

Expert Consensus Treatment Guidelines

Body-Focused Repetitive Behaviors

Hair Pulling, Skin Picking, and Related Disorders





This pamphlet is a project of the Scientific Advisory Board of
The TLC Foundation for Body-Focused Repetitive Behaviors.

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The information in this booklet is not intended to provide treatment for body-focused repetitive behaviors. Appropriate treatment and advice should be obtained directly from a qualified and experienced doctor and/or mental health professional.

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If you or someone you love is suffering from a body-focused repetitive behavior (BFRB) such as trichotillomania (hair pulling disorder) or excoriation (skin picking) disorder, you may feel alone, confused, frightened and in need of help. Many professionals have outdated or simply erroneous information regarding effective treatment options. Members of the Scientific Advisory Board of The TLC Foundation for Body-Focused Repetitive Behaviors have reviewed the latest research and clinical information, and provide these guidelines for individuals seeking treatment for these problems.

Despite data showing that BFRBs are quite widespread (an estimated 2% - 5% of the general public suffer from trichotillomania; 5% from skin picking), few professionals have current information about effective treatment for these conditions. Often, clients or family members have more accurate information about their disorder than their treatment provider. This booklet summarizes the nature of BFRBs and provides treatment recommendations by recognized experts in the field.

What are BFRBs?

BFRB is a general term that refers to any repetitive self-grooming behavior (e.g., pulling, picking, biting or scraping of the hair, skin or nails) that results in damage to the body. In addition to hair pulling, common BFRB behaviors include picking or biting of the skin (e.g., scabs, acne or other skin imperfections), cuticles or nails, and lips or cheeks. These behaviors are all considered BFRBs because they share similar characteristics. The difference between normal grooming behaviors and a BFRB arises when the behavior(s) cause substantial personal distress and/or interfere with daily functioning. The two most common BFRBs are trichotillomania (hair pulling disorder) and excoriation (skin picking) disorder.



Trichotillomania

Trichotillomania is characterized by repetitive pulling out of one's hair (from the scalp, eyebrows, eyelashes or elsewhere on the body). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) of the American Psychiatric Association, trichotillomania is defined as meeting the following five criteria:

- Recurrent pulling out of one's hair, resulting in hair loss.
- Repeated attempts to decrease or stop hair pulling.
- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
- The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Excoriation (Skin Picking) Disorder

Excoriation disorder, also known as skin picking disorder, is characterized by repetitive manipulation of the skin causing tissue damage. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition) of the American Psychiatric Association, excoriation disorder is defined as meeting the following criteria:

- Recurrent picking at the skin resulting in skin lesions.
- Individuals must have made repeated attempts to decrease or stop the excoriation.
- The skin picking causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.
- The skin picking is not attributable to the psychological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies)
- The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body-dysmorphic disorder, stereotypes in stereotypic movement disorder, or intention to harm oneself in non-suicidal self-injury).

*The *International Statistical Classification of Diseases and Related Health Problems (ICD-10)* contains codes for trichotillomania and skin picking disorder. We favor the criteria and description used in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

Information on BFRBs

How does one experience a BFRB?

Many people who engage in BFRBs find that these behaviors often occur during sedentary activities, such as when lying in bed, reading, listening to a lecture (in class), riding in or driving a car, using the bathroom, talking on the phone, working on the computer or sitting at a desk at work. During pulling or picking, a person might be fully focused on their BFRB (e.g., looking in the mirror while picking acne, usually trying to achieve smooth skin, remove a perceived imperfection or enhance healing). Other times, these behaviors may be performed in a less focused manner, only realizing it when a pile of hair is discovered, scratches on the skin, open scabs or bleeding fingers occur.

For some, there is a sensation that draws the fingers to the site of picking or pulling. These sensations can include itching, tingling, pain or other physical experiences. For others, there is no sensation prior to engaging in the picking or pulling behaviors. In these cases, the individual is seeking a sensation, either on the fingers or elsewhere (e.g., running the hair root along the mouth, rubbing a coarse hair between fingers, or seeking the smooth sensation after a scab is removed). Other times people report that they are searching for a particular characteristic of the hair (thicker, coarser, or bumpier) or skin (rough, jagged, or bumpy) in order to remove or fix the perceived problem.

