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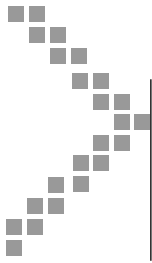
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Case Reports and Shorter Communications

A Case Study of Trichotillomania With Social Phobia: Treatment and 4-Year Follow-up Using Cognitive–Behaviour Therapy

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This article describes a case study that demonstrates an innovative combination of predominantly behavioural techniques in the treatment of trichotillomania (TTM) preceded by social phobia. Outcomes are reported to 4-year follow-up. A master's qualified cognitive–behavioural nurse therapist administered the course of treatment over 1 year and followed the client for 4 years. A combination of exposure and response prevention, habit reversal and serial photography for TTM urges, exposure for social phobia, cognitive restructuring and problem solving were utilised. These treatments were provided sequentially and concurrently. Pre and posttreatment and repeated outcome measures were applied in three domains. The client received a total of 23 treatment sessions over 1 year and follow-up over 4 years. During treatment, discharge and follow-up improved outcomes in TTM and social phobia were achieved and maintained at 4 years. Benefits accrued beyond the presenting conditions to have a major positive impact on the client's life. Theoretical implications for the classification of TTM are discussed.

Trichotillomania (TTM) is a chronic condition characterised by a difficult to control urge to pull one's hair from various places on the body, most commonly from the scalp. It is a condition often associated with severe distress, psychological and social dysfunction, and potential medical complications. TTM is listed within DSM-IV under the category of 'impulse control disorders', a category including conditions such as pathological gambling, kleptomania, pyromania and intermittent explosive disorder (American Psychiatric Association, 1994).

There is a general assumption that, within the impulse control disorders, the impulse action is typically preceded by feelings of tension and excitement and followed by a sense of relief and gratification, which is often, but not always,

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accompanied by guilt or remorse. However, in TTM there is reason to question inclusion under this grouping based on research demonstrating that a proportion of sufferers fail to report tension release, pleasure or gratification associated with pulling of hair, with this being a necessary aspect of the diagnostic criteria (Diefenbach, Reitman, & Williamson, 2000).

Aetiological models coming from biological and behavioural bases of TTM can be found in the literature, (Diefenbach et al., 2000) with various treatment modalities being grounded on these theoretical assumptions. TTM within the psychoanalytic tradition is representative of a symbolic expression of unconscious conflicts arising as a response to real and/or perceived threat of object loss. Some authors have suggested an association between the manifestation of hair-pulling and childhood traumas; however the empirical support for this is limited. According to biological theory, TTM may occur due to neurobiological pathology in mechanisms responsible for grooming behaviour (Diefenbach, Reitman, & Williamson, 2000). Genetic concordance studies have produced only limited and inconsistent results to indicate a familial influence (Diefenbach et al., 2000).

One model proposes that the symptoms of TTM and obsessive–compulsive disorder (OCD), which both belong to the group of obsessive–compulsive spectrum disorders, may be representative of a dimension that ranges from ‘primarily compulsive (or harm avoidance) to primarily impulsive (or risk seeking)’ (Diefenbach et al., 2000). Using this taxonomy it has been suggested that TTM lies toward the impulsive pole while OCD belongs close to the compulsive end of the spectrum. However, recent work indicates the relationship to be more complex than this implied dichotomous distinction (Fontenelle, Mendlowicz, & Versiani, 2005).

A considerable body of literature has emerged describing empirical research into TTM, and effective short-term interventions have been identified (Diefenbach et al., 2000). A question remains, however, with regard to the maintenance of gains over the longer term. The bulk of this treatment related research is based on behavioural models of negative reinforcement, punishment, habit reversal and modeling (Elliott & Fuqua, 2002). There appears to be some acceptance that a treatment model incorporating exposure and response prevention (ERP) is more applicable to OCD, whereas a habit reversal approach is favoured with TTM (Lochner, Seedat, du Toit, Nel, Niehaus et al., 2005). In a meta-analysis on treatment of social phobia, cognitive behavior therapy (CBT) and exposure therapy have been found to be equally effective (Feske & Chambless, 1995). Although other studies have shown benefits of a predominantly cognitive approach (Clark, Ehlers, McManus, Hackmann, Fennell et al., 2003; Clark, Ehlers, Hackmann, McManus, Fennell et al., 2006; Heimberg, Liebowitz, Hope, & Schneier, 1995; Mortberg, Clark, Sundin, & Aberg Wistedt, 2007) exposure treatment for patients with social phobia has been found to provide lasting change for the majority with median 6-year follow-up (Fava, Grandi, Rafanelli, Ruini, Conti et al., 2001).

