and hold the hair until the urge decreases. Similar to exposure and response prevention for OCD, this action serves to interrupt the reinforcement of hair-pulling. Individuals are encouraged to practice this approach in environments in which hairs are typically pulled. The fourth component addresses emotion dysregulation.

Case 1. Ms A, a 20-year-old woman, reported hair-pulling and skin picking beginning in early childhood. The first session focused on collecting hair-pulling history, noting situations in which she was most likely to pull or pick and the generation of competing responses. She denied correlation between mood or emotions and pulling. Inconspicuous competing responses, including feeling the seams of her pants or manipulating an eraser, were generated and applied to various academically oriented scenarios. The second session focused on exposures in which the patient would twirl her hair, increasing her premonitory urge, and preventing pulling and picking behaviors. The third session focused on developing strategies to address acute stressors, specifically anticipated academic stressors. After 3 weeks, she reported that hair-pulling and skin picking were “virtually gone” and noted a decreased urgency in response to stressors. In the final session, strategies were generalized to a wider array of situations. Treatment gains were sustained at follow-up nearly 1 year after treatment.

Case 2. Ms B, a 45-year-old woman, presented with a history of hair-pulling since early childhood. She reported pulling from her head and eyelashes and would typically ingest the hairs. During

the first session, she noted that perceived poor time management increased stress and disrupted sleep, which then led to pulling. In the first session, she developed competing responses in environments where pulling typically occurred, which were her home office and bedroom. The second session focused on hair-pulling exposures, in which the patient selected hairs that were tempting to pull and let the urge pass without pulling. Ms B also engaged in similar exposures during work projects that promoted stress (and thoughts of which typically promoted pulling) without pulling her hair. The third session focused on strategies to enhance emotion regulation. At the final session, she reported a significant reduction in the frequency and severity of hair-pulling. In addition, when episodes of pulling occurred, significantly fewer hairs were pulled (1 eyelash as opposed to multiple). Ms B was contacted 1 month following treatment and noted that she experienced “minimal” hair-pulling and that the infrequent episodes were significantly less severe than they were prior to treatment. She reported the results as “amazing.”

These findings demonstrate that exposure and ritual prevention therapy may be beneficial in the treatment of trichotillomania and highlight the flexibility and effectiveness of this intervention in adults with mild to moderate hair-pulling. Further research is needed to confirm these findings and characterize the neural mechanisms involved.

REFERENCES

1. Grant JE, Chamberlain SR. Trichotillomania. *Am J Psychiatry*. 2016;173(9):868–874.
2. Bloch MH, Landeros-Weisenberger A, Dombrowski P, et al. Systematic review: pharmacological and behavioral treatment for trichotillomania. *Biol Psychiatry*. 2007;62(8):839–846.
3. Franklin ME, Zangrabbe K, Benavides KL. Trichotillomania and its treatment: a review and recommendations. *Expert Rev Neurother*. 2011;11(8):1165–1174.

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