Mental Health Professionals Network Ltd

Tel. 03 8662 6600
Fax. 03 9639 8936
Add. Emirates House,
Level 8 251-257 Collins St
Melbourne VIC 3000
Email. info@mhpn.com.au
Web. mhpn.org.au

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Mental Health Professionals' Network

Webinar

Psychological treatments for Trichotillomania

Thursday 6 December 2018

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

Tonight's panel

Dr Johanna Lynch
General Practitioner

Dr Scott Blair-West
Psychiatrist

Dr Imogen Rehm
Psychology Registrar

Facilitator: Dr Mary Emeleus
Psychiatry Registrar

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Learning outcomes

Through an exploration of trichotillomania this webinar will provide participants with the opportunity to:

- Describe the common symptoms and causes of trichotillomania
- Identify suitable medications and psychological therapies to reduce symptoms of trichotillomania
- Identify best practice for referrals and psychological care for people living with trichotillomania

Supporting resources are in the library tab at the bottom right of your screen.

GP's perspective

Holding the whole in mind:
What broad areas of knowledge do I need in order to make a diagnosis?

- **Environment:** work, study, home, finances, crowding, noise, privacy, green space
- **Social climate:** expectations, tension and conflict, impulsivity, other addictive or compulsive forms of coping in those around her
- **Relationships:** availability, attunement, responsiveness, trust, boundaries. Notice siblings, parents, friends, past therapists, GP, past therapists, work, pets
- **Body:** sleep, exercise, energy, relationship to food, attitude towards her body, behaviours, relaxation, play, movement, pain
- **Inner experiences:** affect regulation, experiences of overwhelm or out of control, fears, memories, compulsions, perceptions and focus of attention, dissociation
- **Sense of Self:** attitude and communication with herself, self-soothing, shame, internal attunement, connection and unity
- **Spirit or Meaning-making:** spiritual resources , existential distress, purpose and meaning

Dr Johanna Lynch

GP's perspective

What parts of Hannah's story am I currently missing?

- **Environment and social context –** comfortable at home and work? Expectations? Financial stress?; Any helpful parts of her treatment in the past?
- **Relationships:** Where is Dad in this story?, What happened in relationship to her boyfriend?, Any key connected relationships that are meaningful and soothing for her?, Does she have any friends who she could reveal her hair to and discover that she would be accepted?
- **Body:** any positive calming sensations in her body?; exercise, dancing, music
- **Inner experiences:** What happened around the time this behaviour first started? What feelings did she have back then? Are these feelings the same ones she is experiencing now?; What do the terms 'anxious' and 'depressed' mean for Hannah?
- **Sense of Self:** Her strengths – what does she love doing? What is she good at? Who is she close to?; How connected does she feel to herself?
- **Meaning and spirit:** What is the message/meaning she has taken in about the recent relationship breakdown?; Why is it so important for Hannah to hide what is going on from her friends?

Dr Johanna Lynch

GP's perspective

What processes are being enacted as part of this consultation and interaction with the GP?

- ***Hannah ambivalent*:** mother seeking help for her, reluctant visit to GP, reluctant compliance with treatment suggested; disconnected relationship to others
- ***Inattention to self*:** minimising consequences to herself – difficulty getting Hannah to engage with her own self care; disconnected from self?
- **Using *behaviour to manage stress*:** distress reduction behaviours; enacting not reflecting
- ***Incomplete knowledge*** – key aspects of the history missing, what else in this family is remaining hidden, what are Hannah's goals?; unaware
- ***Incoherence of story*: e.g.,** Hair pulling exacerbates in response to break up with boyfriend described as "no apparent reason"; not making sense

Dr Johanna Lynch

GP's perspective

What kind of responses am I having towards Hannah and how this story is being told?

- Struck by the incoherence of this self-harming behaviour and its acute exacerbation after the loss of relationship with her boyfriend, and the banal words "no apparent reason" – doesn't make sense to me, not convinced – something is missing.
- Aware of absence of connection – self, body, others, GP... avoidance?
- Some sense of helplessness as her symptoms worsen – feel that in mother and Hannah too …
- Struck by the passive role Hannah is playing in her healing, and the active role she is playing in her hair-pulling – could that active energy be harnessed to help rather than hinder?

