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ACT-Enhanced Behavior Therapy for a Hispanic Adult with Trichotillomania: A Case Report

Abstract

Trichotillomania, also known as Hair-Pulling Disorder, is characterized by recurrent pulling out of one's hair over brief episodes or sustained periods of time and results in hair loss. ACT-enhanced behavior therapy (A-EBT) has been shown to be an effective approach in the treatment of trichotillomania by promoting psychological flexibility around hair pulling urges and teaching stimulus control and habit reversal training. However, there is limited support of A-EBT for clients with an ethnic minority identity. This case report focuses on an adult, Hispanic female client, Luna (pseudonym), who received eight sessions of A-EBT for the treatment of trichotillomania. At post-treatment, Luna showed significant improvements in number of hairs pulled, trichotillomania specific psychological flexibility, depression and anxiety. Luna's case highlights barriers to care such as potential resistance in seeking mental health services, the influence of family members' beliefs on receiving mental health services, and the limited access to specialized treatment of trichotillomania.

Keywords: trichotillomania, hair-pulling disorder, acceptance-enhanced behavior therapy, habit reversal training, Hispanic

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1. Theoretical and Research Basis for Treatment

Trichotillomania, also known as Hair-Pulling Disorder, is characterized by recurrent pulling out one's hair resulting in hair loss and significant distress or impairment. Common sites of hair pulling include one's scalp, eyebrows, eyelids, facial hair, or pubic regions (American Psychiatric Association, 2013). Hair pulling can be categorized into focused or automatic styles. Focused hair pulling is deliberate and functions to alleviate an unwanted internal experience (thought, feeling, urge, physical sensation) while automatic pulling is done unconsciously (Alexander et al., 2016). Trichotillomania generally begins in adolescence (15-years old for females and 19-years old for males), and females seek services for their trichotillomania more than males although the prevalence might be the same for the two sexes (Grant et al., 2020). Individuals living with trichotillomania likely experience psychological distress from their hair-pulling, skin damage (e.g., scarring, infections, hair loss) at the site where pulling occurs, and diminished quality of life from social isolation and low self-esteem (Diefenbach et al., 2005). Common mental health comorbidities include anxiety related disorders, depressive disorders, obsessive-compulsive disorders, and posttraumatic stress disorder (Grant et al., 2020). In extreme situations, individuals ingest whole hairs which may lead to trichophagia, which is where the stomach is blocked by undigested hairs (Grant & Odlaug, 2008).

Habit reversal training (HRT) is a key part of the treatment of trichotillomania and includes awareness training, stimulus control, and competing responses (McGuire et al., 2014). HRT has also been shown to be an effective adjunctive treatment with acceptance and commitment therapy (ACT) for the treatment of trichotillomania (Haaland et al., 2017). ACT

focuses on the promotion of psychological flexibility. Psychological flexibility involves seeing inner experiences for what they are, nonjudgmentally observing them, while engaging in values consistent behaviors. In trichotillomania, psychological flexibility may help reduce hair pulling by decreasing the impact of internal cues to pull and increasing the appetitive quality of forgoing pulling. ACT-enhanced behavior therapy (A-EBT) for trichotillomania teaches psychological flexibility around urges to hair pull and judicious stimulus control and HRT (Woods et al., 2022). Researchers have shown that trichotillomania specific psychological flexibility is associated with a decrease in trichotillomania symptom severity (Houghton et al., 2014; Norberg et al., 2007; Woods et al., 2006), and that increases in psychological flexibility predict improvements in trichotillomania (Ong et al., 2023).