For some people, searching behaviors are part of the process, such as rubbing the fingers over the skin or in hair to find a hair or skin irregularity on which to focus. Further, some individuals will examine the product of their pulling or picking by looking at it closely, rubbing it on their skin, face or lips, smelling it, chewing or swallowing it, or rolling it between their fingers.

The severity of these behaviors varies greatly. Hair pulling can result in small areas of thinning hair, bald patches or extensive baldness that is difficult to conceal. Many people who pick at their skin develop scabs or sores that do not heal because of repeated picking. Sometimes skin can become infected or scarred, resulting in permanent damage that can exacerbate feelings of shame.

Although BFRBs may, in some forms, be relatively benign, when they are done in excess they can cause serious medical problems. For the subset of individuals who swallow pulled hairs, gastrointestinal distress or even digestive blockage called a **trichobezoar** or hair ball can occur, sometimes requiring surgical removal. This is a very serious medical condition that may require immediate action. It is important to see a doctor if you or your child eats their hair.

Regarding skin picking, it is **important to keep wounds clean and treat them with antibiotic cream** to prevent infection. In some cases, frequent practiced BFRB may result in repetitive motion injuries.

In addition to these physical and medical problems, most people who engage in BFRBs also experience some degree of shame, secrecy, and isolation. Because people with BFRBs often feel ashamed of their behavior, they don't talk about it and may try to hide the problem. As a result, **many sufferers feel isolated, confused and reluctant to share their secret with loved ones or to seek advice or treatment from professionals**. Unfortunately, this secrecy contributes to a general misperception that the behavior is less common than it actually is. These complicated feelings also may contribute to interference with intimate relationships, work or study, and avoidance of activities that would otherwise be pursued.

When do BFRBs begin?

BFRBs typically begin between the ages of 11 and 15 years. The onset of hair pulling is generally in the younger range (11-12 years old) than the onset of skin picking (14-15 years old). The appearance of acne with resulting squeezing and picking of pimples is likely to be involved in the emergence of skin picking for many individuals. However, BFRBs can start at any age. Some children begin hair pulling or skin picking in early childhood with cases of hair pulling reported as early as 1 year of age. Early onset hair pulling is often accompanied by thumb sucking. Some experts think that early onset hair pulling is less likely to develop into a long-term behavior than hair pulling that begins at a later age.

Among adult hair pullers, females outnumber males 9 to 1, though the ratio of males and females is roughly equal when hair pulling starts in childhood. It is unclear why many more females than males begin pulling around the time of puberty. Some have proposed hormonal differences between the genders and increased pressure on females regarding their appearance. It is also possible, however, that adult males are not as willing to seek treatment as females, artificially skewing the reported ratio.

What causes BFRBs?

It is unclear why some people engage in these behaviors and others do not. Research indicates that some people may have an inherited predisposition for skin picking or hair pulling. Several studies have shown a higher number of BFRBs in immediate family members of persons with skin picking or hair pulling than would be expected in the general population. Further evidence from a twin study showed higher concordance, or agreement, in the occurrence of hair pulling in identical vs. fraternal twins. Given the possibility that some or

all BFRBs have a genetic origin, researchers are currently studying the genes of people suffering from BFRBs in an effort to isolate gene markers that may clarify the origins of these problems and, it is hoped, lead to more effective treatments.

It is important to note that even if a predisposition toward BFRBs is inherited, there are certainly other factors involved including temperament, environment, age of onset, and family stress factors. Hair pulling and skin picking can be seen in other species such as primates who pick at nits and other insects on their own fur and the fur of others; birds who are stressed will pull out their feathers; mice have been known to pull their own fur and that of their cage mates; and dogs and cats may lick their skin or bite at an area, removing fur until there are bald spots and sometimes damage to the skin. Animal researchers are trying to understand these similar-appearing behaviors in animals to shed light on the complex neurobiology that underlies the human experience of BFRBs.

Common misunderstandings about BFRBs

Are BFRBs OCD?

Although individuals with BFRBs engage in repetitive, seemingly compulsive behaviors, there are enough differences between BFRBs and OCD to suggest that these are different disorders. Currently, hair pulling and skin picking are classified as *Obsessive Compulsive and Related Disorders* in the *DSM-5*.