Dr Johanna Lynch

GP's perspective

Hopes for Hannah

- Make sure she feels safe in her *environment*
- Increase her connection to past supportive *relationships*, find ways to increase her play and interactive relationships
- Help her to use her *body* to calm herself – through mindful grounding awareness of her sensations, beauty, music, creativity, art etc.
- Help her to tolerate uncomfortable *feelings*, (affect regulation) to understand her perceptual distortions and manage her need to escape into repetitive behaviours and numb or dissociate , increase experiences of flow
- Increase self-compassion and internal unity, so she can *befriend herself*
- Help her to *make sense* of what happened at 14 years old, and in recent relationship; and to find a sense of purpose and hope; connect her to any spiritual resources she may have – may need to use creative therapies to help

Dr Johanna Lynch

Psychiatrist's perspective

Characteristics

- Repetitive hair pulling to the point of noticeable loss and/or functional impairment
- With tension and relief 0.6%, without 3%; F>M
- Chronic waxing and waning course
- Average age of onset around 13, often earlier
- Associated physical impairment secondary to damage to hair and skin, to ingestion
- Psychosocial impairment – 56% pull for more than a third of the day, 70% report psychiatric co-morbidity
- Social, academic, occupational and financial difficulties

Dr Scott Blair-West

Psychiatrist's perspective

Model

- Focussed pulling – preceded by a private internal event such as an urge, bodily sensation, emotion or cognition. Focussed pulling occurs as a specific behaviour to reduce or escape from these experiences and/or acquire short term pleasure
- Automatic pulling – seems to occur outside of one's awareness often during sedentary activities and without identifiable triggers
- Interventions can reduce private experiences, also work to accept experiential avoidance

Dr Scott Blair-West

Psychiatrist's perspective

Treatment

- I like the AEBT-T (Acceptance enhanced behaviour therapy for trichotillomania) manualised treatment described by Woods and Twohig
- Combination of Habit Reversal Training (HRT) and Stimulus Control (SC) – especially for automatic pulling – and Acceptance and Commitment Therapy (ACT) – more for focussed pulling

Teaches

1. Awareness of hair pulling and causes
2. Use of self management strategies to prevent/stop hair pulling
3. Stop fighting against urge to pull via defusion and acceptance
4. Improve quality of life via values work

Dr Scott Blair-West

Psychiatrist's perspective

Co-morbidities

Majority of trichotillomania patients have psychiatric co-morbidities

- Major Depression
- Obsessive-Compulsive Disorder and related disorders
- Other anxiety disorders – Social Anxiety, Generalized Anxiety Disorder, Panic Disorder
- Substance use
- Eating disorders

PLUS

Widespread issues with shame, guilt, disgust, low self-esteem and effe on functioning. Requires careful and detailed history taking of specifics of hair pulling and co-morbidities.

Dr Scott Blair-West

Psychiatrist's perspective

Medication treatment

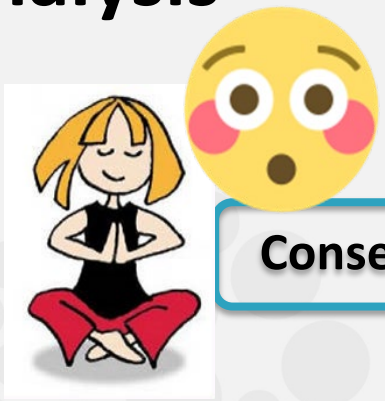
The most common intervention DESPITE very limited evidence supporting its use in uncomplicated hair pulling

- Small number of RCT's using drugs and results generally poor
- Anecdotally, combination of meds and behaviour therapy can be effective
- RCT's comparing behaviour therapy and drugs show behaviour therapy better
- Meds certainly useful in those with co-morbidities especially depression and anxiety
- Evidence for SSRI antidepressants and Clomipramine
- Other drugs including antipsychotics, Benzodiazepines, Naltrexone and others - unclear benefits

