

Hypnosis as a Vehicle for Choice and Self-Agency in the Treatment of Children with Trichotillomania

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Three pediatric cases of Trichotillomania were treated with direct hypnotic suggestion with exclusive emphasis on sensitizing and alerting the patients to impending scalp hair pulling behaviors. These children had presented with total lack of awareness of their scalp hair pulling behaviors until they had actually twisted and pulled off clumps of hair. It was also suggested, under hypnosis, that upon learning to recognize impending scalp hair pulling behaviors, the patients would become free to choose to willfully pull their hair or to resist the impulse and not pull. At no point was the explicit suggestion given that they stop pulling their hair. A preliminary condition was agreed to by the parents that redefined the patients' hair as their own property and affirmed their sole responsibility for its care and maintenance. An element of secondary gain was identified in each of these cases. Scalp hair pulling was hypothesized to provide these particular patients with a vehicle with which to oppose their overbearing and over-involved parents. The technique of direct suggestion under hypnosis, aimed at alerting the patients to impending scalp hair pulling behaviors was combined with forming contracts with the parents to relinquish their authority over matters regarding the patients' hair. This combination provided an effective treatment that extinguished the scalp hair pulling in 7 visits or less. These cases received follow-up at intervals up to 6 months and no evidence of relapse was found.

Keywords: Children, ego-strengthening, family, hypnosis, non-adversarial, obsessive compulsive spectrum, self-efficacy, Trichotillomania

Introduction

Trichotillomania is defined as the recurrent failure to resist pulling one's own hair. It is carried out as the culmination of a tension that mounts before the moment of plucking and is then released during or after the act (Maxmen & Ward, 1995). The majority of the reported cases focus on hair pulling in the area of the scalp but other sites include eyelashes, eyebrows and pubic hair. Hair loss to Trichotillomania varies from barely noticeable thinning to total loss (Maxmen & Ward, 1995). Christenson, MacKenzie, Mitchell & Callies (1991) found that most Trichotillomania patients had

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started the behavior within five years before or after puberty and had the problem for two years before seeking treatment. Co-morbidity is reported for most of the cases and parenthetically, it has been reported that only 18% of the cases that come in for treatment do not have another Axis I disorder (Maxmen & Ward, 1995). Mood disorders have been implicated as co-morbid conditions with Trichotillomania in about 65% of the cases, anxiety disorders in 57% of the cases, eating disorders in 20%, and/or substance use disorders in 22% of the cases (Christensen et al., 1991).

Although included under the classification of Impulse Control Disorders, Not Otherwise Specified in DSM IV (American Psychiatric Association, 1994), Trichotillomania has been hypothesized to share a relationship with OCD and has been included into what is conceptualized as an obsessive-compulsive spectrum (McElroy, Phillips & Keck, 1994; Rapoport, 1994; Stein, 2000). Tukul, Keser, Karali, Olgun and Calikusu (2001) reported on a comparison of clinical characteristics in Trichotillomania and obsessive-compulsive disorder. The findings indicated that their Trichotillomania group had a greater percentage of women and showed earlier age at onset. Their OCD group demonstrated a higher incidence of depressive disorders and Axis II personality disorders. Pryor, Martin and Roach (1995) reported on the efficacy of treating both Trichotillomania and OCD with the serotonin selective reuptake inhibitor fluoxetine, suggesting that such syndromes could share a common serotonin neurotransmitter disturbance, which suggests possible psychophysiological similarities between these two syndromes. The literature indicates that Trichotillomania in children is more likely to present in pure form, or that the symptom of hair pulling comes without any additional observable psychopathology (Zalman, Hermesh & Sever, 2001; Rowen, 1981; Kohen, 1996; Watson & Allen, 1993).

Treatment of Trichotillomania

Pharmacologic Treatment

Pharmacological treatments for Trichotillomania have included the use of the selective serotonin reuptake inhibitor fluoxetine (Pryor, Martin & Roach, 1995). The authors reported favorable results from fluoxetine in their case study of an 18-year-old female with Trichotillomania. Khouzam, Battista and Byers (2002) reported on Trichotillomania and its response to treatment with quetiapine (Seroquel). Their case study of a 33-year-old female veteran with Trichotillomania demonstrated a favorable clinical response to the atypical anti-psychotic quetiapine. Another pharmacologic approach to the treatment of Trichotillomania involved the use of a commercial topical cream that enhances pain sensitivity (Ristvedt & Christenson, 1996). The subject, a 38-year-old female, applied the cream daily to two affected areas on her scalp. The increased pain sensitization, in conjunction with the use of a habit reversal technique, resulted in decreased hair pulling.

