

EMPTYING THE HABIT: A CASE OF TRICHOTILLOMANIA

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Abstract

Some habit disorders involve ‘empty’ behaviours, and symptom-oriented approaches are appropriate. Others appear to be maintained by underlying anxieties and unresolved issues. The case of trichotillomania described here fell into the second of these categories and so a two-stage approach was adopted. Uncovering and ego-state therapy techniques were used first to explore and resolve issues related to the hair-pulling, followed by a more direct behavioural approach to removing the problem behaviour itself. Though this was a habit of some 25 years duration a successful outcome was achieved. The appropriateness of a two-stage approach to these types of problem and the role of hypnosis as an adjunctive procedure in their treatment are discussed.

Key words: hypnosis, habit disorder, hair pulling, trichotillomania, two-stage treatment

Introduction

Wadden and Anderton (1982) concluded that though hypnosis may offer some unique contribution to the treatment of ‘non-voluntary disorders’ such as clinical pain, warts and asthma they could find no strong evidence of a similarly unique contribution to the treatment of what they termed voluntary, or habit, disorders, such as obesity, smoking and alcoholism. More recently, however, a meta-analysis by Kirsch, Montgomery and Sapirstein (1995) comparing cognitive behavioural treatments alone with the same treatments delivered in a hypnotic context indicated that for at least one habit disorder, obesity, the use of hypnosis conferred a significant advantage, especially if longer term follow-up data were considered. Similarly, in an interesting preliminary clinical trial of nail-biting, Wagstaff and Royce (1994) found that therapeutic suggestions preceded by a hypnotic induction were more effective in producing symptom improvement after one session than the same suggestions given alone. The factor that predicted treatment success most reliably overall was ‘believed-in efficacy’ of the treatment and one function of the hypnotic induction may be to increase the credibility of the treatment for some subjects. Within the hypnotic induction group, however, hypnotizability was correlated with treatment success, which may suggest a unique contribution for hypnosis in that group. Whilst this more recent evidence is encouraging, further comparative studies are clearly required before it can be concluded with any certainty that the treatment of habit disorders gains a significant benefit from the concurrent use of hypnosis.

What is certain, however, is that a range of habit disorders have been treated, often successfully, using hypnosis as part of the therapeutic approach in both adults (e.g. Citrenbaum et al., 1985; Alexander, 1991) and children (e.g. Olness and Kohen, 1996). Effective behavioural treatments are available for trichotillomania (compul-

sive hair-pulling) (e.g. Azrin et al., 1980) and this particular habit disorder also seems to respond to treatments that use hypnosis adjunctively (e.g. Galski, 1981; Rowan, 1981; Hynes, 1982; Barabasz, 1987; Karle and Boys, 1987; Olness and Kohen, 1996).

If hypnosis is viewed as an adjunct to therapy (e.g. Oakley et al., 1996) a successful outcome depends crucially on matching the underlying treatment approach to the presenting problem. Part of the difficulty in treating habit disorders is that whereas in some instances these problem behaviours have become 'empty habits' (Crasilneck and Hall, 1985; Karle and Boys, 1987), and so may be approached directly with symptom-oriented therapies, in other cases they appear to be maintained by underlying anxieties and unresolved issues. The case of trichotillomania described here fell into the second of these categories and as a consequence a two-stage approach was adopted. This general strategy would be equally applicable to a range of habit disorders when the behaviour in question seemed to be serving an important psychological function for the individual as well as having distressing consequences.

Background to the case

At the time of her referral to me by her general practitioner, T was 39 years of age. Her hair-pulling problem had first appeared when she was 13, at a time when she was changing to a new school and her mother was pregnant. It had become particularly distressing over the previous summer, around the time of the death of her husband's mother and was now 'frighteningly out of control'. Pulling occurred on a daily basis and involved 'twiddling' (twisting) an individual hair around a finger, usually using her dominant left hand, especially in quiet moments when she was 'alone and thinking about things'. The hair was mostly pulled from the back of her head near her ears and she reported a sense of satisfaction in the sound of the hair being pulled out. The hair at the sides of her head was very thin and uneven in length. Behind her ears she had bald patches about which she felt acutely self-conscious. T often wore her hair tied back as this made pulling from her favourite spots more difficult. She felt that her habit was not necessarily associated with stress, but was increased by it.