Anxiety disorders are commonly associated with TTM (Chamberlain, Menzies, Sahakian, & Fineberg, 2007; Diefenbach et al., 2000). However, within the literature, social phobia is not distinguished within the anxiety disorders in terms of its comorbidity with TTM. Rather, OCD (Chamberlain et al., 2007) posttraumatic stress disorder (Gershuny, Keuthen, Gentes, Russo, Emmott

et al., 2006), generalised anxiety disorder and specific phobias (Chamberlain et al., 2007) are documented as being comorbid with TTM.

This article will describe a case study where TTM presented with primary, comorbid social phobia. The authors are not aware of case reports in the literature describing the concurrent treatment of social phobia and TTM and, in particular, where the social phobia preceded TTM, a reverse of the more expected relationship.

Case Study

At the time of presentation Tina (not her real name) was a 29-year-old woman living with her fiancée in rental accommodation. She worked part time as a computer consultant from home. Her parents died when Tina was 14 years of age, and she developed glandular fever and major depression following her parents' death. An older sibling cared for Tina from the age of 14 onwards.

Tina reported that her depression preceded her social phobia, which was subsequently followed by TTM. She had started seeing a psychologist and a psychiatrist from the age of 14 and was prescribed antidepressants that helped to elevate her depressed mood.

At presentation, Tina defined her main problem as panic and anxiety with symptoms consisting of tension, 'butterflies' in the stomach, blushing, shakiness and dry mouth. These episodes occurred in social and family situations such as her appointments with Centrelink and other authority figures, and any confrontational situations with friends and siblings. She also experienced anxiety to a lesser degree in shopping centres, while travelling on public transport, and when leaving her home. Tina thought that her social phobia became the main drive for her to pull her hair, as it was a way for her to relieve her anxiety and to release emotional pain and frustration in dealing with others.

Tina's main fear was of being criticised or judged by others, especially people in authority, and family members for her inability to achieve life goals or complete activities (e.g., going for a job interview or attending Centrelink appointments). The client specified that at the time her TTM commenced, she was not concerned about her appearance or, later on, the lack of hair on her scalp.

At initial interview Tina presented with both social phobia and TTM. She was wearing a hat and there was no hair on her scalp. She reported the condition of her scalp was due to recurrent episodes of hair-pulling, which were sometimes lengthy. Her hair-pulling occurred whenever she felt unhappy, stressed, anxious, and alone, rejected or low in self-esteem. There were no particular specific fears or obsessional thoughts associated with the hair-pulling. However, Tina expressed a conscious experience of discomfort triggered by cognitions related to stress associated with living with the impact of social phobia on her life, family issues, and grief and loss prior to pulling. Tina pulled hair mainly at night when the stress was greatest and she was alone, that is, when she would not be observed. She used tweezers to pull difficult and very short hair from her scalp, and denied pulling hair from other parts of her body. When she began pulling she was usually aware of the act. However, during an episode she would become less aware. The client experienced overwhelming guilt after each hair-pulling episode.