Psychotherapy

Treatment approaches for this condition have emphasized behavior modification techniques (Stabler & Warren, 1974; Mannino & Delgado, 1969; Schachter, 1961). The literature also reports treatment with psychodynamic methods (Hynes, 1982; Masserman, 1955).

Hypnosis and Treatment

Hypnotic approaches to the treatment of Trichotillomania can be subsumed into two major categories. Both of these approaches reflect the same objective: making the patient stop the hair pulling. These approaches, however, pursue this common goal through different means. One approach states its therapeutic objective only implicitly. The second approach states the therapeutic objective overtly or explicitly.

The first approach includes Ericksonian-based indirect methods (Zeig, 1980) in which suggestions that the patient will stop the hair pulling are implicitly present but expertly couched and hidden by layers of disguising metaphorical language (Zalsman et al., 2001). Olness and Gardner (1988) reported on the use of an indirect Ericksonian-based approach for treating pediatric Trichotillomania, that included guiding the child to stroke herself as an alternative to pulling her hair. Zalsman et al. (2001) employed an indirect Ericksonian-based approach to treating Trichotillomania in adolescents, that they titled imaginative hypnotherapy (Hilgard, 1974). This approach focused on transforming the patients' self-aggression into self-care. The aim of the implicit approach, hidden suggestions notwithstanding, is to control the hair pulling and to eventually extinguish it. The position of the therapist, no matter how permissive the metaphorical language being employed may sound, can be interpreted as adversarial to the symptom and his/her role can be perceived by the child as one of passive executioner of the hair pulling habit.

The second hypnotically based approach for the treatment of Trichotillomania states its objective explicitly: to make the patient stop pulling his hair. Included in this group are approaches that employ aversive hypnotic conditioning involving the coupling of hair pulling behaviors with an intense feeling of nausea (Rowen, 1981). Galski (1981) associated hair pulling to the kinesthetic sensation of the pain one feels when sunburned skin is touched. The aim of the explicit approach is also to extinguish the hair pulling behaviors. There is no doubt that the position of the therapist employing this explicit approach is adversarial to the symptom and his/her role is of active executioner of the hair pulling habit.

Barabasz (1987) used a non-adversarial hypnotic method to successfully treat three adults with extended and complicated histories of Trichotillomania. Her approach avoided any direct suggestions under hypnosis that the patient stop the hair pulling. (Barabasz [1987] used extreme environmental restriction with her adult patients in order to attempt to increase their hypnotizability.) Her treatment results were maintained in long-term follow-up.

The use of hypnosis in pediatric cases has an extensive and well-established history. Documentation is ample in the use of pediatric hypnosis for the management of disorders of impulse control, habit disorders and dermatological conditions (Wester & O'Grady, 1981; Olness & Gardner, 1988; Crasilneck & Hall, 1985).

Clinical Cases

Population and Formulation

Repressed anger was hypothesized as the driving force behind the three pediatric cases of Trichotillomania reported herein. All three of the children came from authoritarian homes where at least one parent demonstrated over-involvement with the

patient and consistently limited and restricted the child's freedoms of expression and choice. Expressing anger openly was not an option in these households. Trichotillomania was hypothesized as a conduit used by these patients to resolve the anger it was presumed had been repressed. The families of these children were professional, successful, and high achievers in numerous pursuits. An interesting dynamic that was observed in each of these families was the failure to recognize and respect autonomy in their children. It appeared that decisions involving matters concerning the children were usually made without regard for the children's opinions. At first glance, the choices that these parents made on behalf of their children were, ostensibly, logical and appropriate. However, when choosing and deciding, they routinely failed to consider the child's point of view. Trichotillomania was further hypothesized to represent a manifestation of the child's basic need for autonomy.

Hypnotic and Non-Hypnotic Elements

Barabasz' non-adversarial method was emulated and adapted to children in this study. (Environmental restriction, however, was not employed as part of the treatment approach with the children in this study). In light of the developmental struggle between these parents and their children, an approach that placed the therapist in an adversarial position to the hair-pulling symptom would have created the same kind of oppositional stance towards the therapeutic situation that these children were exhibiting towards their parents. Instead, the role of the therapist and the goals of therapy were defined non-adversarially, in a way that emphasized boundaries, choice, and autonomy. The goal of therapy was consequently limited to the following definition: to successfully heighten the child's awareness of impending hair pulling behaviors. Moreover, it was further defined that to the degree that this mechanism operated successfully, the child would never pull his hair without knowing, ahead of time, that he/she was about to do so. Once the child had awareness of imminent hair pulling behavior, he/she was in a position to exercise free will: to pull or not to pull.

