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TRICHOTILLOMANIA - A PSYCHOTHERAPEUTIC UNDERSTANDING OF THE SYMPTOMS

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The aim of this thesis is to explore Trichotillomania (TTM), its aetiology and treatment from a psychotherapeutic perspective. A broad overview explaining Trichotillomania is provided, the various symptoms of TTM are described and a selected review of literature to date is completed to understand possible origins of the symptoms. Psychoanalytic interpretations are explored, with a focus being on recognition of the symbolic meaning of the symptom, as TTM is primarily psychogenic in nature (Barahal, 1940). The scope in this area has been limited to classical Freudian analysis. Behavioural and cognitive theorists are also explored. Treatments available are considered in light of the modalities reviewed and symptom elimination. More focus is given to the cognitive behaviour treatments, which appear to have more documented evidence on efficacy. It is apparent that the aetiology of TTM has not been clearly defined nor is it based on verifiable, observable data, without which it will be difficult to devise more effective treatments and achieve a greater understanding of the psychopathology of TTM and its symptoms (Walther et al. 2010, p. 54).
SECTION 1 - INTRODUCTION

The term Trichtotillomania (TTM) was coined in 1889 by French dermatologist, Hallopeau, as an irresistible urge by a person, to pull out their hair. It derives from ancient Greek, with ‘thriks’ meaning hair, ‘till’ meaning I pull out or pluck and ‘mania’ translating as a madness or frenzy, which in the old days described any condition affecting human behaviour. It is considered a disorder, and one mainly affecting women. It occurs as a result of repeated removal or pulling of hair from the body. Hair can be pulled from any area of the body, but the scalp tends to be the most popular, followed by the eyelashes and eyebrows. Recent prevalence studies suggest it occurs in 0.6% to 3.6% of adults (Woods & Houghton, 2014) however it has been noted as seven times more prevalent in children than in adults (Keren et al. 2006).

The medical model classifies TTM in the Diagnostic and Statistic Manual of Mental Disorders (DSM) – V, under Obsessive-Compulsive Disorder (OCD) and Related Disorders, although, there are core differences in TTM and OCD (Philips et al. 2010), TTM being more of an impulsive disorder and OCD being more compulsive (Stemberger et al. 2003). Five criteria are required for a person to be diagnosed with TTM:

1. The person purposefully removes hair from any region of the body and which results in hair loss
2. Repeated attempts are made to stop the hair pulling behaviour
3. The hairpulling causes significant distress or impairment in social, occupational or other areas of functioning

4. It cannot be attributed to another medical condition such as a dermatological condition

5. The hairpulling cannot be explained by another mental disorder (e.g. attempts to improve perceived imperfections in appearance as in bodydysmorphic disorder (Elston et al. 2014))

TTM tends to develop in childhood with early-onset (under 6 years old) cases being more responsive to treatment. Later onset (between 7-17 years old) is considered chronic. TTM is comorbid with other disorders such as mood and anxiety disorders, skin-picking and other body focused repetitive behaviours, which confound the nature and severity of pulling and its impact on the individual (Stemberger et al. 2003).

The fingertips are normally used to pull hair. Stress and anxiety tend to increase the urge to pull. Individuals tend to have their own specific rituals around hairpulled and usually pull whilst alone. Sensory precursors to pulling involve combing through the hair, feeling individual hairs for different textures, lengths, or colour. Emotional precursors include anxiety, boredom, tension or anger, and cognitive precursors include rigid thinking, catastrophising, and over-generalisation (Walther et al. 2010, p.48). Post-pulling, some will dispose of pulled hairs, others will play with them between their fingers, examine them, bite them or even ingest them (known as trichophagy) and put themselves at risk of gastrointestinal issues (Woods & Houghton, 2014).
Certain situations tend to initiate hairpulling such as watching TV, reading, studying, on the computer, driving or when grooming in front of a mirror. Two types of pulling have been identified by Christenson and Mackenzie (1994); automatic is where a person is not conscious they are pulling and most often occurs when performing a task while seated or inactive; focused pulling is more compulsive, has an intention and a pleasure principal, reducing tension in the body and removing hairs with particular features (Woods & Houghton, 2014). The latter is also associated with experiential avoidance, the tendency to evade emotions or events, and symptom severity is usually greater (Flessner et al. 2008). In a study of 436 adults diagnosed with TTM, strong association was noted between TTM severity and evasion of unwanted thoughts or emotions (Begotka et al. 2004).