Both problems had impacted significantly on Tina's life. Fear of criticism and judgment from others associated with social phobia severely limited her work opportunities, negatively impacted on her private and social life, and significantly reduced self-esteem. The hair-pulling stopped her from getting on with more important activities and achieving both daily and longer term life goals, and had resulted in significant damage

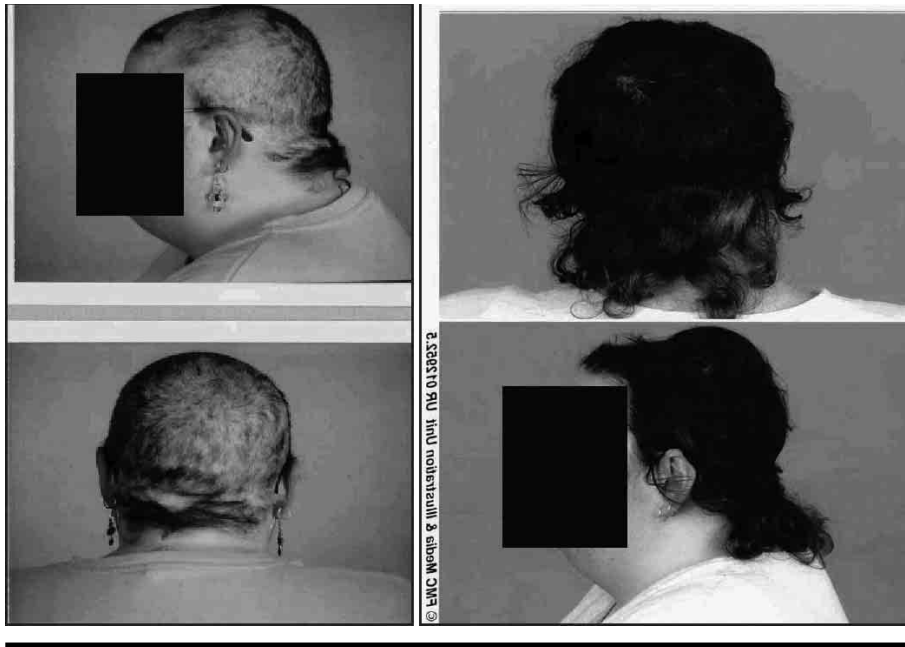


FIGURE 1
Before and after photographs.

to her scalp and hair follicles and further reduced self-esteem. Tina reported that if she did not have TTM, her social phobia would be undiminished. However, if she did not have social phobia she felt her TTM would be greatly reduced.

Assessment

Tina underwent a full diagnostic clinical assessment including developmental and past psychiatric history separately for her social phobia and TTM. Diagnosis was made using the DSM-IV (American Psychiatric Association, 1994). Tina met criteria for Axis 1 social phobia and TTM. The rationale of behavioural psychotherapy using graded exposure for social phobia, and ERP for TTM, with habit reversal for high urges were explained to the client. Emphasis was placed on ensuring she understood the rationale for each technique and their specific targets of change in relation to the problem(s). The therapist and client constructed subjective measurements in the form of client-defined problems and end-of-treatment goals statements, separately for the social phobia and TTM. The client and therapist then rated the problem severity and end-of-treatment goals attainment individually on a 0 to 8 scale at commencement and 4-weekly throughout treatment, discharge and follow-up sessions (see Figures 2 and 3).

Standardised measurements were completed and subsequently repeated in conjunction with the client-specific problems and goals rating. Measurement included avoidance (Fear Questionnaire; Marks & Mathews, 1979), depression (Beck Depression Inventory; Beck, Steer, & Garbin, 1988), anxiety (Beck Anxiety Inventory; Beck, 1993), and disability and handicap (Work and Social Adjustment scale; Mundt, Marks, Shear, & Greist, 2002). The measures are collated in Figures 4 to 6.

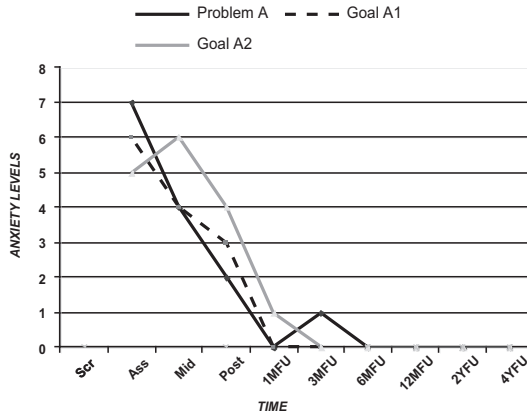


FIGURE 2
Problems and goals for TTM.