All three families agreed to, prior to start of therapy, to recognize their children's hair as their property and agreed that they could choose to do with it as they desired. A verbal contract was agreed to by each family, with the child present, which stipulated that no references to the child's hair would ever again take place. They also agreed to withhold punishment or recriminations for any instances of hair pulling.

The hypnotic sessions were 30 minutes long and included only the child. The accompanying parent was included during the last 15 minutes of each visit in order to provide a general overview of the child's progress and to reinforce the contract. An eye fixation with progressive relaxation hypnotic induction was utilized in each of the cases. Moreover, imagery of the child playing his/her favorite sport, non-competitively and for fun was employed for deepening. The following non-adversarial, direct suggestions under hypnosis were given.

Hypnosis Script

You will hear a bell ringing and will be acutely aware whenever your hand makes the slightest effort to move up to your head. Knowing, ahead of time, that your hand is intending to move up to your head gives you the power and the control to decide if you want to pull your hair or if you choose not to. Never again will your hair get

pulled without your awareness and your permission. Your hair is your property and it is your choice how to care for it.

Case Reports

Case 1

An 8-year-old boy presented with pure Trichotillomania of about 6 month's onset that coincided with his dad's recent remarriage. The stepmother was an overbearing woman who had taken over the day-to-day management of her husband's three children, including the patient. Her parenting style was authoritarian, and in keeping with this style she had ordered the child to stop his hair pulling. The patient was unaware of the pulling behaviors until he had a clump of hair in his hand. It was speculated that the hair pulling became the patient's manifestation for self-determination and autonomy and also served as a vehicle to torment the stepmother. Direct suggestions under hypnosis were made for the child to become immediately aware at the earliest movement of the hand towards his head. Suggestions were further provided that since he was a "big kid," he could decide like a "big kid" whether to pull or not. Ego strengthening suggestions (Hartland, 1971; Frederick & McNeal, 1999; Gorman, 1974; Hammond, 1990) were also provided at each visit. They were aimed at enhancing the child's self-confidence, autonomy and empowering the child with suggestions that he was in control of his life. After 5 visits the Trichotillomania behavior stopped. Follow-up visits at 3 and 6 months demonstrated no relapse.

Case 2

This 10-year-old boy already had a 2-½ year history of "seasonal" hair pulling. He was an avid swimmer and swam competitively for a community swim club. Since he cut his hair off during the swimming season, there was no hair pulling during these months. He pulled his hair the rest of the year. He was from a highly achieving family where he was expected to excel in multiple pursuits. His mother was highly demanding and over-involved in the child's life. The child denied knowing or being aware of the hair pulling behaviors until he had twisted and pulled off a clump of hair. The patient was treated with direct suggestions under hypnosis to sensitize him and make him immediately aware, at the earliest movement of the hand towards his head. He was also treated with guided imagery of swimming and given suggestions that swimming did not always have to involve competition; that one could also swim for fun. He was also told, under hypnosis, that once he became aware of impending hair pulling behaviors that it was his choice to proceed and pull his hair or stop and not pull it. He was also reminded that his hair belonged to him and he was responsible for its care and management. Ego strengthening suggestions (Hartland, 1971; Frederick & McNeal, 1999; Gorman, 1974; Hammond, 1990) were also provided at each visit. They were aimed at enhancing the child's self-confidence, autonomy and empowering the child with suggestions that he was in control of his life. After 7 visits, the hair pulling behaviors stopped. A follow-up visit 6 months later, after the swimming season and after he again let his hair grow, demonstrated no evidence of relapse.

Case 3

This eleven-year-old girl presented with a well-established case of Trichotillomania. She had been pulling her hair for about a year. The patient was a high academic achiever who also excelled in several sports. The hair pulling was only *evident* during the course of each athletic season or, said differently, during the period of time that the patient was participating in a sport. The patient's father was observed to be an unreasonably demanding man who was over-involved with his daughter. She was unaware of the hair pulling behaviors and expressed dismay whenever a clump of hair "appeared" in her hand. The father accepted the premise that he was possibly adding too much pressure to his daughter with regards to her performance in sports and agreed to limit his comments about this subject. She was treated with direct hypnotic suggestion with an emphasis on making her aware of impending efforts to bring her hand towards her head. It was suggested, under hypnosis, that it was entirely her choice to pull her hair or stop. It was also suggested, under hypnosis, that there was going to be less stress associated with her performance in sports and that they would become more enjoyable. After six visits the hair pulling stopped. Ego strengthening suggestions (Hartland, 1971; Frederick, & McNeal, 1999; Gorman, 1974; Hammond, 1990) were also provided at each visit. They were aimed at enhancing the child's self-confidence, autonomy and empowering the child with suggestions that she was in control of her life. Follow-up one month, two months, and six months later demonstrated no evidence of relapse.