Although treatments for trichotillomania have been shown to be effective, there is a need for culturally appropriate treatments. Researchers have found ethnic minorities to demonstrate certain hair pulling patterns that differ from their White counterparts including being less likely to report pulling from their face (e.g., eyebrows, eye lashes) (Neal-Barnett et al., 2010). Ethnic minorities are also less likely to utilize treatment for trichotillomania, which may be a result of stigma associated with the fact that this diagnosis is not fully understood by the community, (Milchorena, 2005), and a general stigma against psychotherapy, and in some cases lack of faith in the scientific community. Although there is a lack of information on the treatment of trichotillomania in diverse populations, what does exist focuses on trichotillomania among African Americans (Neal-Barnett et al., 2011). From this work, it seems clear that there are cultural factors to consider and incorporate in the treatment of trichotillomania among diverse populations. These cultural factors may include childhood messages about hair or the value placed on hair, how the community seeks help (i.e., hairdresser over health professional), habits

and rituals related to hair (i.e., braiding, heat alteration), and understanding of condition (i.e.,

association to anxiety or obsessive compulsive disorder, association to physical health condition)

(Neal-Barnett et al., 2011). When it comes to the Latine community, there is less of an

understanding of trichotillomania patterns, treatment utilization, and treatment effectiveness.

Clinical profiles of trichotillomania in an adult Hispanic population share similarities to Black,

Indigenous, and other people of color (BIPOC) (Grant et al., 2021). More specifically, Grant and

his colleagues (2021) found no significant differences between groups of Black, Asian and

Minority Ethnic (BAME) in symptom severity, quality of life, or type of body focused repetitive

behaviors (BFRBs). In a recent study, researchers noted characteristics and treatment seeking

behaviors of an adult Hispanic population but the sample also included those with a skin picking

disorder (Valle et al., 2022). Results showed that 99.4% wanted specialized help yet 77.7 % felt

a lack of trichotillomania knowledge from their therapist, psychologist, or psychiatrist (Valle et

al., 2022).

2.   Case Introduction

The case of Luna (pseudonym) was an informative case given the lack of empirical support on

the treatment of trichotillomania among the Latine community. First, Luna was in her early 30s

and identified as a Hispanic, cisgender woman. She had been living with trichotillomania for the

past 15 years. Although she had sought mental health services once before, her treatment

involved couples therapy with her husband and was focused on financial spending and

improving communication. Secondly, her case highlights motivating factors in seeking treatment

from a mental health professional. Thirdly, she demonstrated a dedication to her treatment given

that she would drive over an hour to the treatment site each week. Lastly, to her surprise, she

stopped engaging in hair pulling behavior entirely shortly after talking with a mental health

professional who was using specialized treatment (i.e., A-EBT) after hiding it from her immediate family.

3. Presenting Complaints

Luna reported an age of onset of trichotillomania of 15 years old. At age 17, she realized that her repetitive behaviors of hair pulling may be a psychological condition only after seeing a reality television show where someone was hair-pulling. She recalled telling a family member that she may have trichotillomania in which the family member advised her against seeking treatment as she would "look crazy" and it would be documented in her health record. She waited approximately 15 years before seeking treatment. At intake, she primarily engaged in automatic pulling when feeling bored and stressed. While working from home, she noticed the urge to pull from her scalp in stressful times from work or family and would then engage in focused pulling privately. Luna exclusively pulled hair from her scalp, on both sides of her head. After pulling the hair from her scalp, she searched to find the hair follicle to bite. After biting the hair follicle, she would dispose of the hair by tossing it on the floor. She denied eating her hair. She reported pulling a minimum of 20 individual strands of hair per day, over the course of 30 minutes. If she pulled more than one strand at a time, she felt scared and "panicky." Her hair pulling resulted in partial hair loss on both sides of her head which make it difficult for her to wear her hair in certain styles. She used hair from the top of her scalp to hide the hair loss. She noted that her hair-pulling caused her significant distress. Luna disclosed that she was seeking treatment for trichotillomania because she was afraid that her young children would observe her hair pulling and begin to do it themselves.