Do BFRBs mean that there is a deeper problem?

Some people assume that hair pulling or skin picking is a sign of some unresolved issue or problem that needs to be addressed for the BFRB to get better. Current evidence suggests, however, that these behaviors are not generally an indication of deeper issues or unresolved trauma.

Are hair pulling and skin picking a form of self-mutilation?

Those who engage in BFRBs do so to relieve stress or to experience gratification or other sensations. This is in contrast to those who self-mutilate to intentionally harm, punish or attempt to distract themselves from intolerable emotions. Thus, BFRBs do not appear to be a form of self-mutilation, but rather, are separate and distinct disorders.

Recommended treatment for BFRBs

The most important thing that a person can do to address a BFRB is to first become knowledgeable about the problem and its treatment. The TLC Foundation for Body-Focused Repetitive Behaviors (www.bfrb.org) provides up-to-date information regarding BFRBs, with guidance from its Scientific Advisory Board, comprised of expert clinicians and researchers working in this field. Books, lectures, videos, webinars, professional training and articles are all available through the foundation, as well as educational events that are held regularly around the country for interested therapists and for individuals and families whose lives have been affected by BFRBs. The internet can be a valuable source of information; however, caution must be taken as there are BFRB-related websites, chat rooms and products available online which can provide questionable advice. A list of resources approved by the foundation's Scientific Advisory Board is available at the end of this booklet.

Psychotherapy

A psychotherapy approach called cognitive behavior therapy (CBT) is the treatment of choice for BFRBs. Existing studies suggest that CBT is superior to medication in treatment outcome. However, some individuals may need medication first or in conjunction with CBT.

Cognitive Behavior Therapy

CBT is a therapeutic approach that focuses on identifying thoughts, feelings and behaviors that are problematic and teaches individuals how to change these elements to lead to reduced stress and more productive functioning. An emphasis is placed on matching the treatment to the unique symptoms of the individual. There are a number of different treatment approaches for BFRBs that fall under the umbrella of CBT: habit reversal training (HRT) and comprehensive behavioral treatment (ComB). Acceptance and commitment therapy (ACT), and dialectical behavior therapy (DBT) are two treatment approaches that may bolster the effectiveness of other cognitive behavior therapies.

Habit Reversal Training

Habit reversal training (HRT) is an early treatment for BFRBs developed in the 1970s by Nathan Azrin and Gregory Nunn. HRT is the method that has been examined most in research studies. HRT has a varying number of components in its treatment package. The three components that are considered most critical are awareness training, competing response training and social support.

Awareness training consists of helping the person focus on the circumstances during which pulling or picking is most likely to occur. This enables individuals to become more aware of the likelihood that the behavior will occur, and therefore provides opportunities for employing therapeutic techniques designed to discourage performance of problem behaviors.

Competing response training teaches the individual to substitute another response for the pulling or picking behavior that is incompatible with the BFRB. For example, when an individual experiences an urge to pull or pick, he/she would ball up their hands into fists and tighten their arm muscles and “lock” their arms so as to make pulling or picking impossible at that moment. This response is to be repeated each time that individual experiences an urge to pull or pick or when faced with a situation where pulling or picking is likely to occur.

Social support involves bringing loved ones and family members into the therapy process in order to provide positive feedback when the individual engages in competing responses. They may also cue the person to employ these strategies and provide encouragement and reminders when the individual is in a trigger situation.

The research literature is encouraging using HRT for short-term improvement; however, professionals and sufferers have found that when used by itself, achieving long-term improvement in symptoms is much more difficult.



Comprehensive Behavioral Treatment

The comprehensive behavioral (ComB) model, developed by Dr. Charles Mansueto and his colleagues, is based on the assumption that a person engages in their BFRB because it meets one or more need in the individual (e.g., helping to relax, to fall asleep, or to feel like a goal was accomplished). This model focuses on understanding why, where and how a person engages in their BFRB so that individualized interventions can be selected to help the person achieve what they want to achieve without engaging in the BFRB. The ComB model consists of four components: Assessment, Identify and Target Modalities, Identify and Choose Strategies, and Evaluation. It focuses on understanding five domains: Sensory, Cognitive, Affective, Motor, and Place (SCAMP).