In addition, Tina agreed for the therapist to photograph her head at the commencement of therapy and every four weeks after in order to provide visual evidence of gradual improvement of her hair (see Figure 1).

Treatment

Tina and her therapist planned to have one session per week for an hour to work simultaneously with her social phobia and TTM. The sessions were planned to be client focused with the therapists role as educator and coach working with occasional involvement of her partner.

Each session was collaborative with an agreed agenda between the therapist and Tina. Tina was initially required to document and score her anxiety in social settings and her urge for hair-pulling in different situations using a 0–8 scale in order to establish a hierarchy from least to highest provoking anxiety for her social phobia and urge for her TTM.

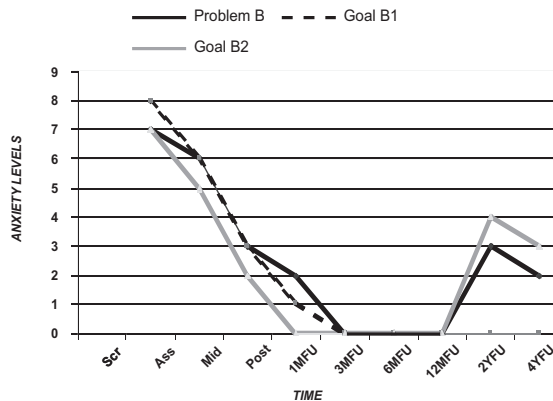


FIGURE 3
Problems and goals for social phobia.

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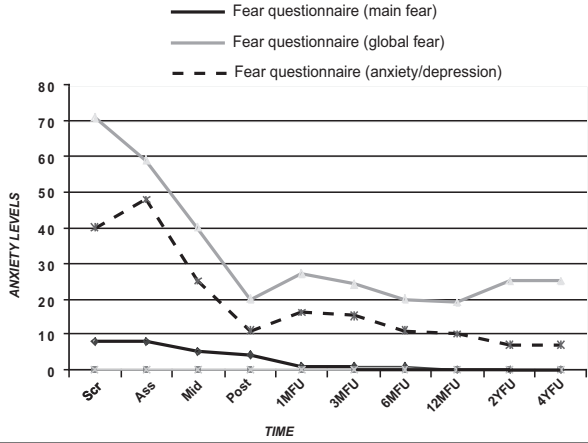


FIGURE 4
Fear Questionnaire.

Her social phobia was managed with in vivo graded exposure (Andrews, Creamer, Crino, Hunt, Lampe et al., 2003; Marks, 1987). Emphasis was placed on delivering a credible client-specific rationale for graded exposure to social anxiety triggers based on the behavioural assessment. Tina was asked to confront her anxiety for her selected tasks until habituation occurred or she felt comfortable in the setting without the use of any self-reassurance, distraction or safety behaviours.

With TTM, graded ERP was utilised where Tina induced the urge to hair pull and then resisted the urge. By blocking the hair-pulling response, and thereby the negative reinforcement of this activity, extinction occurred. An important aspect of this process was to remain focused. One of the strategies

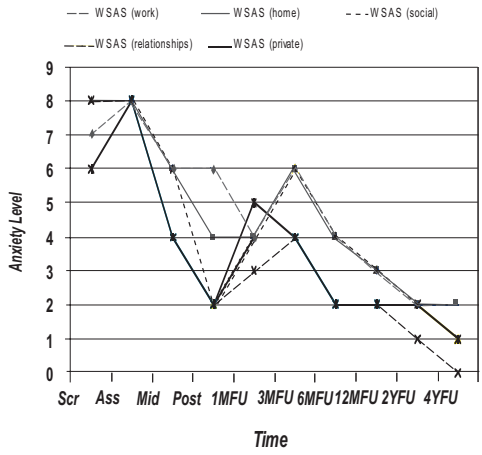


FIGURE 5
Work and Social Adjustment Scale.