Luna delivered her first child and began experiencing depressive-like symptoms for approximately six months. A year and a half later, she gave birth to her second child in which the

depressive symptoms returned but were less severe. She sought treatment through her physician who diagnosed her with postpartum depression. At the time of this diagnosis, the physician provided Luna with a referral to our clinic for mental health services because we specialize in treating trichotillomania and related issues. Luna waited until her depressive symptoms improved (approximately 3 months) and contacted our clinic for specialized services. At the time of intake, Luna was no longer endorsing depressive symptoms.

4. History

Luna identified as cisgender, Hispanic women in her early 30s. She lived in a city in Utah with her husband and two young children. She was raised on the west coast of the USA by her biological parents along with three other siblings. Along with her sister, they were the first members within her family to go to college. She received a graduate degree and was employed full time.

5. Assessment

Self-report assessments were administered at each session except for two sessions. Surveys were not administered at these two sessions due to clinic staff mistake and the switch to telehealth. At intake, Luna met criteria for Trichotillomania based on her responses to a semi-structured interview, the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018). Luna also completed a self-assessment that was adapted by Weiner et al (2018) from the ADDRESSING framework (Hays, 2016) that attempts to capture various identity domains and their interaction (i.e., intersectionality). Domains of age, disability, diagnosis, religion, ethnicity, sexuality, socioeconomic status, indigenous heritage, nationality and citizenship, and gender include five questions each that are rated on a Likert scale from 1 (*"never"*) to 5 (*"very often"*).

Trichotillomania symptom severity was measured throughout treatment by the Massachusetts General Hospital Hairpulling Scale (MGH-HPS; Keuthen et al., 1995). The MGH-HPS is a 7-item self-report measure assessing hairpulling symptoms (i.e., frequency and intensity of urges, ability to control urges, frequency of hairpulling, associated distress). Each item was scored on a 5-point Likert scale from 0 (no symptoms) to 4 (severe symptoms). Scores range from 0 to 28 with higher scores indicating higher severity of hairpulling. Luna also tracked the number of hairs pulled per day over the course of treatment.

Psychological flexibility was measured by the Trichotillomania specific version of the Acceptance and Action Questionnaire (AAQ-4TTM; Houghton et al., 2014). The AAQ-4TTM is a 9-item self-report measure assessing how individuals interact with their urges to pull hair. Each item was scored on a 7-point Likert scale from 1 (*"never true")* to 7 *("always true")*. Scores ranged from 0 to 63 with lower scores indicating greater psychological flexibility.

Anxiety severity was measured by the Generalized Anxiety Disorder 7 (GAD-7; Spitzer et al., 2006), which is a 7-item self-report measure. The GAD-7 has been validated in English and Spanish in Latine populations (Mills et al., 2014). Each item was scored on a 4-point Likert scale from 0 (*"not at all"*) to 3 (*"nearly every day"*). Scores range from 0 to 21 with lower scores endorsing fewer anxiety symptoms.

Depressive symptom severity was measured by the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001). This measure has been validated in English and Spanish in Latine populations (Merz et al., 2011). The 9-items in this self-report measure were scored on a 4-point Likert scale from 0 (*"not at all"*) to 3 (*"nearly every day"*). Scores range from 0 to 27 and are categorized in five categories where 0-4 indicates minimal to no depressive symptoms, 5-9 mild

depressive symptoms, 10-14 moderate depressive symptoms, 15-19 moderately to severe

depressive symptoms and 20-27 as severe depressive symptoms.

6. Case Conceptualization

Luna began treatment with a high level of willingness to engage in treatment. She drove

more than an hour for mental health services. Further, her readiness for change was motivated by

her desire to enjoy family vacations in Mexico that involved being in the water and having her

hair micro-braided. She also demonstrated a readiness for change so that her young children did

not observe and learn hair pulling behaviors from watching her. Luna had been living with

trichotillomania for the past 15 years and never sought treatment due to familial influences.

Although she had a strong social support system of immediate and extended family, she

experienced social isolation in coping with trichotillomania because she chose to not discuss it

with her social support system. Luna pulled the hair from her scalp from both sides of her head.

