

One Woman's Skin Picking Strategies: Based on the Comprehensive Model for Behavioral Treatment of Trichotillomania and Skin Picking

By Rahel, TLC Member

Editor's Note: My first TLC event was four years ago, the same Retreat which Rahel writes about in this article. I had the opportunity to work with Rahel on a few other projects after that Retreat. Then, about two years ago, I received an email from Rahel in which she shared that, "picking is not as big a part of my everyday life these days." The Comprehensive Behavior Model for Behavioral Treatment of Trichotillomania and Skin Picking (ComB), developed by Dr. Charles Mansueto and his colleagues at the Behavior Therapy Center of Greater Washington, played a large part in Rahel's recovery. Below, Rahel shares her skin picking-specific adaptations of the ComB. You can read more about the ComB on TLC's website. Dr. Mansueto and his colleagues will also present their treatment model at the 2010 Retreat (informal agenda pages 6-7). Rahel shared this article with me at the retreat where she began using the ComB model in earnest and I am more than pleased to pass it on.

I was lucky to be a part of a support group of skin pickers who met daily with Charles Mansueto, PhD, Suzanne Mouton-Odeh, PhD, and Sherrie Vavrichek,

LCSW-C. We reviewed the ComB Model, adapted specifically for skin picking. As we discussed strategies for interrupting and preventing skin picking behaviors, I made a list of strategies I'm using, and strategies I could use.

Writing this out has been really helpful. It's quite powerful to notice how I've incorporated nearly 50 practices into my daily routine. I've really enjoyed this a priority and it's good to notice that I'm working. Skin picking has dramatically decreased from 3 years ago, when I was doing only 25% of the strategies.

The ComB model has 5 categories. My notes are divided into sections for each category.

- Sensory
- Cognitive
- Affective (emotions)
- Motor
- Place / environment

These categories are also referred to as SCAMP. I've provided some background information where it's relevant.

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A Tale of Two Kids: How Hair Club for Kids Made a Difference

Compiled by Jennifer Raikes
TLC Executive Director
Los Angeles, CA

At our 2010 Conference, two young TLC members, Max and Claire, spoke about their experience with "Hair Club for Kids," a non-profit foundation that provides free hair restoration for children battling hair loss as a result of medical treatments. Their stories are so touching that I thought I'd share them with you. You might also want to get to know the special families.

The Sherwood Family A conversation with Candy Sherwood

We're Candy, Ed, Max and Mason Sherwood and we live in Urbandale, Iowa (near Des Moines). Max is in 5th Grade and Mason is in 1st. I'm a Spanish teacher, and Ed is a purchasing agent for a heating and cooling company.

Max started pulling in 2nd grade. He had a teacher who was pretty strict and overbearing, and he started pulling his eyelashes. He had a great 3rd grade teacher and quit pulling, but he was diagnosed with ADHD. In 4th grade, we changed schools, and again he had a strict teacher - if you weren't a certain type of student, you had trouble.

Eventually, what started out as a small spot on his head grew so large we couldn't hide it anymore. The other students teased him. The boys would say, "Well, at least I don't pull my hair." The girls were worse. They called him a freak. When we had to shave his head, they said he looked like an old man.

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Group Behavioral Treatment for Trichotillomania and Skin Picking: A Case Presentation

By Johanna S. Kaplan, MA, The Catholic University of America, Department of Psychology
Sherrie M. Vavrichek, LCSW-C, The Behavior Therapy Center of Greater Washington

The majority of cognitive-behavioral treatments for Body Focused Repetitive Behaviors (BFRBs), such as Trichotillomania (TTM) and Skin Picking (SP), have been developed and empirically studied for individual treatment. For example, Woods et al. (2006) found that after seeking medication, the most common form of treatment modality applied for an individual with TTM was behavior therapy, with a specific concentration on self-monitoring and relaxation techniques. A more all-inclusive behavioral treatment known as the Comprehensive Model for the Behavioral Treatment of Trichotillomania and Skin Picking (COMB) (Mansueto, Sills, Berger, Thomas, & Golomb, 1997), was designed to address the complex cognitive, emotional, behavioral, and environmental aspects of individuals with BFRBs. The treatment has typically been applied to individuals who are a client's own and can be assessed. Although previous attention has been paid to the possibility and benefits of group treatment for BFRBs, in this article, we will describe an individual group treatment for TTM and SP that was based on the COMB model and *The Hair-pulling Habit and You* (Golomb & Vavrichek, 1990). This group met for 1.5 hours on a bi-weekly basis.

The BFRB treatment group had two leaders: a licensed certified clinical social worker and an upper-level clinical psychology Ph.D. student. The group consisted of a total of six female members (one member only came to the first session, and one joined at the second session). Two members were diagnosed with SP (one who picked both face and breasts, and one who picked at legs), three with TTM (two who pulled scalp hair and one who pulled eyelashes), and one

with both TTM and SP (picked and pulled at scalp and scalp hair). All six members had picked or pulled since early adolescence, and all but one was currently in or had been in individual therapy.