Sufferers experience great shame, low self-esteem and often have to conceal their hair loss. A significant impact of TTM is the loss of control over one’s own actions, with the destructive and compelling impulse to pull presiding. It can be compared to a trauma where one is at constant war with oneself, ravaged by lack of self-restraint. There is a sense of conflict, impulsiveness, lack of hope and simultaneously a struggle for honesty, self-control and purpose (Grubb, 1996).

There is no known definitive cause of Trichotillomania. Despite the term being in existence since 1889, literature around the psychotherapeutic understanding of it remains scant. Classical Freudian literature deduced that somatic symptoms are an expression of unconscious mental processes such as repressed wishes or prohibited desires and the resulting behaviour is often driven by the libidinal and
aggressive drives (Parkinson, 2013). These unconscious processes arise because tension built up in the body causes pressure or excitation of the drive, which when not released appropriately stays in the body and is expressed as a somatic symptom. The concept of pre-genital organization of the libido (oral, anal and phallic) is relevant, the failure or surrender of which is considered the key source of regression to childlike states in obsessional neurosis (Essman, 2001). Freud’s Obsessional Neurosis corresponds to the modern day Obsessive Compulsive Disorder, which has some phenomenological and psychological overlaps with TTM.

Behavioural and cognitive theorists on the other hand, do not appear focused on the aetiology of TTM. Their aim is to erase the problem behaviour by reference to the symptoms displayed. The emphasis is on the part played by conditioning in reinforcing the pulling behaviour. Skinner’s concept of operant conditioning is based on the idea that in responding to a stimulus there are several response options, the one chosen being based on habit or reward (McLeod, 2013). Hairpulling is a means of coping with stress and reducing tension. There can be both positive and negative affects, which are reinforcing the pulling behaviour e.g. a person may pull to relieve boredom/anxiety but post pulling feels guilty and sad, provoking yet another pulling episode. They may on the other hand, gain a sense of pleasure and satisfaction from pulling an imperfect hair, or one of a particular texture, length or colour (Walther et al. 2010).

Genetics have been reviewed as a possible cause of TTM, with results showing there may be a genetic link. Concordance rates in twins with TTM were higher
in studies of monozygotic twins (38%) than in dizygotic twins (0%). Further research is required on larger sample sizes, however, for any concrete confirmations that TTM is linked to genetics. Those with TTM showed an increase in density of grey matter in the brain, in areas associated with cognition, habits and emotion regulation, suggesting neurochemistry may have a role to play. Some studies also show those with TTM have greater difficulty adapting to change in their environment indicating impaired cognitive flexibility. This correlates with repetitive behaviour problems although research is still showing contradictory results (Walther et al. 2010, p.50-51).

As knowledge of this disorder is not extensive clients often claim treatment by medical and psychological practitioners is ineffective (Woods & Houghton, 2014, p.311). Pharmacological treatments such as Selective Serotonin Reuptake Inhibitors (SSRIs) have not proved effective for Trichotillomania. Clomipramine, one of the more popular SSRI’s, has showed mixed results. A 56% reduction in hairpulling was noted in 50 adults tested for taking N-acetylcysteine, which regulates levels of glutamate (responsible for stimulating excitement) in the brain. This result is promising although further controlled trials are needed (Walther et al. 2010, p.53).

Nonpharmacological treatments include Habit Reversal Training, which has shown to be somewhat effective. Habit Reversal Training is considered promising and involves ‘awareness training, competing response training, stimulus control and social support’ however, a noted deficiency is that emotion regulation was not reduced in the long term (Walther et al. 2010). Therapies
such as Acceptance Enhanced Behaviour Therapy and Dialectical Behaviour Therapy are attempting to address these deficiencies. Treatments to date for TTM have not taken into account the psychopathology of a hairpuller. Gaps have also been noted in existing literature such as poor evidence of large random controlled trials and follow-up assessment with the therapy not being backed up by empirically supported theory (Walther et al. 2010).