By pulling from this location, she was able to wear her hair in various style to conceal the hair

loss. She made multiple attempts to stop hair pulling which included collecting all the hairs she

pulled and placing them in a pile to "disgust" herself. When she needed a haircut, she would cut

her own hair to avoid feeling embarrassed at the hair salon, having to talk about it with

hairdressers and have other patrons see her hair loss. These days, she has found a hairdresser

whom she trusts and schedules during non-busy hours and is seated in a chair that is tucked

away. Amongst friends, she was the one who helped do others' hair and make-up but never had

hers done. Therefore, living with trichotillomania had been a lonely experience in which

avoidance was the primary maladaptive coping strategy prior to treatment.

Results from the ADDRESSING Identities assessment provided valuable information for

capturing Luna identities and how the intersection of these identities may be considered in the

case conceptualization. For age and generational influences, Luna identified as a woman in her 30s which she considered to be a visible identity that was a source of strength and stress and was connected to experiences of barriers (instead of privilege). She added that this identity did not impact her mental health at all. When asked if this identity interacted with other identities, she wrote "Yes, Hispanic – double barrier." She noted that she did not have a disability identity, "no mental health issues" under diagnosis identity, and denied religious identity by stating "not religious." Regarding her ethnicity and racial identity, she identified as Hispanic in ethnicity and "Best option is white even though I don't consider myself white" for racial identity. She added that her Hispanic identity is one that is visible, stable and has historically led to more barriers or stigma (compared to more privilege) and is a source of strength and stress. She specified that "my ethnicity affects my mental health when I feel it is taken into account for other Hispanics unable to progress due to this identity." Luna added that her racial identity has led to more privilege or power (compared to barriers and stigma). Her sexual identity is considered to be heterosexual and a stable identity. Regarding her socioeconomic status, she identified as "middle class" which was stable, associated with more barriers and stigma compared to privilege, and was a course of strength and stress. Luna identified as indigenous in which her immigration status and indigenous heritage led to more barriers and stigma. She views her indigenous identity as one that is visible and a source of stress. Further, she identified as a U.S. citizen which she considered to be associated with experiences of privilege. Lastly, Luna's gender identity and sex assigned at birth were listed as "female." She considered this identity to be visible, stable, and a source of stress. She also considered both identities (i.e., sex and gender) to be associated with experiences of barriers and stigma. Throughout this assessment, she noted that education was one action that she could take to positively influence her treatment, functioning, or mood.

7.   Course of Treatment and Assessment of Progress

Treatment was guided by 10-session manualized protocol (Woods & Twohig, 2008) that includes contingency management, habit reversal training, stimulus control procedures, ACT concepts taught through experiential exercises, metaphors, and behavioral commitments. Behavioral commitments were collaboratively decided upon as an opportunity for the client to practice skills outside of the session. Stimulus control procedures involve those that reduce environmental or behavioral triggers that may result in pulling. Examples of these strategies include disposing of tweezers, sitting in the middle of the couch while watching TV, and removing "make-up mirrors." Habit reversal training included obtaining an in-depth understanding of the client's pulling patterns and promoting awareness training and self-monitoring and learning a competing response to engage in when about to pull or when pulling. Luna's therapist was a clinical psychology doctoral student who was supervised by a clinical psychologist with expertise in ACT, treatment of trichotillomania and a co-author of the manual used.

Sessions 1-2 focused on an introduction to the treatment and aspects of behavioral therapy. In session 1, an overview of A-EBT for trichotillomania and psychoeducation on trichotillomania was discussed (e.g., prevalence rates, common pulling behaviors). Luna described her pulling patterns in detail and simulated steps leading up to pulling (i.e., searching for certain texture of individual strand then wrapping strand of hair around finger). Session 2 focused on identifying pulling triggers and signals (i.e., behaviors occurring just before pulling). Competing responses and stimulus control options were introduced and collaboratively discussed to determine which to begin implementing. Examples of competing responses included sitting on her hands or folding her arms for a minimum of one minute when noticing her pulling signals.