Assessment/Self Monitoring

Using the ComB approach, the therapist and client complete a thorough assessment of the functions that the behaviors serve for the individual as well as the internal and external triggers for the BFRB. Internal triggers may be sensations, thoughts and feelings, while external triggers may be places and activities that lead to pulling or picking. Clients spend time monitoring behavior between sessions to illuminate all aspects of the behavior.

Choosing individualized strategies

The therapist helps the client explore the use of individualized strategies selected specifically to target internal and external triggers of the BFRB. For example, if itching is a trigger and scratching starts or leads to pulling, the individual might be encouraged to use a wide tooth comb as a sensory substitute, not only to provide relief for itching, but also to discourage the fingertips from making contact with the scalp. An individual who picks scabs to feel the smooth sensation on the skin might be directed to carry a smooth stone with her to manipulate when she wants to feel the smooth sensation. Another person who picks skin or pulls hair to reduce worrisome thoughts might be taught cognitive interventions for reducing worry. Each intervention is strategically designed to address unique needs that are achieved by picking or pulling.

Internal and external triggers for BFRBs

Internal triggers refer to sensory experiences (sight, touch, smell, taste and sound), thoughts and feelings that can trigger a BFRB episode. Interventions are selected specifically to address needs in any of these areas. For example, if a person has a belief that “all coarse hairs must be removed,” an intervention would focus on challenging this thought and changing this rigid belief. External

triggers for BFRBs refer to identifying the environment or activities that typically lead to a BFRB and finding ways to alter them in order to reduce the behavior. For example, for those individuals who engage in picking or pulling in front of a mirror, it might be recommended that the mirror be removed or covered for a period of time or that the lights in the bathroom be dimmed to reduce the ability to see. Knowing when and where the behavior is likely to happen is helpful. Techniques to raise awareness of the behavior are important because many people engage in BFRBs in a habitual or automatic way, without much awareness of their behavior. Barriers such as gloves, Band Aids, medical tape or hats are used to raise awareness so that an individual can become more conscious of their behavior and ultimately change it.

The ComB model provides a useful framework for pullers and pickers to evaluate the triggers and consequences to their behavior. This model also suggests tools to increase behavioral awareness and multiple and varied interventions for early prevention as well as all throughout the behavior chain that leads to picking and pulling. This treatment has had limited empirical evaluation to date though studies are currently being conducted.

Acceptance and Commitment Therapy

A promising treatment approach that may serve to add strength to other cognitive behavior therapies is called acceptance and commitment therapy (ACT), developed by Steven Hayes. This approach differs from others in that it **promotes an increased acceptance of, and tolerance for, urges to pick or pull, without acting to reduce or eliminate them.** Thus, individuals are asked to experience negative emotions that come before or after pulling as events to be observed without judgment rather than as events that must be acted upon. Understanding, feeling and experiencing that one does not have to respond to an urge or emotion can be quite freeing.

Understanding a Patient's Values

A key part of ACT is to understand what is meaningful and important to the individual. What do they want to be remembered for? The rest of treatment is set in this context. Patients ask themselves throughout treatment if what they are doing in the BFRB process is moving them in a way that is consistent or inconsistent with their stated values.

Understanding How Patients Relate to Urges and Negative Experiences

Part of the therapy process involves discussing how the patient uses pulling/picking and other methods to reduce or eliminate urges, anxiety, or sensations that they experience as unpleasant. Through this process, it is often the case that patients have not found an effective and healthy strategy to control these

experiences that does not also prevent them from doing things that they value.

Seeing Internal Experiences for What They Are

A large part of ACT involves teaching patients what private experiences like urges, thoughts and emotions are, and what they are not. Often, people treat their private experiences as if they must cause pulling to occur or must cause people to react. However, through various exercises, patients are taught to understand what urges, thoughts and emotions are—events that a patient can choose to react to or not react to—and that these events are temporary. Often, people have a tendency to try to eliminate unpleasant experiences. In ACT, mindfulness-based strategies are used to teach patients to openly accept (not necessarily enjoy or like) any internal experience they have without trying to reduce, modify, or eliminate them.

