

Trichotillomania: A comparison of CBT and ACT in causal reasoning and treatment outcome stability

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Introduction

Trichotillomania is defined as an impulse control disorder which is characterized by the inevitable urge to pull out body hair. The disorder can be divided into two distinct styles of hair. The disorder can be divided into two distinct styles of hair pulling, i.e. focused and unfocused pulling. Unfocused pulling is pulling occurring primarily out of one's awareness and can effectively be treated with habit reversal (HR), focused pulling on the other hand is compulsive pulling, which may include situations in which an individual pulls in response to a negative emotional state and is often approached with a form of cognitive behavioural therapy (CBT) [1]. An attempt is made to compare differences in causal reasoning and its consequences for treatment outcome stability between two therapy forms, classical CBT and Acceptance and Commitment Therapy (ACT).

CBT is a psychotherapeutic approach that aims to identify distorted negative thinking styles and the maladaptive behaviours associated with those thinking styles. Trichotillomania is seen as such a maladaptive behaviour and is considered a consequence of both behavioural as well as cognitive variables. According to CBT, trichotillomania is learned and maintained by operant conditioning due to for example perfectionism and unrealistic expectations. These beliefs are accompanied by tension and cause tense-release behaviour in the form of hair pulling [2]. CBT challenges patients to change their behaviour by self-monitoring, awareness training and controlling the unwanted behaviour.

As shown in Figure 1 psychological flexibility or well-being in ACT is seen as the result of many different psychological elements. Acceptance of one's thoughts and feelings is one such element. Experiential Avoidance, the escape from or avoidance of negative feelings and thoughts, forms one possible causal factor of psychological illness and has been linked to trichotillomania in the past [3]. ACT tries to change avoidance in acceptance, therefore it is thought to be a suitable way to treat trichotillomania. Patients suffering from the pathological urge to pull out body hair are thought to have lost contact with the present moment and their values and to have fused with disorder related thoughts. For a broader description of the theoretical image of mental pathology we refer to Hayes [4].

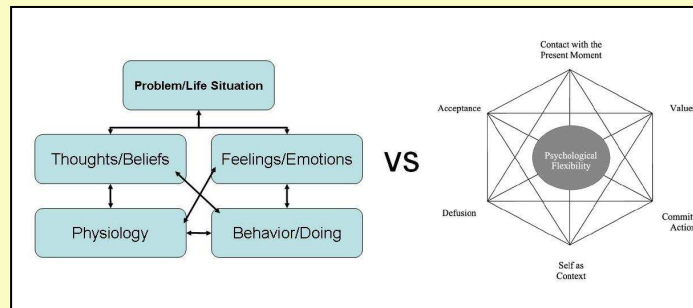


Figure 1. CBT and ACT models of psychological well-being.

Results

CBT approaches often have limited reported efficacy and questionable long-term maintenance of treatment gains [5]. Mouton and Stanley (1996) reported that 80% of patients exhibited symptom improvement, but after 6 months follow-up only 40% maintained benefits. Also, Lerner and colleagues (1998) had an efficacy rate of 86% but at follow-up 31% was still considered treatment responders. Other studies found efficacy rates of 52% [6] and 64% [7]. Two articles examined the effectiveness of ACT in the treatment of trichotillomania. One study, conducted by Woods and colleagues [8] found that a group of trichotillomania patients treated with ACT compared to a waiting-list group showed a significant reduction in hair-pulling severity, impairment ratings, hairs pulled and a measurement of experiential avoidance. These results show that ACT is better than a waiting-list condition. A second study by Twhohig and Woods [9] furthermore showed, through using six clinical replications with multiple baseline measurements, that even after 3 months follow-up 50% of the patients nearly pulled any hair.

Discussion

CBT is based on the theory that cognitions or thoughts control a large portion of behaviours. Patients are therefore challenged to change distorted thinking styles and the behaviours associated with them. An explanation that the amount of relapse at follow-up research is high is that patients have to keep challenging their thoughts and actively control of the situation. This costs energy and chances are high that there will be a day a patient is just not motivated anymore to fight and therefore falls back in old maladaptive behavioural patterns. Rather, we suggest that acceptance of one's emotions and cognitions may result in a greater amount of long-term responders to psychological treatment of trichotillomania. Furthermore through not simply focusing on the core elements of a disorder but by aiming at overall psychological flexibility of the individual treated with ACT treatment may result in positive side effects for the patient besides the reduction of the symptoms of the problematic behaviour.

Although the research described here suggests a lower relapse rates in ACT treatment compared to CBT treatment, the body of research on treatment of trichotillomania with ACT is still rather small. Further research is necessary to determine if this new theoretical approach keeps up with the assumed expectations. All in all it is evident that ACT forms a good alternative to traditional CBT in treating trichotillomania.

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