Dr Scott Blair-West

Psychologist's perspective

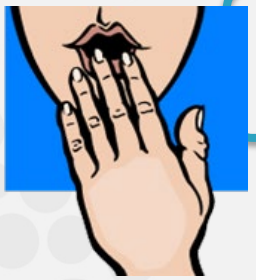
Formulation & Functional Analysis



Conditioned Cues

Facilitative/ Inhibitive Factors

Hairpulling Behaviours



Consequences

S = Sensory

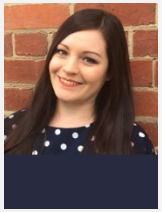
C = Cognitive

A = Affect

M = Motor

P = Place

(Falkenstein et al., 2015; Mansueto et al., 1997, 1999)



Dr Imogen Rehm

Psychologist's perspective

Psychological Interventions

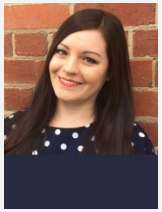
Habit-Reversal Therapy enhanced with cognitive therapies:

- Acceptance Commitment Therapy
- Dialectical Behaviour Therapy

Date	Time spent pulling	Sensory	Cognitive	Affect	Motor	Place
Monday	40 minutes	Tingling in finger tips, tearful, felt my heart beating	"I can't cope! Pulling will help me relax, I'll just pull a couple"	Sad, nervous, on edge	Restless, foot tapping, hunched over, rubbing neck with fingers	10pm, alone, in bed, scrolling through facebook

Core components of enhanced therapies:

1. Psychoeducation
2. Self-monitoring
3. Awareness training
4. Competing response training
5. Stimulus control
6. Mindfulness, relaxation and emotion regulation strategies
7. Values and other motivational strategies



Dr Imogen Rehm

Psychologist's perspective

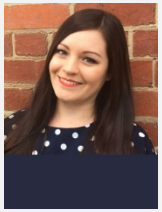
Habit Reversal Therapy

- Use of strategies should be **collaborative**

- Awareness training
  - Simulated hair-pulling
  - Can build 'urge surfing' techniques into this
  - Role of social supports, loved ones?

- Competing responses
  - Clench fists, fold arms, grip steering wheel etc. for 1-minute
  - Fidget toys? No one-size-fits-all

- Stimulus control – 3 principles:
  - Should make pulling more effortful
  - Should be simple & relatively easy
  - Not to prevent or entirely avoid uncomfortable experiences (urges, emotions)
    - Control the stimuli, not the behaviour!

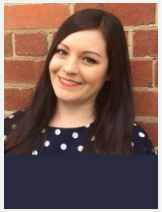


Dr Imogen Rehm

Psychologist's perspective

Monitoring Progress

- Massachusetts General Hospital Hair Pulling Scale (Keuthen et al., 1995)
  - Control, severity of urges, distress over past seven days
- Milwaukee Inventory for Styles of Trichotillomania (Flessner et al., 2008)
  - Automatic – habitual hair pulling
  - Focussed – pulling for emotion/other forms of regulation
- DASS-21, K10, Brief Fear of Negative Evaluation Scale, Acceptance & Action Questionnaire, others as relevant to formulation
- Keep up self-monitoring as much as possible
  - role for technology?
- Problem-solve around barriers to homework, treatment strategies

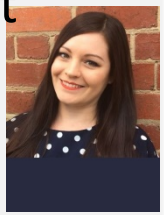


Dr Imogen Rehm

Psychologist's perspective

Further considerations

- Don't underestimate importance of psychoeducation, normalising and empathy for shame reduction, therapeutic alliance and engagement
  - Not "the only one"
  - Not "random" or "weird" – serves a purpose, positives and negatives
- Treatment goals need to be realistic
  - Ingrained behaviours spanning 10+ years won't be "cured" in 10 sessions
  - Goal is not necessarily to be "pull free"
  - Sense of self, what it means to live a fulfilling life – with or without trichotillomania
- Leisure, self-care and behavioural activation



Dr Imogen Rehm

Q&A

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Thank you for your contribution and participation

Good evening

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