T had been seeing a psychoanalyst for a number of years and some five years previously she had consulted a psychologist, who used hypnosis, specifically about her hair-pulling problem. She had terminated the latter treatment after two sessions however, partly because she realized that hypnosis was not the 'magic cure' she had been looking for. The treatment described below involved nine therapy sessions at one or two week intervals unless noted otherwise.

Preparation and understanding the problem (sessions 1–3)

The first session commenced with taking a brief history followed by a standardized hypnosis routine. This routine involved an eye-fixation induction accompanied by suggestions of muscle relaxation and regular breathing, followed by a deepening procedure incorporating imagery of descending in a lift and finally 'special place' imagery with a reverse-counting de-induction. T's special place was an imaginary room with a warm fire, a comfortable chair and bookcases. This sequence lasted 25 minutes though she estimated its length as 10 minutes. She chose the words 'my quiet room' to designate her special place and to act subsequently via a post-hypnotic suggestion as an anchor to retrieve relaxed and comfortable feelings. She was told how to use the hypnotic sequence as a self-hypnosis routine and was asked to practise it on a daily basis between sessions. She was also asked to keep a diary of her hair-pulling

activity. She soon abandoned her diary, however, as she said she felt 'too ashamed' to continue with it. The same hypnotic sequence was used on all subsequent therapy sessions for induction and deepening.

At the second session T was asked to talk in hypnosis and experienced herself as wearing a red velvet dress, sitting comfortably on the chair beside a table. She said that on the table there was a book that seemed to be of some special significance to her and for the resolution of her problem. She believed she could pick it up but the thought of doing so made her feel sad. She said:

If I picked up the book which somehow helped me to relinquish it, the hair-pulling, it would be a loss . . . giving up a comfort . . . like losing an old companion . . . it's more painful than I expected . . . like saying 'I don't need you anymore' . . . a rejection.

Later, when writing an account of her experiences of treatment, T noted:

For myself, I wanted just a few sessions of hypnosis that would take away what I believed to be an empty activity. I was not prepared for the discovery early on in my treatment, whilst under hypnosis, that I was very resistant to the idea of giving up my habit.

Session three was taken up with rehearsing the hypnosis sequence and establishing the clenching of her right hand and holding a pebble as additional anchors for confident feelings as well as for relaxation and comfort.

Treatment stage 1. Emptying the habit (sessions 4-7)

A conceptual model, which had been developing in the course of our discussions over the previous sessions, was that of 'empty' versus psychologically important habits. All the evidence indicated that T's habit was not 'empty'. An approach that fitted this emerging view was to first 'empty the habit' and then to attempt to effect its removal. We agreed therefore to adopt this strategy using uncovering and resolution techniques as a first stage of treatment.

As exploring the background to T's hair-pulling might involve difficult or painful memories it was decided to employ an intermediate regression procedure (Alden, 1995) for uncovering and T chose a 'video-booth' technique. It was felt that a simple ego-state approach (the 'adult – child split') would be appropriate as an avenue for cognitive restructuring and for resolving any uncovered material (Watkins, 1993; Watkins and Watkins, 1997).

During session four in hypnosis T was rehearsed in the use of the video technique. She was able to imagine being in a video room and was able to 'allow her unconscious' to select a positive scene from her childhood. She reported seeing herself on the screen as a six-year-old in a park, climbing rocks with her sisters. She was then able to freeze the video, to enter the scene and experience the events at first hand, and then to return to viewing the scene on the screen. When de-induced she said she had found the video controls easy to operate and had enjoyed the scene, although it was not one she had anticipated would appear.

In the fifth session the video technique was used in hypnosis to view a scene 'selected by the unconscious part of your mind, which is relevant to the habit of pulling your hair.' This non-directive, client-oriented uncovering suggestion was also used in the next session. It evoked a series of experiences that incorporated themes of loss of emotional support, a need for companionship, conflicts of loyalty and in par-

ticular the unavailability of her mother as a source of comfort. It is perhaps worth noting here that I had no foreknowledge of these incidents or their possible relevance to the hair-pulling habit and T herself was surprised that they were the incidents which emerged.