In order to be able to treat TTM successfully through therapy the possible causes underlying the symptoms need to be understood, and while individual cases may differ several theories have been put forward on the underlying causes of TTM. The aim of this thesis is to explore some of the various theories put forward to date, firstly psychoanalytic, followed by an examination of behavioural and cognitive theories with the aim of gaining a deeper understanding of the symptoms of TTM. Treatments to date favouring symptom removal will be reviewed and considered in light of the psychotherapeutic theories reviewed. Finally, there will be a conclusion noting the limitations of this review, a summary of the salient points and any recommendations for future research.
SECTION 2 – THE SYMPTOM FROM A PSYCHOANALYTIC PERSPECTIVE

Freud’s notion of an ‘obsessive action’ could be likened to hairpulling, it being one with a purpose, an expression of active or emotive thoughts, which represents itself symbolically through the action of hairpulling. Freud said it is through psychoanalysis that one can become conscious of the meaning of the symptom (Freud, 1906, p.111). He notes that with obsessional neurosis there is always repression by the ego of an innate impulse with a sexual content aroused by the id, which was experienced as pleasure in childhood but later became the subject of repression. The conflict between the innate impulse striving for expression and the repression causes a continuous anxiety or deformed self-reproaches, which are then expressed as a mechanism of defense in the form of an obsessive action. The obsessive action or hairpulling becomes a priority and is a means of displacing the meaning of the symptom (Freud, 1906).

In Freud’s 1911 paper entitled ‘The Disposition to Obsessional Neurosis’ a characteristic in cases of obsessional neurosis is an extremely strong fixation of libidinal development in the pre-genital phase of organization. This phase is in operation between the ages of two to five years and is often representative of the sexuality that will emerge in later adolescence. In this phase the genital zone has not yet assumed a dominant role (this happens in puberty). These phases consist of firstly the oral – where sexual activity has not yet been separated from the ingestion of food; secondly, the sadistic-anal, which is already developed and
part of sexual life but cannot yet be identified as masculine and feminine. It relates to an active aim being the muscular action of defecating and a passive one being the erotic mucous membrane organ of the anus. Finally, the phallic phase concerns itself with the male genitalia where infantile interest in the genitals is at a height. The fixation, where conflict develops may be genetic or due to traumatic events during the anal phase causing sexual compulsions or destructive impulses (Chlebowksi et al. 2009). Even though progression is made to the later stages, circumstances or life events cause a regression to the pre-genital phase that drives the obsessional neurosis. In adolescence genital organization can fail or need to be abandoned due to moral or cultural factors and associated thoughts of shame or disgust at which stage the regression occurs. This failure can result in maladaptive ways of dealing with their sexual excitation such as an inhibited sexual life or on the other hand, one preoccupied with masturbation (Verhaeghe et al. 2007). To make an analogy of the above conclusions to hairpulling, which itself generates a sense of unease and frustration, as a symptom it is replacing the repressed original sexual wish (Pepeli, 2015).

Another central feature of obsessional neurosis is ambivalence of feeling, where there are feelings of both love and hate towards a love object e.g. one’s mother/father. This arises due to conflict between the id and the superego in the anal phase of development. Libidinal regression can be activated in response to this conflict, generating aggressive impulses which if not integrated, result in conflicting emotions of love, hate, rage and guilt. In this situation the ego is compromised and resorts to defense mechanisms or hairpulling in this case, as a means of disguising the latent cause and at the same time defending the ego
against instinctual demands. Isolation is one such defense mechanism, where an unacceptable idea is blocked out of consciousness with hairpulling being used as a means to numb the unacceptable idea. Undoing is another, where a compulsion act such as hairpulling is performed to undo some event or expected consequences arising out of a compulsive thought or emotion. An attempt is made to erase the event or expected consequence by motor means. The repetitive nature of compulsions or hairpulling further reinforces this aim. There is no logic to this form of repression yet it is one of the motivating factors in obsessional neurosis (Freud et al, 1993, p.274-275, 324).

