

Hypnotherapy in Adolescents with Trichotillomania: Three Cases

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Trichotillomania is not rare in adolescence. Psychotherapy is often ineffective, and cognitive behavioral therapy in combination with serotonin-specific reuptake inhibitors seems to be the treatment of choice. Some cases are resistant to all therapy. This paper reports on three adolescents with pure trichotillomania who responded to the imaginative hypnotherapy technique with Ericksonian suggestions. The patients described their hair as weak and vulnerable and needy of protection. In therapy, the patient was assigned the role of “patron of the hair” thereby giving him/her control of the situation. Hair pulling was significantly reduced, and the improvement was sustained throughout the 6-month follow-up. These cases suggest that imaginative techniques may be effective in adolescents with trichotillomania. Further controlled studies in adolescent population are needed to confirm this assumption.

Trichotillomania is not rare in adolescence with a reported lifetime prevalence of 1% (King et al., 1995a; Swedo et al., 1989), in developed countries, and 0.5% in Israel (King et al., 1995b). Some clinicians consider trichotillomania part of the spectrum of obsessive-compulsive disorder (OCD) (Keuthen et al., 1998a). It may appear in association with other symptoms, such as tics (Wester & O’Grady, 1991) or as pure trichotillomania. The term *pure* means that the symptom of hair pulling comes without any additional observable psychopathology. Common sites of hair pulling are the scalp, eyebrows, chest, and legs. Patients describe an irresistible impulse to pull their hair and a feeling of release of tension after doing so. Despite the availability of a wide range of therapies, most authors report only partial success. Cognitive-behavioral

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techniques, alone or in combination with serotonin-specific reuptake inhibitors, seem to have the best results (Christenson et al., 1991; Keuthen et al., 1998b; Koran et al., 1992), though some reports indicate that hair loss may be induced by this group of medications (Zalsman et al., 1999).

Kohen (1996) described five children with trichotillomania who underwent self-monitoring, dissociative hypnotic techniques and self-hypnosis. He emphasized that although trichotillomania is analogous to habit disorder, it is more resistant to interventions. Rowen (1981) considered trichotillomania a self-destructive habit and suggested the use of regression therapy. Other hypnotic techniques have also been described (Barabasz, 1987; Galski, 1981). Some patients remain resistant to all therapy, and there are no known predictors to identify this subgroup (Keuthen et al., 1998a). In a recent comprehensive review in the *Archive of Dermatology*, the author (Shenefelt, 2000) concluded that a trained clinician may successfully use hypnosis in selected patients as alternative therapy for many dermatological conditions including trichotillomania.

In this work we report on three adolescents with pure trichotillomania who responded to treatment with imaginative hypnotherapy, Ericksonian suggestions (Zeig, 1980, Rosen, 1991) and cueing. The case descriptions follow the technical description.

Therapeutic Technique

Our underlying assumption of therapy is that some adolescent patients with trichotillomania in our setting need to protect themselves from their unconscious impulse to harm their body. Using an imaginative hypnotherapy technique, we assign the patient the role of “patron of the hair.” After induction, during the hypnotic state, the following text is used: “Imagine yourself wearing special binoculars that give you the ability to see the hair of your eyebrows (or scalp, chest, etc.) very, very closely. Each hair looks very big, and you can observe it carefully. You may even look under the skin to the hair root and watch the hair as it starts to grow. The hair starts off tiny and thin, like you were as a child (Zeig, 1980), and tries to grow up and out to reach its full size. You feel that you want to protect and guard the tiny hair and prevent outside forces from harming it.” At this point, we sometimes add a cue, which “allows” the impulse of pulling to disappear. For example, patients may be instructed to press the first and second fingers of their hands together every time they have an urge to pull. This served to discharge the tension, like two electric wires that short circuit. Usually no more than two sessions are needed; however, follow-up sessions are essential and a combination of hypnotic sessions with family support and education seemed to us important for long-lasting results.

Case Reports

The imaginative hypnotherapy technique is demonstrated in the following representative cases. It is interesting to note that our patients did not have a clear understanding of their symptom and described it as a “bad habit.” All three patients had high scores on the Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1988). Our experience indicates that this scale has a predictive value in adolescents but this

clinical impression needs further empirical investigation. All patients and their parents signed an informed consent form prior to the first session. The sessions were held by a child and adolescent psychiatrist who is a certified hypnotherapist (Dr. GZ).