On the first of these occasions T found herself viewing a scene of herself aged 13 years with her friends sitting in the sun in the playing fields at school. When T was asked to enter the scene as young T (YT) she described her feelings of not being part of the group. She was able to continue with the scene in which she went to meet a teacher in a classroom. She felt both pleased at his attention and also that it was not right that he should be giving her so much of his time. T particularly remembered that he had lent her many books over the summer holiday. She later drew a link for herself between those books and the fact that earlier in her special place the thing that seemed to hold the key to her problem and its resolution had also been a book. She had confided some of her problems at home to the teacher but felt she could not tell him just how bad she felt, particularly about feeling pushed out at home by the new baby. An ego-state approach was then adopted to attempt to resolve some of these feelings. When YT was alone in the classroom it was suggested that T could enter the scene as her older and wiser self (OT) and could make contact with YT. She was able to do this and OT said to YT: 'It is only natural you feel pushed out and worried that Mum will not have time for you.' OT offered to give YT the help and support she needed and told YT that it would be better than seeking help from the teacher. OT then chose to take YT back to her classmates in the playing field whereupon YT reported experiencing feeling part of things once more and enjoyed spending some time with her friends.

On reflecting on the classroom incident T came to the view that it was not just about losing mother but also about trying to find a man to give her emotional support, which she felt her father had been unable to do. T also felt that her mother was jealous of the possibility of any close relationship between T and her father and had contrived to prevent it. She also said she had not realized before how much she had missed as a result of feeling distanced from her friends. Two further scenes were uncovered, which related to feelings of T's loyalties being divided between her parents and were resolved by means of an interaction between OT and YT.

At session seven T said that the experiences of the previous sessions had led her to think about the recent death of her husband's mother, to whom she had been very close, in terms of a further loss of emotional support. She saw the subsequent increase in hair-pulling as compensating for that loss. On this occasion T was asked in hypnosis to bring to mind a recent occasion when she pulled hair and to focus on the feelings she had then. She was then asked to allow her 'unconscious' to use those feelings to select a video scene that was relevant to them and their resolution (a form of modified affect-bridge procedure, Watkins, 1971).

T found herself watching her younger self, aged about 14 years, in her parents' home. T was sitting on the kitchen worksurface feeling very upset, trying to explain something to mother who would not listen. Going into the scene as YT she said:

I feel I can't get through to her – it feels like a dream. I'm screaming at her but no sound comes out – I feel angry at getting so upset in front of her – mostly I would go to my bedroom – normally I would not have asked for emotional support from her – I just feel it was too difficult for her to see me being upset.

At this point the scene changed and T, aged 22 years, was at the funeral of her paternal grandmother, standing at the graveside. T said that she 'became aware that

mother could not handle it – my being upset – I should have known.’ T was then asked how all this related to hair-pulling. She said ‘it’s more like a comfort – compensation for the loss – when I feel I would like help.’

Back at the worksurface episode, OT was then asked to go into the scene and offer YT what she needed to compensate for her emotional needs not being recognized. YT said she would like to know there was someone who could understand her – she would like it to be her mother. OT explained that mother had suffered her own losses and so could not respond to her daughter’s needs at that point. YT said she needed to know it was OK for her to feel sad. OT gave her that reassurance, took YT to her bedroom and left her with the pebble and advised her she could use the words ‘my quiet room’ whenever she needed to feel comforted and secure. At the end of the session out of hypnosis T said she had not thought about that worksurface scene before but recognized the feelings as those that had been reactivated by the death of her husband’s mother. She found it helpful to realize that her mother was not able to give YT what she needed because she was unable to, not because she didn’t want to. In retrospect she realized it was ‘unreasonable to expect that of mother – though the 14-year-old did not see it that way.’