A build up of frustration arising out of the loss of a love-object could cause hairpulling to arise as a symptom. The loss brings about a dissatisfaction causing a sense of frustration and pent-up libidinal energy which if not discharged in a healthy manner that satisfies the libido, instead sublimates it and redirects it internally, awakening previously untapped innate tendencies, which if have strength may lead to a regression to infantile libidinal aims, conflicting with more realistic aims, and which resolve themselves in the formation of symptoms (Freud et al, 1993, p.119-123).

TTM’s comorbidity with the anxiety disorders correlates with the idea that hairpulling arises due to a build up of tension or anxiety in the body. Freud initially opined that anxiety resulted from sexual energy arising from repression of innate impulses, which manifests itself in the form of a symptom as a way of avoiding subsequent anxiety. He subsequently revised his theory on anxiety in 1926 when he published Inhibitions, Symptoms and Anxiety where he noted that
anxiety was caused by a reaction to a traumatic event or danger. Faced with a trauma, anxiety results from the ego’s inability to handle the increased demand on the excitatory process. Faced with danger, anxiety arises as the ego’s response to a threat. Dangers that are likely to cause a traumatic event include birth, loss of the primary caregiver, castration, loss of love (Freud et al, 1993, p.232-233). The anxiety is responsible for activating the defense mechanisms including repressions and the resulting formation of the symptom eradicates the danger situation (Freud et al, 1993, pp. 284).

Psychoanalytical theory indicates that the act of hairpulling is symptomatic of a repressed sexual wish or conflicts arising at the libidinal stage of development, or if it arises in puberty is the subject of regression to the libidinal stage. It indicates that the ego and super-ego play a significant role in the formation of the symptom (Freud et al, 1993, p. 267). There may be emotional ambivalence towards a primary caretaker or loss of a caretaker that is driving the hairpulling. It is important to note that little has been added to psychoanalytical literature in the area of TTM or OCD over the past few decades despite a profusion of articles in psychiatry and behavioural psychology. The psychodynamic focus on the unconscious and the symptom contrast with the focus of the cognitive behaviourists on present behaviour.
SECTION 3 – THE BEHAVIOURAL AND COGNITIVE APPROACH

Cognitive behaviour theories emanated originally from Watson’s behavioural psychology in the 1920’s, which initially focused on understanding and observing how present behaviour is learned, rather than focusing on the more abstract unconscious processes of psychoanalysis. Behaviour theory values empirical evidence, and initially conducted its research through animals. It was not until after World War II and an increase in the provision of psychiatric services in the USA, that learning theory was applied to behaviour therapy. Several basic principles emerged, namely, that changes in behaviour are driven by environmental conditioning or learning (McLeod, 2013). These principles assist our understanding of the aetiology of TTM.

Pavlov’s Classical Conditioning Theory postulated that behaviour becomes a conditioned response and is learned passively when an unconditioned stimulus becomes associated with a neutral stimulus for example the hairpuller pulling in front of the mirror while grooming because they have come to associate this situation with hairpulling and daily grooming reinforces and increases this association. Skinner’s Operant Conditioning Theory (1953) associates rewards or punishment with behaviour to provoke a change in behaviour. Active involvement is required such as giving a treat to a child that refrains from hairpulling may initiate a change in behaviour (McLeod, 2013). Afflicting a self-induced rubber band snap to punish pulling urges might initiate changes in hairpulling behaviour. Azrin and Nunn, who were the first to analyse TTM from
a behavioural perspective, noted hairpulling was a response to stress, reinforced by the associated reduction in tension following a hairpulling episode (Nejatisafa and Sharifi, 2006). Hairpulling could be described as a mainly unconscious uncontrollable habit, arising through the processes of classical and operant conditioning, and a diverse range of both internal and external triggers (Nejatisafa and Sharifi, 2006).

Bandura’s Social Learning Theory demonstrated we learn cognitively through observation or instruction, in social situations e.g. observing a parent pull their eyebrows when anxious may encourage a child to pull hair from their eyebrows/scalp when anxious. This addition of a cognitive focus to learning theory was an important step in the emergence and integration of cognitive behaviour therapy (CBT) in the 1960’s and 1970’s.