Luna began implementing behaviors such as pulling her hair back, putting lotion on her hands, putting a mirror up at her desk, and wearing a hat when talking on the phone with her family members as stimulus control behaviors. Each of these functioned as stimulus control as they made it more difficult for Luna to engage in hair pulling. More specifically, Luna was less likely to pull from her scalp when her hair was pulled back and gelled or when she was wearing a hat. She found it more difficult to grip the hair follicle when there was lotion on her hands. The mirror on the desk served as a deterrent for Luna as the mirror showed her the hair loss she was experiencing as a result of hair pulling and she was reminded of why she wanted to relate to her urges differently. Lastly, she would typically pull when she was alone in the car so she would use her hands to drive and distract herself by connecting with her family members on the phone.

Sessions 3-7 focused on introducing ACT concepts and skills while maintaining the behavioral therapy components learned in sessions 1 and 2. Sessions 3 focused on identifying the costs of living with trichotillomania (i.e., the impact on domains of life), identifying and clarifying personal values and goal setting, and assessing the degree to which she is currently taking action towards personal values. Through discussion, Luna identified personal values of growth (personally and academically) and connection with loved ones (*familismo*). Luna set goals such as of being able to swim in public (e.g., pool or beach) without having to cover her hair loss. Session 4 focused on the tendency to avoid thoughts, emotions and social interactions, and how control of these internal experiences can be self-defeating. Session 5 introduced acceptance or willingness to experience unpleasant internal experiences (e.g., urge to hair pull) and relate to them differently through self-compassion. Experiential exercises were conducted to highlight that her urges can be viewed as "warning signs" and that she has a choice in her action. She described her urge to engage in hair pulling as a dog which led to a conversation on

compassion. More specifically, Luna imagined her hair pulling urge as a Rottweiler dog, which she believed are often misunderstood as aggressive and should be treated with more compassion. She connected this analogy to how she would like to relate to her hair pulling urges (i.e., with self-compassion). Session 6 included a review of defusion of language (seeing internal experiences as just internal experiences) and acceptance (allowing internal experiences to exist without struggle against them), as well as introducing self-as-context (you are not your urges). Luna expressed worry that she will hair pull in the future as she was surprised at the lack of hair pulling since early treatment. She used this as an opportunity to practice defusion with the "worry thought." The passengers on the bus metaphor (where the client is the driver and internal experiences are passengers) was discussed and she connected the "passengers" to characters in the "Inside Out" film. For additional context, "Inside Out" takes place in the mind of a girl where the main characters are five emotions including Joy, Anger, Sadness, Disgust, and Fear. Luna connected with the imagery of each internal experience being a part of her. Lastly, Session 7 was the termination session. It focused on reviewing habit reversal training concepts and ACT related concepts, as well as relapse prevention planning. Habit reversal training aspects (competing response, stimulus control) were addressed at sessions 3 through 8 to determine if any changes or modification were needed.

Cultural adaptations of psychological interventions are typically guided by the ecological validity model (EVM) framework (Bernal et al., 1995). This framework included eight dimensions of treatment including language, persons, metaphors, content, concepts, goals, methods, and context. For language, there were no adaptations needed as the treatment was delivered in English and Luna spoke both English and Spanish fluently. In considering person or the comfortability with the relationship, rapport was established quickly and with ease.