Commitment to the Process

The individual will need to commit to working on their difficulties by experiencing and tolerating these thoughts and emotions instead of attempting to avoid them.

ACT-Enhanced Behavior Therapy

Dr. Douglas Woods and his colleagues developed an ACT-enhanced behavior therapy that **combines principles of ACT with other strategies typically used to treat BFRBs, including HRT and stimulus control**. These latter strategies are employed only to make the pulling or picking more difficult for the individual (not to eliminate urges) so the individual can engage in more value-driven activity.

Early research has documented that the use of ACT-enhanced habit reversal treatment is more effective than a control condition in reducing pulling symptoms. Importantly, short-term treatment benefits were also maintained several months after treatment termination. Additional research is needed to confirm these findings. A large-scale randomized, controlled trial of ACT-enhanced behavior therapy is underway.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT), a treatment developed by Marsha Linehan, is another treatment approach that may add to the effectiveness of other learning-based therapies. DBT was researched by Dr. Nancy Keuthen in conjunction with more traditional habit reversal and stimulus control approaches. A pilot and a randomized controlled study demonstrated the superiority of DBT-enhanced behavior therapy to a minimal attention control condition for TTM. Maintenance of treatment benefit months after treatment termination was demonstrated. As with all other approaches discussed earlier,

additional research is needed to confirm treatment efficacy and to understand the mechanisms by which they reduce symptoms. This approach has not yet been utilized to treat BFRBs other than hair pulling.

DBT has four modules including mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. In DBT-enhanced behavior therapy, all of the modules were utilized except for interpersonal effectiveness. These modules are discussed below.

Mindfulness

This module borrows from Buddhism in its focus on living in the moment and experiencing feelings and senses fully with a nonjudgmental perspective. Mindfulness can help the individual to be more aware of BFRB triggers and early motor movements that precede the BFRB, reduce worry by being present-focused and accept and tolerate powerful emotions without acting on them.

Emotion Regulation

This module instructs individuals in how to better manage their emotions using the follow techniques:

- Identify and label emotions
- Identify obstacles to changing emotions
- Reduce vulnerability to emotions
- Increase positive emotional events
- Increase mindfulness to current emotions
- Take opposite action
- Experience uncomfortable emotions without acting on them

Given that emotions often trigger picking and pulling behavior, the goal is to instruct the individual in more functional methods of emotion regulation that can preclude the need for engagement in the BFRB.

Distress Tolerance

This module is designed to instruct the individual in different ways to tolerate or get through a crisis situation in the short-term without making it worse. These techniques can be employed to tolerate uncomfortable urges to pull or pick without acting on them.

Note: The types of cognitive behavior therapy described above are not mutually exclusive. Elements derived from several approaches may be helpful for an individual striving to manage a BFRB.

Children with BFRBs

Children with BFRBs can be treated quite effectively using the same cognitive behavioral approach used for treating adults; however, there are some special considerations. When children are experiencing difficulty with BFRBs it becomes a challenge for the entire family, therefore treatment should include parents for some portion of the therapeutic process. It is common for parents to be highly motivated for treatment, while children are typically less motivated. Therapists experienced in working with children can assist in constructing a well-developed reward system to help initiate and strengthen behavior change and they can work with the child and parents to develop techniques to successfully sustain new non-damaging behavior patterns. Each developmental stage of childhood encompasses unique challenges that also need to be considered during the treatment process.

Very young children

When BFRBs occur at this stage (0 to 5 years old), the parents must be primarily involved in the treatment. Children at this age are quite used to having their parents guide, direct, pace and structure their behavior and their environments. Since children at this age are so dependent on their parents for most of their needs, having the parents structure, guide, and pace the treatment at home is very consistent with this developmental stage. Very young children often respond well to treatment. At this stage it is completely up to the parents to oversee, monitor and manage the entire treatment process with the guidance of a trained therapist.



Elementary-aged children

When children 6 to 11 years old engage in BFRB behavior, the treatment is similar to that of the very young; however these elementary school ages are more able to engage in treatment. Children at this age may not be strongly interested in reducing their BFRB, but can be encouraged to do so with the use of effective positive reinforcement. At this stage, children are able to be more self-aware, articulate and are often interested in the world around them. To assist in engaging the child at this age, introducing a well-developed reward system where the focus is on successfully using intervention techniques or strategies (and not on the act of pulling/picking) can be most helpful.