Cognitive therapy is based on the premise that thinking affects mood and emotions, that by working through ‘erroneous beliefs’, improvements can be made to ‘emotional reactions’ (Beck, 1976, p.214). CBT incorporates in addition into this interrelationship the environment, physical sensations and behaviour, with any of these elements at any given time influencing each other (Kinsella and Garland, 2008). The cognitive behavioural model is based on the notion that individuals have different ways of interpreting events, that it is not the event which causes the feeling but our interpretation of it, and much of these interpretations appear in the form of involuntary Negative Automatic Thoughts, Rules for Living and Core beliefs (Briers, 2009). With CBT these three levels of thinking are identified and modified; Negative Automatic Thoughts (NATs)
relate to what and how we think, Rules for Living guide our behaviour and actions as well as represent dysfunctional assumptions or conditional beliefs, and Core Beliefs are the underlying assumption or beliefs relating to our interpretation of ourselves and others in the world (Kinsella and Garland, 2008). What NATs might one expect in a hairpuller? The automatic hairpuller may unconsiously think ‘I will just pull a few hairs to relieve my stress’ while the more focused hairpuller is consciously thinking ‘Just one more and I will stop’. The rigid thinker may repeat to themselves ‘Thin or split hairs are bad’, the catastrophiser is thinking ‘I will never get this essay completed’ as a precursor to pulling despite disqualifying the fact that they have successfully completed essays in the past. There may be over-generalisation where the wig-wearing hairpuller thinks ‘everybody knows my hair is not real’. These thoughts may be a reaction to emotional precursors (boredom, tension or anger) and in addition feelings of frustration, isolation, and embarrassment. An example of a rule for living might be ‘I should be perfect’ or ‘If I am going to do something I should do it properly’ and examples of core beliefs are ‘I am not perfect’, or ‘I am stupid’.

Clark and Fairburn (1997) noted that obsessive-compulsive disorder is characterized by a deficit in cognitive control, affecting decision-making capabilities and arising from a pattern of behaviour in response to a stimulus to which the sufferer is emotionally sensitive e.g. stress. The deficit is usually specific e.g. hairpullers usually pull when alone, yet control their impulses when with specific crowds. They also note that Salkovskis (1985) postulated obsessions arose out of the interpretation of intrusive cognitions which increase a sense of personal responsibility and with it anxiety, frustration and depression.
resulting in a neutralizing behavioural compulsion or impulse to pull as a way of avoiding responsibility, or to numb the obtrusive thought.

CBT is a theoretical approach that builds on our natural inclination to hypothesise about, ourselves and the world (Briers, 2009). TTM may be a learned behaviour however CBT is based on the idea that this behaviour can be unlearned despite it being a mostly unconscious uncontrollable habit. Recognising and monitoring distorted thinking patterns that can be traced back to their core beliefs is how CBT can be used to help the hairpuller overcome this debilitating habit.
SECTION 4 – HOW TO TREAT TTM?

TTM sufferers have tried many different ways of treating TTM from hypnosis, psychoanalysis, eye movement desensitization, supportive therapy to cognitive behaviour therapies. The cognitive behaviour therapies have more reported success rates than any of the other methods of treatment. The cognitive behaviour therapies effect change by overpowering previous learning experiences, behaviour and cognitions. They also teach new coping strategies to respond to environmental situations. An experimental or scientific approach is adopted with change being constantly re-evaluated and updated (Hazlett-Stevens and Craske, 2002).

Habit Reversal Training (HRT), is the most researched behaviour therapy and research to date has shown some efficacy. It was initially developed by Azrin and Nunn, in 1973 and considers TTM a motor habit, and has been revised to incorporate cognitive elements and relaxation training into its approach (Stemberger et al., 2003). It involves a program of awareness training, which aims to increase the hairpuller’s awareness, of where and when they pull, and thoughts that precede pulling (incorporating elements of classical conditioning and cognitive theories). The program is implemented by taking note of how the body and muscles react to hairpulling, getting a parent, partner or other family member to highlight pulling incidences, and keeping a record of how many times pulling has occurred on a daily basis. Competing response training, another element to this therapy, involves performing an action when one recognizes an
urge to pull or preceding the pertinent cognition or emotion (incorporating operant conditioning theory). Examples include closing one's eyes for 10 seconds, or pulling an elastic band worn on the wrist. Support, praise and encouragement from family or friend’s are also important in helping ensure continued use of the competing response. Stimulus control is the final strategy used to prevent hairpulling e.g. if a tweezers is used to pull hair in front of the mirror, then removing the offending instrument from the home and covering the mirror are other methods that can be used to prevent hairpulling (Walther et al. 2010, p. 54).