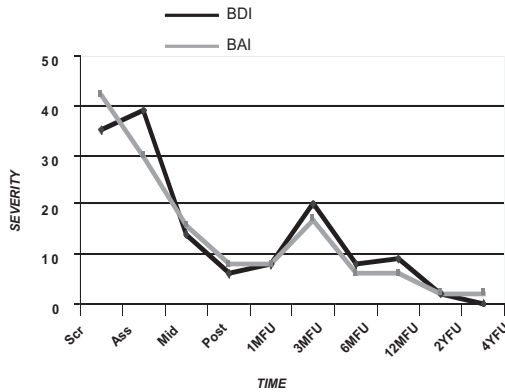


FIGURE 6

Beck Depression and Anxiety.

used for focusing was for Tina to type the actual thoughts and associated feelings that were present at the moment of the urge to pull hair. At the same time she was asked to focus on the pain and the emotional distress caused by these thoughts, and habituate to that, rather than distract or escape via the hair-pulling.

At each session Tina and her therapist would establish tasks based on graded exposure for different social settings and ERP for hair-pulling. She would then practise each task daily as homework, staying with her anxiety in social settings and her urge to pull hair until she achieved habituation of at least 50%. She was required to later record the level of her anxiety and urge to pull hair before, during and after each task on homework sheets. Tina brought her homework sheets to every session for review and discussion with her therapist before designing the next tasks. This process continued until she was able to achieve her end-of-treatment goals and feel comfortable with no social anxiety or hair-pulling urge for the respective situations or tasks.

In the treatment of TTM, habit reversal therapy became one method used outside of set ERP tasks to respond to high hair-pulling urges. Emphasis was placed on changing the habitual associations and patterns of hair-pulling, rather than exposure. Techniques included: *competing response training*, which involved stopping the urge to pull her hair by competing with another neutral behaviour, such as putting both hands under her thighs, and *awareness training and self-monitoring* to improve awareness of her hand movement during pulling episodes by having written and symbolic reminders around the house. If she pulled any hair, she was to attach each hair separately to her diary and write the reason why she pulled it, looking at her thoughts, behaviours, emotions and physical symptoms. *Contingency management* was used, in which her partner was encouraged to positively reinforce her improvement by giving compliments when her hair was growing back. For *relaxation training* she preferred muscle relaxation, and this was taught in the first session and practised almost every day for 10 to 15 minutes and for 1 to 2 minutes during high hair-pulling urge. *Generalisation training* was also used, involving role play, real-life practice and imaginal exercises with her therapist.

Additional techniques were applied as part of the overall treatment plan. Cognitive restructuring was used to identify and challenge negative automatic thoughts associated with the client's family and her past that seemed to cut across all of her problem areas. Maintaining change(s) and relapse prevention were discussed and applied at every session from the beginning of therapy. This enabled the client to gain a clear understanding of the nature of change, and skills and practice in preventing or responding to lapse and relapse. Problem-solving skills were also taught from the beginning of therapy as part of relapse prevention and as an additional strategy to habit reversal for responding to high hair-pulling urges. Treatment interventions were applied sequentially and concurrently as shown in Table 1.

Results

Clinically significant change was observed in terms of the client's problems and goals with a complete reduction in the problem and attainment of goal scores, changing from worst (8/8) to best (0/8) for both social phobia and TTM (see Figures 2 to 3). Collation of standard measures also showed consistent score reductions, indicating clinically significant changes for both social phobia and TTM (see Figures 4 to 6).

Initially, Tina had a high urge to pull her hair, however, after four sessions she was able to see the improvement in hair growth through the use of serial photography and affirmation from her partner and others. She reported that looking at the photographs of herself provided a combination of visual, tangible evidence and affirmation of her improvement that was critical in increasing motivation and reducing her urge further, particularly in the initial stages of therapy. It supported her in remaining compliant with her tasks and she felt more at ease with the tasks after the initial four sessions.

Overall she had two minor setbacks: first, when her cat died, and second, when she had a difficult confrontation with her sister. She did not pull hair during other stressful episodes. The client reported that her anxiety symptoms intensified during these lapses and she was able to practise her skills and newly gained knowledge about graded exposure that enabled her to habituate to her anxiety in various social settings. She was able to go by herself to the shopping centre, use public transport and attend appointments with Centrelink and other organisations. Additionally, she found the process of focusing on her feelings through writing and expressing them had shifted the need or urge away from having to pull hair.