Metaphors used in treatment were not intentionally culturally adapted but were delivered flexibly. For example, she understood the "Passengers on the Bus" metaphor and then related it to characters in a Pixar movie as she was a mother of two young children. As for content, cultural relevance was highlighted in Luna's efforts of identifying and clarifying her values. She expressed a strong dedication and commitment to her immediate and extended family (i.e., *familismo*). She spoke to them often. She would help them with life management tasks (e.g., booking flights). She made sure to speak Spanish when speaking to family residing in Mexico when they were adamant in speaking English to her. When she spoke of her parents and aunts, she displayed a respect for their view of her (i.e., *respeto*). She seemed fearful of a perceived stigma in being diagnosed with trichotillomania and seeking treatment for it at the beginning of treatment as she was hesitant to tell her family members. She reported getting name-called or teased for being more educated than her older family members. In treatment, she expanded on gender roles in her family culture by adding that the older men in her family expressed a preference that women have long hair. Luna seemed to be keeping a balance of dependence, independence, and interdependence within her family system. She held strong values of "good" behaviors (i.e., *buena educación*) through seeking higher education, working a full-time job while also being a wife and mother to two young children. Concepts and goals went hand in hand with Luna. She reflected a harmony with her Latine culture through her personal goals. Meaning, she aimed to set goals that aligned with her values and cultural context. For example, Luna would travel to Mexico frequently with her family where the women engaged in microbraiding and swimming in the ocean. She felt low confidence at these activities due to her hair pulling and set goals around these events so they were meaningful. For methods, the therapist offered a flexible format of telehealth sessions as an option to save Luna from driving long distances for

therapy. However, she noted she enjoyed the drive as it gave her an opportunity to call and connect with her family in California.

8. Complicating Factors

As previously stated, Luna was diagnosed with postpartum depression prior to seeking treatment for her trichotillomania. Although this could have been a complicating factor if symptoms were severe, she noted that her symptoms had improved in the weeks prior to treatment. Further, there was lack of empirical evidence and guidance on a culturally adapted A-EBT intervention for the Latine community. To address this factor, the student therapist consulted with the supervising clinician who has experience in implementing A-EBT for other minority groups (Neal-Barnett et al., 2019). Although Luna had a close connection with her husband, sibling, parents and extended family members, there was a cultural factor that made it difficult for openly discuss her mental health condition and receive support for being in treatment. This could have provided a lack of encouragement, validation, communication, and feelings of isolation. After the values-based conversation in session, Luna began sharing more about her condition and being in treatment with her family members. Lastly, the rate in which Luna improved in her reduction of hair pulling was complicated. It was unclear if this progress was more from Luna "powering through" not pulling as compared to implementing psychological flexibility and behavioral techniques to no longer hair pull.

9. Access and Barriers to Care

Luna's access to specialized care was limited. She drove approximately one hour one way to receive specialized services for the treatment of trichotillomania. After eight weeks of in-person treatment, she attended the remaining two sessions via telehealth as they served as check-in or maintenance sessions. There seemed to be some resistance in seeking treatment when she first

noticed her hair pulling. She discussed her hair pulling behaviors with a family member and was advised against seeking services as it would be on her medical record and others would think she was "crazy." Luna was the only member of her extended family to seek mental health treatment. She noted that her family members did not "believe in" therapy and not asking for help was part of her family culture. She recalled being teased by family members for being "whitewashed" in seeking mental health services. In recent years, her husband noticed and inquired about her hair loss and assumed it was due to high levels of stress. At that time, Luna did not disclose her condition to him. These factors likely maintained the social isolation she experienced in coping with her trichotillomania. By the end of treatment, she felt comfortable communicating the benefits she received from seeking treatment for her trichotillomania to her family members.

10. Follow-Up

Luna appeared to respond well to treatment as assessed through self-report measures and tracking of behaviors. At each session, she would report the daily number which was averaged for the week. She continued to track daily even when sessions became bi-weekly which is why there are 10-weeks of data. At intake, she pulled an average of 140 hairs per week. By week 4 (i.e., session 3), Luna did not engage in hair pulling. This sustained throughout the course of treatment (i.e., week 10). In addition, Luna's progress was monitored by scores on measures following each session (Table 1) and self-reported number of hairs pulled per day. Luna's anxiety and depressive symptoms reduced from 5 to 4 and 3 to 0 from intake to end of treatment, respectively. Her trichotillomania symptom severity measured by the MGH-HPS reduced from 6 to 4 from session 1 to session 7. Luna's psychological flexibility improved as shown by scores on the AAQ-4TTM from session 1 to end of treatment (score of 29 to 18).