HRT is considered effective for the automatic hairpuller but does not address affect and the sensory antecedents to hairpulling. Acceptance Commitment Therapy, developed in the 1980’s by Steven Hayes, has been used in conjunction with HRT to address this deficiency. It focuses on the context in which behaviour occurs as opposed to the behaviour itself and believes our issues stem from the concepts represented in the acronym “FEAR:

Fusion with your thoughts
Evaluation of experience
Avoidance of your experience
Reason-giving for your behaviour

and the healthy alternative is to ACT:

Accept your reactions and be present
Choose a valued direction
Take action”

ACT teaches the client to accept negative emotions that arise before or after pulling, to learn not to react to them and not to avoid situations in which they occur. It differs to CBT in that rather than trying to change thoughts and behaviour it advocates accepting and embracing them. It helps get in touch with one’s transcendent self that observes oneself from a distance (Wikipedia, 2015).

Dialectical Behaviour Therapy is another behavioural therapy that is being used to address the affect deficiency noted with HRT. Using CBT techniques and reality testing it enables emotional and cognitive regulation by increasing awareness of unwanted situations and recommends skills to avoid these situations. Concepts such as distress tolerance, acceptance and mindfulness are in-built in its approach.

Arising out of the medley of cognitive behaviour therapies devised for TTM with no one treatment effective for all hairpullers and HRT despite its relative success not being totally reliable, Mansueto, Stemberger, Thomas and Golomb (1997) devised a Comprehensive Behavioural Model (ComB) for Trichotillomania with the aim of providing a customised treatment plan for each individual based on an understanding of their pattern of behaviour and emphasizing relapse prevention in addition to CBT. A fundamental functional analysis is performed by interview and self-monitoring. During this process the antecedents to pulling are identified from the five modalities it considers in operation with hairpulling. These are environmental (where the pulling occurs), motoric (action involved with/without awareness), sensory (feelings of enjoyment obtained pre and post-pulling and
associated stimuli) affective (soothing or invigorating affect) and cognitive (thoughts about hair). ComB places emphasis on effecting change in the sensory modality which if successful, hairpulling can be halted before it even begins. Secondly, preparatory and post-pulling behaviours are identified e.g. reaching for a tweezers and magnifying mirror, choosing the site, tactics involved in hair search. Finally, the consequences of hairpulling are identified. Two types of consequences are identified, one which reinforces the hairpulling and the other which punishes it. As with any behaviour therapy the results must be monitored and assessed and re-evaluated as necessary to provide a successful treatment outcome. ComB however is a relatively new therapy and published studies on its efficacy do not appear to be available yet.

Despite relatively successful outcomes associated with the cognitive behaviour therapies, barriers to effectively eliminating hairpulling have been noted. Successful treatment can be complicated as much by individual motivation levels as goal aspirations (Stemberger et al. 2003). Where severe shame, embarrassment, avoidance of social relationships exist, areas such as acceptance, self-esteem, and relationships may need to be worked on first before an effective strategy can be formulated. When hairpulling is comorbid with other disorders such as Depression or Body Dysmorphic Disorder these may need to be worked through before the hairpulling can be addressed (Stemberger et al. 2003).

So where does psychoanalysis fit in the treatment of TTM when its aim is to identify and resolve the client’s unconscious struggles? Through analytical work embedded in a theory of human subjectivity, it strives to identify the unconscious
conflicts and show how they are represented through the bodily symptom of hairpulling. Classical psychoanalysis is no longer widely practiced due to demands on client resources and psychoanalytic psychotherapy is the more widely used form of psychoanalysis today. It is less intense and focuses on current issues and how they relate to early conflicts and feelings. It is also non-directive when compared with CBT. Psychoanalysis of TTM has demonstrated its effectiveness in case reports where its aim was to treat the underlying symptom. However psychoanalytical theory can be difficult to validate and constructs such as defense mechanisms, are identifiable, yet not precisely defined enough for research purposes (Fonagy, 2003). Psychoanalysis is less suited to standardized methods of evidence-based evaluation, as it is constituted by a very different aim. Research shows more emphasis is needed on the documentation of psychodynamic procedures, the reduction of symptom distress, not just process outcomes and the monitoring of therapist success rates with additional supervision for those with lower rates (Fonagy, 2010).