In total, Tina had 13 sessions of behavioural psychotherapy for both the TTM and social phobia. As the effects of TTM and social phobia on her life decreased, her confidence grew and Tina began to introduce an increasing number of pleasurable social activities into her week. Additionally, she wanted to help others and started up a TTM support group, believing it was important to have access to appropriate information and a forum in which to discuss treatment options. She also created a web site for TTM. Tina became a member of a 'regional anxiety round table' that focused on increasing the awareness and services for anxiety and related disorders. The final word we have left to Tina:

... even though I was sceptical at first it really did work for me. I saw her [therapist] once a week for several weeks and had several tasks to complete and learnt how to deal with my anxiety and stress differently. I also learnt several things to do with my hands when I found myself reaching for my head, which soon became second nature. At this time I was more aware of my trichotillomania and at some stage it had become a conscious thing.

Discussion

This case illustrates the importance of an accurate assessment, separating the antecedent stimuli and feared consequences of social phobia from TTM. It was unexpected to find that social phobia preceded the TTM. When TTM developed, this client did not become fearful of critical scrutiny regarding her hair loss, instead the central fear remained critical scrutiny by authority figures and siblings, particularly in confrontational situations. The precursor to the TTM was distress associated with her social phobia, family issues and grief and loss, with hair-pulling providing relief from this.

The relationship of the client's TTM and social phobia was interesting. Clearly it was important to treat the social phobia in its own right; however, it was also important in terms of minimising risk of relapse of TTM.

ERP was the major element of treatment for TTM, reinforcing the proposition that it belongs to the OCD spectrum disorders rather than the impulsive disorders. The urge to pull hair was extinguished by deliberate exposure to triggers and habituation of the urge by response prevention. Although Tina's urge to pull hair was not triggered by obsessional thoughts as such, it was like a compulsion as it involved a set of behaviours associated with temporary relief from consciously experienced discomfort triggered by thematic content around anxiety related stress, family and grief and loss. Pulling was reinforcing in the sense that temporary relief or avoidance from aversive, consciously experienced discomfort was obtained. This suggests that the urge was a conditioned response rather than a spontaneous impulse.

The case is a complex one where social phobia and TTM presented together at assessment and were treated concurrently. Treatment began prior to the consolidation of more contemporary cognitive-based social phobia models. The core treatment component for both social phobia and TTM was graded live exposure. This supported the concurrent treatment of the problems because of the efficiencies that come with the client essentially learning the same set of skills to deal with two different problems. More importantly, the core treatment component of graded live exposure therapy was an effective intervention for social phobia and TTM, with maintenance of long term clinical gains for both conditions.

The use of sequential photographs was a strategy that provided visual evidence and acknowledgment of improvement that was central in enhancing motivation and self-esteem. The use of sequential photographs is a commonly mentioned therapeutic strategy for TTM within the literature, but is rarely reported on within the context of clinical practice.

Tina is currently working full time, married and has undertaken part time study at university. Repeated follow-up indicates that social phobia and TTM are no longer problems. She has learned how to differentiate between normal and abnormal anxiety in her every day activities. Her problem solving strategies are advanced and she is well aware of relapse prevention strategies. Tina has maintained all the gains from therapy. Despite underlying psychodynamic issues, focusing on the present and learning a set of skills has led to a major reduction in symptomatology and handicap, and enabled this young woman to achieve her potential.

