Trichotillomania and Hypnotherapy – Mia Lack

There is a split in the medical world as to whether trichotillomania (TTM) is an Obsessive Compulsive Disorder (OCD) or an impulse-control disorder and as such is a form of “nervous” illness. Another view is that it’s entirely a behavioural disorder learnt as a reaction to prolonged stress. However, whatever it is classified as, about 2% of the population know it causes them a great deal of embarrassment, discomfort and distress.

TTM involves recurrent hair pulling, resulting in a noticeable loss of hair. It includes compulsive and habitual pulling of eye lashes, eye brows, head hair, and pubic hair. Tension before the act and feelings of pleasure immediately thereafter are typical affect conditions. The obvious hair loss results in increased anxiety and often may lead to an avoidance of social situations and even intimate relationships. Reduced self-esteem is also a factor. Hypnotherapy is now seen as a valid clinical intervention for TTM treatment.

The occurrence of TTM is unknown, but seems to affect more women than men; with only about 1 in 10 trichsters being male. The average age people start hairpulling is 12 years old. The most common triggers are stress, boredom and anxiety. If the client is still at school check for bullying problems etc.

Too many doctors ignore young TTM sufferers as they frequently believe that they will eventually outgrow it. However, if they do not, the problem will last well into their adult years and waiting to see if the young person will outgrow it may prevent the individual from receiving adequate treatment during the period when it may be best and easiest to resolve.

TTM often tends to affect very intelligent and sensitive young people, and while it is a disorder, the behaviour itself may even be a reaction to boredom, due to that high intelligence. Even though TTM is believed to be a genetic disorder, the probability of a person with TTM having a child with the disorder, is still very small. Sensitivity issues are more likely to be passed on than the actual TTM behaviour.

While hair pulling and eyelash pulling is frequently believed to be either ADHD or an obsessive-compulsive disorder (OCD) there are important differences between TTM and OCD. The term trichotillomania was formally incorporated into DSM-III (Diagnostical and Statistical Manual of Mental Disorders) in 1987. It is still classified as an impulse-control disorder much like pyromania, and kleptomania. If the client has been diagnosed as having ADHD and TTM, this could be an example of the doctor not understanding the complexities of TTM and its attention related problems.

Considering the conditions when TTM occurs may be the key to truly understanding hair pulling and designing hypnotherapeutic interventions. Hair pulling often occurs in sedentary and contemplative situations while the client is sitting or lying down and absorbed in thought or concentrating on other tasks. Therefore, their acting out is often out of their awareness or in only partial awareness. Also, tension, boredom, anger, depression, frustration, indecision, lethargy, and fatigue states are also frequently occurring.

TTM is a learned behaviour that is programmed into the client’s brain during a period in their life when s/he does not have sufficient neo-cortical resources to understand and deal with threats. Therefore, it is somewhat of a defensive reaction that is programmed (i.e. habituated). Should the client not grow out of it, the resulting neural networks become so strong that they tend to resist any type of intervention.

The psychotherapeutic treatment of TTM needs to address empowerment, self-efficacy, the development of dissociative awareness, and habit replacement. Essentially, the client needs to develop the belief that they can change, awareness of hair pulling incidents, and replace their self-

image and habitual behaviour. The re-focusing of their mind can help the neural networks associated with the problem to wither and strengthen new pathways.

Hypnotherapy is uniquely suited as an intervention for the treatment of TTM. This is for two primary reasons. First, the essential nature of hypnosis is to bypass resistance to change. This is often referred to as a bypass of pattern resistance, a bypass of the critical faculty, or splitting the symptoms from the cause. However, the primary fact here is that once a TTM sufferer becomes an adult, the associated neural patterns are extremely strong and, like any entrenched patterns, they will resist any efforts to change.

The second benefit of the therapeutic use of hypnosis is that it has the ability to create alternate neural pathways. Post hypnotic suggestions that a hair pulling incident will trigger a dissociated awareness are extremely helpful, as the client will automatically become aware and potentially able to find alternate behaviours. Additionally, hypnosis can be used to install new behaviours, to establish and reinforce the client's belief that they have the power to alter affect responses, and to establish a more empowering self-image. The most beneficial therapy for clients with TTM is SOLUTION based, as research has shown clients rarely benefit from regression or past based therapies. Guided imagery, direct and indirect suggestions, parallel communication, and humour are among the variety of techniques available to a competent hypnotherapist.

With the use of hypnotherapy, it is important for the hypnotherapist to realise that treatment is not a short-term solution. A TTM hypnotherapy protocol should include several weekly or bi-weekly sessions with the hypnotherapist. These sessions should sequentially focus on self-empowerment, dissociative awareness, establishing alternate responses, and reinforcing new self-imagery. These sessions should be aided by having the client listen daily to self-hypnosis CDs that either focus on the specific topic of the previous visit or a multi-topic CD, which is specifically designed to address TTM.

TTM is a very resistant mental pathology. Symptom-based treatment alone is ineffective in the long-run. However many hypnotherapists have found that, especially for adult clients, to equate hair pulling with something negative, like nausea so that when the client feels the urge to pull out their hair, the negative feeling of nausea will help them to avoid it. While at the same time using a solution-based hypnotherapy treatment to attack the underlying entrenched patterns and thus attempt to establish alternate ones.

On the other hand trichotillomania comes in many stages of severity and it may be that symptom transference is initially needed. Here the patient is hypnotised and the 'part' causing the obsession is negotiated with and, for example, pulling hair from the scalp is traded down for pulling hair from the arm or leg, etc. It might even be possible to transfer the hair pulling 'off site' onto a doll / wig/ or piece of material.

Regardless of the techniques used the number of sessions required may vary depending upon the client's particular situation and severity. Sometimes just 1 or 2 sessions are enough, however, sometimes a short course of treatment is required lasting maybe 2 – 5 sessions. The client should also be taught self hypnosis to practice between visits.

In conclusion although there are many psychotherapeutic avenues that may show significantly positive results, hypnotherapy appears to be the best and most successful.