Currently, psychoanalysis is being overshadowed by behaviour therapy and neurobiological approaches whose focus on learned behaviours, and the chemistry of the brain respectively, present as more effective (Essman, 2001). The amount of evidence in favour of the behaviour therapies far out-weighs that of the psychoanalytic psychodynamic approaches (Essman, 2001). This is due to the value placed on evidence-based treatments in a society where accountability is paramount. Evidence based treatments have the advantage of a record showing reduced symptoms and improvement in functioning. Treatment is usually short term, appears to be effective in the long term and is more valued by
professional organisations. Overall, trichotillomania treatment studies of adults and children lack randomized controlled trials involving large numbers. Research that has been completed shows inadequate follow-up and recurrence rate statistics.
SECTION 5 - LIMITATIONS AND CONCLUSION

Limitations
The limitations of this review are mainly due to word count. As a result, other psychoanalytical theorists were not explored such as Winnicott’s notion of ‘too-good mothering’ and the transitional object, Mahler’s object constancy or specific interpretations on TTM from current psychoanalytic perspectives. Detailed case study examples and results of randomized controlled trials have also not been used to backup evidence for treatment efficacy.

Conclusion
Trichotillomania is a multidetermined condition involving irresistible urges to repeatedly remove or pull hair from the body that causes sufferers extreme hair loss accompanied by a sense of shame and embarrassment which can lead to impairment at a psychological, social, academic and occupational level. Precursors to pulling comprise any combination of sensory, motor, environmental, cognitive and emotional factors and individuals present with various specific rituals to hairpulling.

Psychoanalysis understands the aetiology of TTM through analysis of the symptom, which “denotes the presence of some pathological process” (Freud et al, 1993, p.237). It identifies this process as arising from a repressed sexual wish at the libidinal stage of development and which may have been instigated by the loss of a love-object, ambivalence of feeling towards a love-object or feelings of
frustration or anxiety, which are repressed and represented in symptomatic form or the urge to pull. The behaviour therapies argue that hairpulling is a learned behaviour or conditioned response that can be unlearned by associating rewards or punishments to provoke a change in behaviour. Distorted cognitions, dysfunctional assumptions or conditional/underlying beliefs affecting mood and emotions also drive the symptomatic behaviour.

Despite the prevalence of TTM and perhaps due to the diversity of its phenomenology, its aetiology has not been defined preventing development of the psychopathology of the disorder as well as more efficient therapies (Walther et al. 2010, p. 54). From a treatment perspective psychoanalysis identifies the root cause of the symptom, whereas CBT focuses on eradication of the problem behaviour. The Cognitive Behaviour therapies have shown more evidence of success and are therefore the favoured form of therapy for Trichotillomania with Habit Reversal Training currently leading the way. ComB looks promising as it appears to address affect regulation and relapse rates however evidence is not yet available to prove its efficacy. The theoretical foundations of psychoanalysis and the behaviour therapies are very different with psychoanalysis more focused on ‘process outcomes’ and the behaviour therapies valuing client feedback as their measure of success (Fonagy, 2010, p.84).

Given the inefficacy of any one treatment to date in this area, with improvements in CBT noted being mainly limited to pulling outcomes, and many of the co-occurring symptoms such as anxiety and depression not being addressed, an approach which would take into account all of the psychotherapeutic evidence
available may help devise approaches to this debilitating disorder that may prove more effective. Perhaps an approach combining the psychoanalytical understanding and at the same time addressing the cognitive behavioural issues could have more success as both the root of the problem and the behaviour itself would be addressed simultaneously and might improve current relapse rates, or is the thought of amalgamating these very different modalities so inconceivable one might pull one’s hair out!


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