Middle school-aged children

Pre-adolescent children (aged 12-14) are certainly more independent; however, they still need some guidance, support and structure from the family. A reward system at this age often works well to focus and motivate the child. Allowing the children to fully participate in their own treatment and engage in developing the strategies, intervention techniques and structure will be most successful. Often the family will need support and guidance themselves regarding their own involvement in therapy. Many parents need regular feedback with respect to how much help they should be giving, how to provide help, and what to do if they see their child pulling or picking. During treatment the parental role will evolve and change, depending upon the child's temperament, needs and stage of treatment.

Adolescence

Older adolescents, aged 15-18 years, are able to be actively engaged in treatment, without much involvement of parents. In the best of circumstances, the teenage years are a challenging time, but when a teen has the added burden of struggling with a BFRB, this stage of life can be extremely painful. Teenagers will benefit from a degree of privacy about their picking or pulling behaviors while in treatment. Thus, parental contact with the therapist will likely be more limited than with younger children. Parents may wonder what is taking place in therapy and may be impatient to observe progress. Teenagers often need time to process information in their own way and move at their own pace. Therapy might consist of helping adolescents become ready to actively engage in therapy. Other times, teenagers may simply not be ready or willing to start active treatment, even if their parents are more than ready.. Parents will need a lot of support to help navigate this challenging time and may want to get some support and guidance in addressing their own concerns to help relieve the pressure at home.

Medication for BFRBs

While the main treatment for trichotillomania and skin picking is behavior therapy, medications often can be helpful. **No one medication helps everyone with skin picking or hair pulling**, though a few have been found to reduce symptoms in some individuals.

Medications are often used to lessen feelings or sensations that can increase picking or pulling rather than treat the disorder itself. Some research has suggested that taking medications temporarily allows individuals to make better use of behavioral techniques that would otherwise not have been as helpful. Some medications work only if taken every day, while others may help if taken as needed for certain times of the day or stressful situations.

Unlike with other psychiatric disorders such as OCD, we are less clear about the neurologic system or chemical messengers that are involved with BFRBs, therefore experts are less certain about which medications to prescribe for BFRBs. Glutamate, GABA, serotonin, and dopamine are some chemical messengers or neurotransmitters thought to be involved in BFRBs.

Over the past 15 years, many of the medications used for OCD and other anxiety disorders have been tested on subjects with BFRBs, with limited success. That said, there is still a certain subset of people who do benefit, especially those with additional psychiatric conditions such as depression or anxiety.

In some studies, skin picking and hair pulling were shown to improve moderately with the use of medications, but these results are not compelling enough to suggest that any one medication is the single best choice for BFRBs. As of the printing of these guidelines, **there has not yet been any single medication or combination of medications approved by the Food and Drug Administration (FDA) for the treatment of BFRBs.**

Much of the choice in medication treatments is based on the doctor's clinical experience. **If a medication is considered helpful for other current symptoms (e.g., depression or anxiety), then it should be tried first.** Safe treatment should be given priority, such as when using medications in children and pregnant women, and the risks must always be weighed against the benefits.

As there are too many types of medications to discuss individually in this booklet, they are categorized on the following pages as either taken every day, only when needed, or applied to the skin, such as topical medications.

Daily medications

Psychoactive medications usually need to be taken on a regular basis to be helpful, and often take weeks to start working. Selective serotonin-reuptake inhibitors (SSRIs) are prescribed for anxiety and depression. Scientific studies using SSRIs for TTM and skin picking show mixed results, though positive to a mild degree or for small numbers of people. Many individuals report that their effects seem to wear off over time. Other medications of interest have included opioid antagonists (pain blockers), mood stabilizers and dopamine blockers. N-acetylcysteine (NAC) is an amino acid that has been tested in a controlled study for trichotillomania, and was proven effective for over half the participants. There have been promising open trials of the over-the-counter supplement N-acetylcysteine for skin picking suggesting that a non-prescription alternative may be useful for at least some people with BFRBs. Another food supplement, Inositol is also being investigated as potentially beneficial for BFRB sufferers.