Case 1

A 12-year-old girl with severe scalp trichotillomania of one year's duration was referred to our clinic. She was completely bald, and wore a hat; she reported being too embarrassed to be seen by her peers and had not attended school for 2 months. Some of the eyebrows and eyelashes had been pulled out as well. Most of the trichotillomanic activity was performed in the shower. Prior to referral she had undergone 6 months of treatment with fluvoxamine 100 mg/d and intensive family therapy, with no improvement. She had no major psychiatric diagnoses and a negative history for OCD. Her score on the Yale-Brown Obsessive-Compulsive Scale was minimal. She had just started puberty. An Ericksonian suggestion guiding her to stroke herself instead of pulling her hair (Olness & Gardner, 1988) did not bring a subjective relief of the symptom. One may speculate that unconscious aggressive impulses against the self caused this "failure" in therapy. This trial was followed by the imaginative hypnotherapy technique. After two sessions, the trichotillomanic behavior disappeared. The 3-month follow-up showed that her hair had grown back and she had stopped wearing a hat, and was attending school.

Case 2

An 18-year-old male with pure trichotillomania was referred to our clinic during military service. The patient tended to pull out his eyebrows and eyelashes and, occasionally, his leg hair. He had no other psychopathology and had never tried to treat the problem. During military service, pressure from his peers made him seek help. When the patient showed strong resistance to arm-levitation techniques (Hammond, 1989), the treatment strategy was changed to the imaginative technique. As part of his job in the army, the patient had to read maps with special binoculars. We used this skill to direct him on an imaginative trip over his eyebrows and eyes. The patient was told that: "it might be interesting to take one of your map binoculars and take a look into one of your hair roots...and you may see now the details of the root...how delicate and sensitive it is...how easy can the others harm this tiny hair root...and you feel that you want to protect the hair root..."etc. By identifying with his hair, he can feel how he can take over and become the protector of the hair. One session was enough to eliminate most of the hair pulling. During the hypnotic session the patient was told he could occasionally resort to hair pulling in one small skin area if he felt it absolutely necessary, in order to avoid a symptom shift ("safety valve").

After 2 months he requested repeated therapy for a stronger effect. The hair pulling stopped completely after one session, and the improvement has been sustained for 6 months.

Case 3

This 17-year-old male had recently begun to pull out his eyebrows concurrent with the termination of a romantic relationship. The school counselor referred him after he

communicated his anger towards his girlfriend and told the counselor that he pulls his hair. He showed no DSM-IV (American Psychiatric Association, 1994) signs of major depression, but he was very anxious and induction was difficult at the beginning because he was afraid to close his eyes and “lose control.” During the session we performed a separation ceremony from the girl and the symptom, as it was assumed there was a dynamic explanation to the occurrence of the symptom in the time of separation. Then, we used the imaginative technique to change his self-aggression into self-care. At the 2-month follow-up, no trichotillomania was noted, and the patient reported better coping and higher self-esteem. The improvement in the trichotillomaniac behavior has been sustained for 6 months.

Discussion

We describe the successful use of the imaginative “patronage” in three cases of pure trichotillomania. Apparently, this method meets the patients’ deep need for control and provides them with an attractive alternative.

Imaginative techniques have been found to be very effective in children and adolescents because their imagination is developed but the boundaries between reality and fantasy are not yet fully formed (Olness & Gardner 1988). Using imaginative techniques to allow patients to examine their body from very close up adds another dimension that is particularly effective in adolescents, who are aware of every change in their bodies.

Watson and Allen (1993) reported on a 5-year-old child whose trichotillomania was controlled when a concomitant thumb-sucking habit was eliminated. They suggested that when trichotillomania is a benign habit disorder, it is easier to treat by indirect behavioral techniques. This may apply to our three patients as well who had “pure” trichotillomania and no other comorbid DSM-IV (American Psychiatric Association, 1994) diagnoses.

The technique suggested here should be a general frame for more individualized strategies. It is important to note that what is adequate for an 18-year-old soldier with high sensitivity to his image in his male peer group, does not essentially fit a girl in puberty with high occupation with her body changes.

We are aware of the limitation of this paper to prove a measurable success. Hair pulling is difficult to measure, and the complaint has subjective dimensions. However, the results are sufficiently promising to warrant further controlled studies.

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