

Trichotillomania: Prevalence and Prevention within an Academic Setting

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Abstract

This presentation is intended to assist participants in developing a deeper understanding of the cause, course and social commentary surrounding trichotillomania (TTM) as it presents in children and adolescents. TTM is a chronic hair-pulling disorder which, when present within a school setting, often goes untreated until intensive support through special education is deemed necessary. This reactionary approach to intervention is consistent with a more pervasive underutilization of proactive strategies for internalizing conditions. The intent of this presentation is to explore educational interventions which take into account the ecological components of the disorder and possible alternatives to special education referral. We will review the etiology and assessment of TTM as well as a methodology for providing student-centered interventions within a Response to Intervention (RtI) framework.

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According to the *Diagnostic Statistical Manual of Mental Disorders* (2000), Trichotillomania (TTM) presents as, “the recurrent pulling out of one’s own hair resulting in noticeable hair loss, in which an individual experiences persistent tension prior to pulling out the hair or when attempts are made to resist the behavior” (p. 674). TTM impacts the lives of approximately 2.5 million individuals within the United States, including a large number children and adolescents (Diefenbach, Reitman, & Williamson, 2000). Despite its prevalence, many clinicians, including counselors and educators, have had little to no experience in working with this population (Kress, Kelly, McCormick, 2004).

Anxiety-based disorders, such as TTM, are some of the most prevalent and, paradoxically, under-treated mental health concerns among children and adolescents. It is estimated that 10% of individuals under the age of 18 could have “serious emotional or behavioral problems that are severe enough to impair their functioning at home, school or in the community” (Levitt & Merrell, 2009 p.13). Untreated, such challenges often present into adulthood and manifest alongside depression, drug/alcohol abuse and/or negative interpersonal interactions (Cartwright-Hatton et al., 2004).

Franklin et al. (2008) found that many children and adolescents with TTM tend to avoid social situations, experience less social interaction, and fail to establish close friendships as a result of the disorder. Additionally, due to the aesthetic complications of TTM (namely significant and noticeable hair loss) peers will often ostracize the affected individual (Tarnowski, Rosen, McGrath, & Drabman, 1987; Boudjouk, Woods, Miltenberger, & Long, 2000). Children and adolescents with TTM report feeling unattractive due to their hair loss. Feelings of

depression, shame and guilt often accompany the hair-pulling behaviors (Stemberger, Thomas, Mansueto, & Carter, 2000).

Academically, children and adolescents with TTM have a harder time focusing on curricular material, remembering what they have learned, and studying for exams. As a result, they struggle to maintain the level of academic rigor necessary for success in school and are often placed into the special education environment as an individual with an Emotional Disturbance (Franklin et al., 2008).

Early identification and intervention are critical in preventing the manifestation of academic and social difficulties and the resulting reliance on special education services. Research consistently supports the finding that reactive techniques, implemented after difficulties have become problematic, are far less successful than early intervention (Lane, Gresham, & O'Shaughnessy, 2002).

Students with TTM have been found to benefit from curriculum that is relevant to their lives and personal needs as well as more generalized coping strategies (Crews, Bender, Cook, & Gresham, 2007). These students need to be supported in a positive school environment with instructional techniques designed to facilitate achievement and participation. They benefit from structured school rules, classroom routines, and clearly communicated expectations. They also benefit from socialization with peers, parental involvement in school-based events and activities, forming relationships with peers and adults in the school and community, and working with public and private agencies (Johns et al., 1996).

Response to intervention (RtI) is useful model when attempting to operationalize a support structure for students with TTM. These school-based interventions follow a three tier sequence of application (Gresham, 2007).

Tier I interventions are considered universal and delivered to all students at a district, school-wide, and/or classroom level. For students with TTM, this level of intervention might take the form of positive behavioral support, in which the entire school recognizes and abides by a common set of behavioral expectations. Other general education intervention options might include fostering supportive learning environments based on student input about individual needs (Wood, 1996), the use of mentors and creating combined classrooms (Flicek & Anderson, 1994). These approaches have been historically successful in alleviating the internal stressors that interfere with full academic engagement.

Tier 2 interventions direct more attention to those students who have not responded to Tier 1 support. The supports implemented at this level generally include individualized attention and targeted intervention strategies such as social skills training, token systems, behavioral contracts, and self-management training.

At a Tier 2 level, students with TTM may benefit from selected interventions focusing on specific skill training and stress management techniques. It is essential for educators to individualize their approach by considering all personal variables including social goals, peer affiliations, social prominence, and social interactions. A continuum of flexible supports designed to meet individual student needs can be achieved through the use of strategies including cooperative learning, peer tutoring, goal setting, thought restructuring, and creating conducive social structures (Lane et al., 2002; Cook, et al., 2008).

The implementation of effective interventions for internalizing conditions like TTM is of paramount importance. Using a systematic, research-based approach to intervention, educators are able to make discernable differences in the lives of affected students in a proactive capacity. This workshop will provide educators a methodology for “unpacking” TTM- specifically how to

identify/mediate external triggers as well as engender positive behavioral alternatives. At the conclusion of our workshop we feel confident that participations will be able to engage knowledgeably with students affected by TTM and successfully work in partnership with them to thwart the educational and social difficulties generally associated with the disorder.

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