Medications used as needed

While medications for depression and other disorders must be taken every day for them to work, this may not be true for all drugs helpful for BFRBs. Tranquilizers can be used at times of stress or anxiety to prevent a flurry of pulling or picking. SSRIs or tranquilizers used cyclically can diminish premenstrual tension. Antihistamines may be taken to reduce itching and help with insomnia. As trying to fall asleep can be a difficult time to resist BFRBs for some, sleeping pills can be used to facilitate sleep onset.

Skin medications

Often skin problems are the cause of picking or pulling and medication applied to the skin can aid in reducing them. Itching can be reduced using topical steroids or antihistamine cream. Bumpiness of the skin or pimples may be prevented or treated with acne medications or other dermatological treatments. Tingling



is often described as a trigger for hair pulling and may be modified by astringents, topical anesthetics, or creams causing a mild burning sensation (often containing capsaicin). When dermatological issues seem to underlie pulling or picking, consultation with a dermatologist is appropriate.

Treatment is a process

Behavior change is a process that involves both forward and backward movement over time. Even with successful treatment of BFRBs, slips are often a normal part of the landscape and should be expected. It is important to understand that treatment is typically not a miracle cure that results in complete remission of the problem, but that improvements are more likely to be slow and steady. When slips in behavior occur, it is important to ascertain why they happened and refocus on getting back on track. Being negative or giving up is not helpful and can lead a person to a complete relapse. When slips are handled well, learning can take place and improvement in behavior can follow.

To minimize slips and setbacks, it is essential to remain vigilant. **Once a BFRB has developed, it is important to be aware that it is possible to reoccur, even after a significant period of remission.** In the event of the return of the BFRB itself, or of strong urges, techniques and strategies that worked best during active treatment can be re-employed during vulnerable phases. Some individuals find it especially useful to check in with their therapist for added support. In some situations, the formerly useful techniques may no longer be as effective as they once were. This would present a good opportunity to see a therapist and explore some additional interventions or approaches.

Some individuals do not handle slips well and are at risk for relapse. These individuals may feel as though they were cured of the problem and therefore view a recurrence as a sign of failure. For others, the pulling or picking episode is viewed as just a phase. Often, such individuals take a wait-and-see attitude and do not employ problem-solving or effective management techniques. In both of these circumstances, relapse is highly likely.

Effective maintenance includes:

- Acceptance of the lapse and a willingness to re-engage in problem-solving and reinstate the use of techniques that have been successful in the past.
- Assumption of a nonjudgmental perspective in which the likelihood that the BFRB or urge may come back from time to time is acknowledged and accepted.
- Willingness to contact a therapist to enlist appropriate support when necessary.
- When the individual acknowledges the possibility of a slip and is willing to use appropriate and effective resources, maintenance can be quite successful and manageable.

Treatment Considerations

When choosing a treatment or treatment provider, there are some important ideas to take into consideration. There are some treatments that may have worked for a few people, yet no scientifically valid studies support their efficacy and therefore they are not typically recommended by expert clinicians. Diets, electric stimulation, massage, acupuncture and hypnosis are all approaches which lack adequate research to be recommended by expert clinicians. Some of these approaches might prove useful as an adjunctive or additional treatment to use with cognitive behavioral treatment, but they cannot be recommended as stand-alone treatments.

Other approaches, such as “miracle cures,” “secret remedies,” or “simple solutions” promised by some websites are also unsupported and thus not recommended by the scientific community or by The TLC Foundation for BFRBs. Remember, any treatment that might work for one person, may not work for most or all people. The treatment approaches endorsed in this booklet are derived from cognitive behavioral principles and behavioral and medical research. Thus they are based on scientific evidence.