The first session began with a review of the process and group, which each subsequent session began with a review of the previous session and homework. Following a didactic/psychoeducation with a group discussion regarding the topic of the day or re-known issues, members shared between sessions, and members implemented plans that were reviewed and revised as needed during each session. Mind-body relaxation, mind-body awareness, and visualization exercises that members were encouraged to use when they were anxious for picking and/or pulling. Handouts related to the didactic material and recordings of the mind-body exercises (on CDs) were provided at the end of each session for use between sessions.

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Finding My Own Path Through Psychoanalysis: Finding Recovery from Chronic Skin Picking

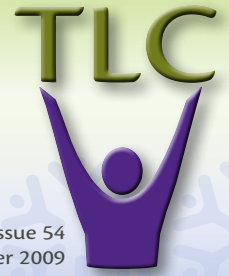
Wini Jebian
Mountain View, CA

Note from Christina Pearson, longtime TLC member and supervisor: I have known Wini since the early nineties. It gives me great pleasure to introduce her to you. She has been in recovery for so long, and her story is a wonderful one. It tells us that recovery may be achieved by many different pathways. It is extraordinary to me that we took the picture together at the end of this article - see all the safety pins? What an achievement for a woman who did not want others to see her in public. Her commitment to her own recovery process is an inspiration to me, and I hope for you also.

Christina Pearson, Founding Director

When I was in high school, my mother took me to a dermatologist for my habit of picking at my skin. My skin improved over the first year of seeing the dermatologist, but then my willpower to leave it alone started to wane. Finally the dermatologist said to me, in front of my mother, "I thought you had more character than that. You don't need a dermatologist, you need a psychologist," which was a shameful thing for us to hear in those days, so we ignored him. But, from that moment on, I knew I had a problem. As I got older, it just got worse and worse. By the time I was forty-five years old and taking care of my mother-in-law, who suffered from Alzheimer's disease, I was spending up to three hours a day skin picking, mostly

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NIMH-Funded Trichotillomania Treatment Research: Current Status and Future Directions

Douglas W. Woods, Ph.D.

University of Wisconsin, Milwaukee, TLC Scientific Advisory Board Member

Martin E. Franklin, Ph.D.

University of Pennsylvania School of Medicine, TLC Scientific Advisory Board Member

In the last year, we have seen a revolutionary shift in the way TTM treatment research is viewed in the scientific community and funded by the National Institutes of Health. Thanks to the efforts and unfailing support of TLC and its members, Drs. Martin Franklin and Doug Woods (both members of TLC's Scientific Advisory Board) have received over \$3,000,000 to test new behavioral treatments for TTM in children and adults. This article describes how this funding was obtained, and offers a description of these exciting new projects.

The truth is, it is very expensive to do good treatment research, and the study procedures that drive up costs are Quality Assurance measures for manuscripts and evaluations, independent evaluations, blind to treatment condition to conduct assessments) are necessary to ensure the validity of a study's results. Some estimates range from \$15K per subject, and some studies require thousands, if not tens of hundreds of subjects to properly test their hypotheses. Because it is so expensive, researchers invariably apply to the National Institute of Mental Health for grants to conduct such studies. Unfortunately, the NIMH does not simply give money away. In fact, right now, about 90 percent of the grants that are submitted are NOT funded. To maximize an application's competitiveness for NIMH grant funding, you not only must propose sound science, but you must also clearly demonstrate that the problem you are treating has a public health impact, and you must provide good evidence that the treatment you are proposing to test has promise to reduce these public health costs.

In 2004, with the exception of a grant to develop a treatment for TTM (awarded to Dr. Franklin in 2001), NIMH had never funded TTM research. To begin the process of putting TTM on the NIMH radar, NIMH and TLC co-sponsored a meeting about the disorder on November 2-3, 2004. In this meeting, basic researchers and clinical researchers from all over the world met to discuss what we knew about TTM, what we needed to do to get key questions answered derived from the meeting. From that meeting, we well-supported and effective treatments for both adults and children with TTM were developed, but not currently available. However, the NIMH research community was also informed of the need for more research. I would not be competitive unless the public health significance of TTM could be demonstrated with scientifically credible data. In other words, the NIMH wanted proof that TTM actually caused people significant problems in their lives.

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Defining Trichotillomania: Classification and Name Change Considered for the DSM-V

Jennifer Raikes, Executive Director

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, is the common reference used to diagnose mental disorders and to guide treating, researching or conducting a mental disorder, "the DSM" has become a well-known term. It is sometimes jokingly called the "bible" of psychiatry.

The DSM is important to you because it defines the criteria by which TTM and Skin Picking are diagnosed and the categories under which they are grouped. It influences how treatment providers and researchers (and insurance companies) understand a disorder. Does a particular set of symptoms qualify as a disorder at all? Which other problems is this disorder like? Therefore, how should I think about treating it?

Every decade or so, the DSM is revised. The next edition, the DSM-V, is due to be published in 2014. The process for revising the DSM is a large-scale, global effort that takes place over many years. Right now, teams of doctors, psychologists and other professionals all over the world are compiling data and debating the merits of the names, categories and diagnostic criteria of all the mental disorders to be included.

TLC, and the members of our Scientific Advisory Board, are advocating for some important changes to how trichotillomania and skin picking are listed in the next

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