Discussion

The successful use of direct hypnotic suggestion, with an exclusive emphasis on sensitizing and enhancing immediate awareness of impending hair pulling behaviors, was employed in three cases of pure pediatric Trichotillomania. Additional therapeutic components included successfully persuading the parents to relinquish their authority over matters concerning their children's hair, and conveying to each child patient important messages about his/her boundaries and rights. These elements of the treatment provided the therapist with a milieu in which he could confidently make the hypnotic suggestion that the patient had the choice to pull his/her hair or not pull it.

The technique of direct suggestion under hypnosis has been effectively used with children (Olness and Gardner, 1988), but, as these authors aptly point out, it has to be accompanied by attention to and resolution of the underlying dynamics of the behaviors in question. The core dynamic in each of these cases was hypothesized to be rebelliousness and a protest against overbearing parents. The resolution of this dynamic was achieved by negotiating for the patients the acquisition of control and autonomy over their hair. Additionally, these patients were products of highly demanding and competitive households, and it was hypothesized that internalization of demands and competitive attitudes could be contributory to the overall significant stress and pressure with which the patients were struggling (and which probably contributed to symptom production). To help reduce these internal pressures, hypnotic suggestions that redefined competitive sports into activities that could also be engaged in for simple pleasure and enjoyment were given. Ego strengthening suggestions (Hartland, 1971; Frederick & McNeal, 1999; Gorman, 1974; Hammond, 1990) were also provided at each visit.

At no point were direct hypnotic suggestions made that indicated to the patients that they should stop pulling their hair. Instead, direct suggestions under hypnosis indicated that as they became cognizant, ahead of time, of hair pulling behaviors, they were becoming increasingly “in control” of their lives. This control could be experienced as a freedom to decide and then carry out either choice: to pull or not to pull.

It is believed that the significant therapeutic alliance that was achieved with these children came as a result of a non-adversarial treatment posture adopted by the author. This posture communicated an unconditional positive regard to the children that was devoid of the parents’ condition that they had to stop pulling their hair. Unconditional positive regard is a relationship variable that has been posited as a necessary condition for positive change to occur in psychotherapeutic relationships (Rogers, 1951, 1957, 1961). To the degree that the children were regarded unconditionally, and to the degree that the treatment became non-adversarial, the children, in turn, accepted the hypnotic suggestions free of obligations and/or expectations. This allowed for the success of the treatment to be attributed to the children’s renewed sense of empowerment and self-efficacy (Bandura, 1977). The success of the treatment and the changes effectuated in the lives of the children embraced more than the management of Trichotillomania. The therapy allowed the children to literally achieve identity and psychosexual advances and growth (Erikson, 1968) that resulted in ego-strengthening and increased sense of autonomy and personal worth.

It is hypothesized that the crucial psychodynamic issues addressed by the family interventions and hypnotically facilitated psychotherapy of these children were:

- Allowing the children to experience a new, healing model of unconditional acceptance, cooperation, and respect in the therapeutic alliance.
- Allowing the children to experience new, healing models of unconditional acceptance, cooperation, and respect in the changed behavior of their parents.
- Strengthening boundary formation in both children and parents.
- Facilitating the normal developmental emergence of autonomy (Erikson, 1968) and self-efficacy (Bandura, 1977) and consequently “strengthening the egos” of the children (Frederick & McNeal, 1999; Hartland, 1971).

As Hartland (1971) reminded us, it is when patients’ egos are strengthened that they are able to relinquish their symptoms.

As distinguished from Barabasz’s (1987) adult patients, the patients described herein entered trance easily. The relatively easy hypnotizability of these children was hypothesized to be a result of innate predisposition for trance states in the young. This point is eloquently elaborated by Gardner and Olness (1988). These authors further asserted the need to select an age appropriate induction technique when working with children. The eye fixation technique employed for induction of hypnosis in the three cases presented in this study was selected based on the guidelines offered in Gardner and Olness (1988).

Possible contraindications to this approach would be its use in children with Trichotillomania that is not pure, but rather is complicated by Obsessive Compulsive

Disorder (OCD) that could cloud the ability of the child to actually make a choice; the presence of the symptoms of hypomania, mania, or psychosis; or other seriously compromising co-morbidities that could compromise the childrens' decision-making abilities.

There are always limitations inherent in case studies. Generalizability is not possible because of small sample size, and issues of validity and reliability are a major source of statistical weakness. However, the case studies described suggest that there is merit in considering further investigation of the efficacy of the treatment approach used with these patients.

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