The Toll of BFRBs

People who experience BFRBs often have other important issues to discuss in therapy. Many sufferers experience shame, isolation and low self-esteem as a result of coping with their BFRB for years. Many individuals have been reticent to establish close interpersonal relationships or have not pursued vocational interests. These problems do not simply disappear once the behavior is being addressed. The therapist must assist individuals to develop skills in these areas as well. If too much attention is paid to the picking or pulling and none to these life issues, the individual has a much higher chance of relapse. However, if too much attention is paid to these life issues and little to the picking or pulling behavior, the individual will likely not experience improvement in their BFRB. **Finding a therapist who can balance the important needs of individuals with BFRBs is critically important.** The TLC Foundation for BFRBs may be able to help you find a trained professional in your area. If you are currently in treatment with a caring therapist who would like to learn about treating BFRBs, the foundation has been training professionals since 2004 through its Professional Training Institute.

What can families and friends do to help? As a family member of someone with a BFRB, it is also important to be well informed. Well-meaning friends and family members often wish to be helpful, yet at times their efforts can actually



be hurtful and may even contribute to the problem. Maintaining a supportive role and making efforts to communicate directly, but in a sensitive manner with the person you are trying to help can be beneficial. In addition to effective communication, patience and flexibility can be very important for family members who are attempting to help an individual with a BFRB.

It can be extremely difficult to be a loved one of someone who is suffering with a BFRB, and it is very important to take care of yourself as you try to support and assist your family member. Books, self-help groups and other resources are available to family members who need extra support. To be a supportive, helpful, and fully invested resource, it is important that you are strong, informed, empathetic and calm when helping your loved one.

How You Can Get Involved

If you or someone you love is affected by BFRBs:

Join the TLC community to find support and resources to help you take charge of your recovery from body-focused repetitive behaviors. Foundation members receive discounted event pricing, free admission to live webinars, exclusive access to our members-only website content, and our quarterly *InTouch* newsletter.

If you are a mental health professional:

Attend our training programs to improve your ability to identify and effectively treat hair pulling, skin picking, and related body-focused repetitive behaviors. Become a professional member to stay up to date on research, treatment developments, and to obtain a referral listing on our website.

If you are a researcher:

Participate in breaking new ground in the treatment of body-focused repetitive behaviors—a still little understood category of disorders in the OCD spectrum affecting at least three percent of the population. Partner with leading scientists from around the world on truly cutting-edge research.

Additional Resources

The TLC Foundation for Body-Focused Repetitive behaviors offers the following resources for patients, families, and clinicians:

Professional Training Institute

Licensed mental health professionals are encouraged to learn evidence-based, effective treatment for trichotillomania, skin picking disorder, and related BFRBs. The Foundation offers two ways to train:

In-person Weekend Intensive: A three-day intensive training program facilitated by leading experts in the treatment of hair pulling disorder, skin picking disorder, and related body-focused repetitive behaviors (BFRBs). Check www.bfrb.org for upcoming trainings.

DVD-Training: The Virtual Professional Training Institute (VPTI) is a 3-DVD training program based on TLC's live, in-person PTI. Offers 13 CE credits. Purchase online at www.bfrb.org

www.bfrb.org

Our website offers:

Treatment Provider Referrals

A free directory of local mental health professionals and online treatment resources

Support Group Locator

A searchable database of regional support groups and online forums

Salon and Service Provider Directory

Find a BFRB-aware cosmetologist, skin care provider, and other providers

Books, Sensory Fiddles and Other Products

A curated selection of clinical books, biographies, fiddles, brochures, and BFRB awareness products

Articles, webinars and events

Visit www.bfrb.org for treatment articles and personal stories, live webinars, and information on local events or the Annual Conference on BFRBs

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for Body-Focused Repetitive Behaviors

The TLC Foundation for Body-Focused Repetitive Behaviors is a donor-supported, nonprofit organization devoted to ending the suffering caused by hair pulling disorder, skin picking disorder, and related body-focused repetitive behaviors.

We take a comprehensive approach to helping people overcome and heal from body-focused repetitive behaviors by:

Connecting affected individuals and their families with each other, thereby helping to end their isolation and providing a community of support.

Referring people to appropriate treatment providers, services, and educational resources so that they can take better control of their recovery.

We conduct outreach to healthcare providers and educators, teaching them how to recognize these disorders, and train qualified mental health professionals in the latest evidence-based cognitive behavioral treatment approaches.

We design and fund research projects aimed at understanding the neurobiology of these disorders and identifying pharmacological and behavioral treatments, as well as possibilities for prevention.

**To learn more visit us at:
www.bfrb.org**

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