Stage 2. Removing the habit (sessions 8 and 9)

T reported that, in the two weeks that had intervened before session 8, the number of hair-pulling incidents had not noticeably changed, but her general levels of anxiety had become lower and she had the impression that her hair-pulling had become much more related to ‘everyday hassles, like the photocopier at work breaking down.’ She also said that anxieties from the past could be dismissed much more readily without resorting to the habit. It was put to her that this suggested that the habit had been emptied of its emotional significance from the past and as a consequence this might be a good time to move towards a direct symptom removal approach. In contrast to previous occasions when this possibility had been raised she readily agreed. The technique used was similar to one described by Karle and Boys (1987, p. 94) for trichotillomania. Before hypnosis T was asked to identify her negative thoughts associated with her habit. The most significant of these were:

1. the shame of being trapped in a habit,
2. anxiety about going to the hairdresser, and
3. anxiety about people noticing the pulled patches in other situations.

She identified her positive thoughts as:-

1. being free of the need to pull,
2. looking forward to the future,
3. being more confident and positive, and
4. feeling freer to go to the hairdresser without embarrassment.

Following the standard hypnotic sequence, T was asked to imagine herself in an everyday situation where she had begun to feel the urge in her left hand to pull her hair. She was asked to allow the hand to make an actual movement towards her head, to contact her scalp and to begin to twiddle a hair. At this point she was asked to bring to mind her negative thoughts (covert sensitization – Cautela 1966; Degun and Degun, 1983; Wright and Humphreys, 1984). Direct suggestions of catalepsy in the

left hand were then given so that the hand felt knotted and the fingers unable to continue moving. Once the hand catalepsy was felt T was instructed to bring her arm down and to experience as she did so the positive thoughts and a return of the hand to its normal function as it came back down to rest (covert reinforcement). The sequence described above was then repeated for an intention to hair pull with the right hand. Finally the sequence was repeated for the left hand but with the catalepsy occurring before the hand reached the head. T was then returned to her special place and given the suggestion that the words 'my quiet room' could convey to her all the comfort she needed. Finally a post-hypnotic suggestion was given that the hand catalepsy would occur 'all by itself' as soon as the urge to hair pull began but would not occur under any other circumstances. T was instructed that if she did detect an anticipatory hair-pulling movement she would bring to mind her negative thoughts and would replace them by positive thoughts once the hand returned to rest. When de-hypnotized T reported that she had experienced the catalepsy as automatic and irresistible.

Three weeks later (session 9) T reported that she had not pulled her hair at all since the previous session despite a series of what were usually stressful events, such as the school holidays and a visit to her parents' house with the children. Before this the longest period she had managed to avoid pulling was in the order of a few hours. On some occasions where she might have pulled in the past she said she felt 'pulled-up in her mind' and was aware that the negative thoughts about the consequences of pulling came back to her 'in a very stark way'. At other times she said she simply noticed that she hadn't had the urge to pull for a very long time without any real effort or awareness on her part 'and that's nice'. She had felt very good about not pulling – not deprived – not lacking in comfort as she had feared. It was also significant that she reported being at home with her mother without any of the usual feelings of awkwardness or stress that had been present on previous occasions. In hypnosis the 'catalepsy' sequence established on the previous session was rehearsed twice, once with each hand, but with the hand movement being barely noticeable before the catalepsy occurred. T was given a tape of the hypnosis/catalepsy sequence and was encouraged to continue practising self-hypnosis and listening to the tape as often as possible in her own time.

Follow-up

The first follow-up session was at four weeks. T said she had practised the self-hypnosis procedure approximately twice per week and there had been some occasions in one particularly stressful week when she got as far as 'twiddling' but had not pulled any hair. By 20 weeks T's hair had regrown, with no bald patches and was thicker and more even. She was wearing her hair loose and just above shoulder-length. There had been some days over the intervening three months when she has been particularly stressed and if these had occurred at times when she had not had time to practise her self-hypnosis she had twiddled and occasionally pulled out hairs. On an arbitrary scale from 'completely absent (0%)' to 'as strong as it ever was (100%)' T estimated her habit problem to be approximately 13% of its former strength. At 33 weeks T's hair had continued to thicken to the extent that both her husband and her hairdresser had commented. She was able to wear it loose without any anxiety about that encouraging pulling, which she said was 'a lovely release.' She had practised self-hypnosis and stress-management more regularly and the amount of control she felt over her habit had increased a little more. She said 'I control *it* now rather than *it* controlling

me.' She said she had reached a 'trade-off point' where she balanced the residual very occasional pulling against the time and effort it took to practise self-hypnosis and listen to the tape. She estimated her problem was now 12% of its former level. A passage from T's own account of her therapy, written at 41 weeks, described her progress as follows:

I am sure that I shall be able to continue to resist pulling out my hair, and at times for it not even to cross my mind for some time. But I also know I can present myself with less risk of even thinking about it, the more regularly I practise the relaxation technique I have learned. For me, hypnosis was not a magic solution and has not made my problem vanish. It has made me more aware of my levels of anxiety and has given me an effective tool to use to reduce these. How successful I am, though, is still very much up to me.

At 59 weeks T rated the problem at 10%, saying that now she paid very little attention to it and was of the opinion that she could remove it completely if she wished. This improvement had been maintained at 87 weeks and T was 'really pleased with how things are going' despite no longer practising her self-hypnosis routine on a regular basis.

Discussion

The outcome in the case described here is one with which the client is pleased. She has achieved what she considers to be an acceptable level of control and her therapeutic gains have been maintained and improved upon during almost two years of follow-up. There are a number of questions that could be raised however. The first concerns the necessity of a two-stage process in this case. It has been assumed here that cognitive restructuring and processes of resolution achieved via the uncovering and ego-state procedure in stage 1 were an essential precursor to the more behavioural methods of habit control which were used in stage 2. However, it is possible that using the catalepsy/covert sensitization procedures straight away would have worked. There is of course no way of determining this in T's case. There was considerable clinical evidence, however, that the habit was fulfilling some important psychological needs for T, and the decision to use a two-stage approach was based on this evidence. In addition it seems likely from her own comments that T would have resisted a strictly symptom-oriented approach. There is also the question whether the clinical outcome would have been as good or better if different therapeutic approaches had been used. An alternative avenue that might have been explored would have been to utilize more directly the idea of the habit as an initially well-meaning companion and to use an ego-state approach to contact that 'companion' (the part which knows about the hair-pulling) and to negotiate a way of abandoning the old behaviour and providing a new more acceptable way of providing self-comfort (Watkins, 1993). A closely related approach using the notion of 'misplaced help' would be to use a (Ericksonian) 'reframing' technique, possibly with ideomotor signals to address the problem habit via 'unconscious' processes (e.g. Citrenbaum et al., 1985). The attraction of the particular two-stage strategy used in T's case is that it fitted the model which she had been developing of her problem over the initial therapy sessions. Adopting an approach that conforms to the client's own views is more likely, arguably, to have a good prognosis in that it may reinforce belief in the efficacy of the procedure, which in turn has been shown to be associated with positive therapeutic outcome (Wagstaff and Royce, 1994).

A further important consideration concerns the extent to which hypnosis was an important variable. Such evidence that there is suggests that the use of hypnotic procedures, especially if labelled as such, does improve the efficacy of both psychodynamic and cognitive-behavioural therapies (Kirsch et al., 1995; Kirsch, 1996). It could be argued in particular to have contributed here to the vividness of the imagery used in the covert sensitization and reinforcement procedures, to the experience of catalepsy as an involuntary response, and possibly to the ability to retrieve and focus on unexpected images and experiences of relevance to T's problem and its resolution. There is also the likelihood that hypnotic procedures provide an enabling context and increase therapeutic effectiveness by adding further to some clients' beliefs in the efficacy of the underlying treatment (Wagstaff and Royce, 1994) and also by directly changing the client's response expectancies in clinically useful ways (Kirsch et al., 1995; Kirsch, 1996).

It remains for clinical trials to establish the efficacy of this sort of two-stage approach, as well as the adjunctive use of hypnosis, in cases of trichotillomania and other compulsive behaviours. Nevertheless, the strategy described here is a plausible and apparently effective way of establishing control in cases where an unwanted habitual behaviour is maintained in part because it seems to fulfil underlying psychological needs. In the case of already 'empty' habits the second stage of the procedures described above could be entered directly.

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