High prevalence disorders such as anxiety disorders and depression occur in nearly 20% of the population in a twelve month period (Andrews, Hall, Teeson, & Henderson, 1999). The National Mental Health Plan (Australian Health Ministers, 1992) recommends increased training of the mental health workforce

TABLE 1
Description of Individual Sessions

Week	Session description	Measurements for TTM and social phobia: Problems and goals; standard	Graded exposure (GE) for social phobia	Exposure and response, Prevention (ERP) for TTM, Habit reversal (HR) for TTM: Awareness training and self-monitoring (ATSM), Contingency management (CM), Generalisation training (GT) Relaxation Training (RT)	Relapse prevention (RP): Problem-solving (PS) Cognitive restructuring (CR)
1	Full Clinical assessment		Social phobia	TTM	Rationale for RP/CR
2	Psychosocial assessment		Rationale for GE	Rationale for ERP/HR	RP/CR
3	Problem and goals session	Client's rated	Hierarchy list	ERP/RT/ATSM	RP/PS/CR
4	First treatment session		In vivo GE	ERP/RT/ATSM	RP/PS/CR
5	Second treatment session		In vivo GE	ERP/RT/ATSM	RP/PS/CR
6	Third treatment session		In vivo GE	ERP/RT/ATSM	RP/PS/CR
7	Fourth treatment session	Client's re-rated	In vivo GE	ERP/RT/ATSM	RP/PS/CR
8	Fifth treatment session		In vivo GE	ERP/RT/ATSM	RP/PS/CR
9	Sixth treatment session		In vivo GE	ERP/RT/ATSM/CM	RP/PS/CR
10	Seventh treatment session		In vivo GE	ERP/RT/ATSM/CM/GT	RP/PS/CR
11	Eighth treatment session	Client's re-rated	In vivo GE	ERP/RT/ATSM/CM/GT	RP/PS/CR
12	Ninth treatment session		In vivo GE	ERP/RT/ATSM/CM/GT	RP/PS/CR
13	Tenth treatment session		In vivo GE	ERP/RT/ATSM/CM/GT	RP/PS/CR
14	Eleventh treatment session		In vivo GE	CM/GT	RP/CR
15	Twelfth treatment session	Client's re-rated	In vivo GE	CM/GT	RP/CR
16	Thirteenth treatment session		In vivo GE	CM/GT	RP/CR
17	Discharged session	Client's re-rated	Review GE	Review HR/ERP	Review RP/CR

TABLE 1 (CONTINUED)
Description of Individual Sessions

Week	Session description	Measurements for TTM and social phobia: Problems and goals; standard	Graded exposure (GE) for social phobia	Exposure and response, Prevention (ERP) for TTM, Habit reversal (HR) for TTM: Awareness training and self-monitoring (ATSM), Contingency management (CM), Generalisation training (GT) Relaxation Training (RT)	Relapse prevention (RP): Problem-solving (PS) Cognitive restructuring (CR)
18	1-month follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance
19	3-month follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance
20	6-month follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance
21	12-month follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance
22	2-year follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance
23	4-year follow-up	Client's re-rated	Maintenance	Maintenance	Maintenance

Note: This table gives a description of each individual session; at what interval the problem and goals plus standard measurements were rated and re-rated; how often in vivo graded exposure (GE), exposure and response prevention (ERP) and habit reversal (HR) techniques were applied such as: awareness training and self-monitoring (ATSM); contingency management (CM); relaxation training (RT) and generalisation training (GT). It also shows the additional strategies such as relapse prevention (RP), problem-solving strategies (PS) and cognitive restructuring (CR), and describes the follow-up sessions and whether the client was able to maintain her gains through therapy.

to provide evidence-based treatment. This case study clearly demonstrates that complex evidence-based treatments can be provided by masters level non psychologists such as graduates of the Master of Mental Health Sciences at Flinders University (Flinders University, 2006).

Conclusion

This case illustrates a unique relationship of social phobia to TTM that is not found elsewhere in the literature. Combinations of standard and novel interventions were utilised resulting in significant therapeutic gains being maintained over a 4-year period. The primary interventions of graded exposure for social phobia, ERP for TTM, and relapse prevention strategies for both conditions worked well for this client. Theoretical implications for TTM suggest that it may be better placed diagnostically in the obsessive–compulsive spectrum disorders than impulse control category. This case illustrates the importance of having a range of mental health professionals in addition to psychologists, such as nurses, social workers, occupational therapists and others with evidence-based levels of skill and knowledge in the Australian mental health system.

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