11. Treatment Implications of the Case

There are a few implications to highlight from Luna's case. First, it seems there may be some benefit in seeking specialized treatment for trichotillomania. Luna's interactions with health care involved health services through her primary care during her pregnancy and couple's therapy. She had been married for approximately 10 years at intake. She recalled approaching the marriage in a business-like manner which she later felt guilt for. She entered couples therapy to address financial spending and learned she also wanted to improve their communication. Although she sought mental health treatment once before, it seemed more acceptable for her to seek treatment that focused on behavioral aspects (e.g., spending), as compared to psychological conditions. For psychological conditions like depression, she went to her physician. Shortly after receiving specialized treatment, the number of hairs pulled per day from intake to week 1 dropped drastically then resulting in no hair pulling by week 4. Secondly, it should be noted that she credited the reduction in hair pulling to the power of speaking to someone about her hair pulling patterns after hiding it from loved ones for 15 years. Third, the cultural family values played a role in her treatment seeking (i.e., risk of delay in seeking care) and staying in treatment (i.e., desire to not have her children engage in similar behaviors). Luna reported that the intersection of her ethnic and gender identity (i.e., Hispanic woman) act as barriers and are minority group identities. Fourth, Luna's case is consistent with previous literature on trichotillomania among ethnic minority groups including a stigma to seek treatment from community and family members and pulling primarily from her scalp.

12. Recommendations to Clinicians and Students

Our first recommendation would be to encourage clinicians and student therapists to understand the cultural factors maintaining symptoms to build a strong case conceptualization. Be sure to assess avoidance behaviors that are common in trichotillomania (e.g., cutting one's

own hair) and those that are culturally relevant (e.g., not engaging in microbraiding on family vacations). In addition to avoidance behaviors, it is highly recommended that the therapist should use appropriate methods to inquire about the stigma and social isolation the client experiences because of their diagnosis. For example, the ADDRESSING Identities assessment tool was a useful resource in understanding the client's identities and the experience of how they interact. It is recommended that the clinician understand how these factors may also be contributing to barriers to care. The ADDRESSING framework approach emphasizes clinicians recognize the areas in which they are a member of the dominant group to help increase awareness of ways that such identities limit knowledge and experience of those from minority groups. Further, the framework helps clinicians avoid inaccurate generalizations of a client based on their characteristics (e.g., appearance, name). Understanding a client's identities also allows the clinician to seek out culture-specific information that may help them better treat the client. In A-EBT, clinicians aim to promote values-based action. This requires the clinician and client to identify personal values, the values from their social support system or community, and the interaction of these values. It is recommended that the clinician and client work to identify why changing hair pulling behaviors would be worth it to the client as the treatment involves internal and external strategies.

Given this was a clinical case, the collection of follow up data from the client was not permitted after the termination of therapy. However, there is evidence to support the effectiveness of A-EBT in reducing trichotillomania severity and trichotillomania related distress at both 3-month and 6-month follow up, with medium to large effect sizes (Petersen et al., 2022). It is recommended that future research examine the effects of A-EBT on trichotillomania at delay timepoints to further understand the impact of psychological flexibility.

Another recommendation is to encourage more clinicians and students to participate in trichotillomania specific trainings or familiarize themselves with evidence-based trichotillomania treatment manuals. A recent survey study showed that Utah licensed mental health providers had outdated or inaccurate knowledge of trichotillomania and felt their training had not prepared them to treat trichotillomania (Capel et al., 2023). Helpful trainings are offered online or in-person by The TLC Foundation for Body-Focused Repetitive Behaviors and by the International OCD Foundation (IOCDF). Suggested evidence-based treatment manuals for trichotillomania include a clinician's guide for HRT in trichotillomania (Morris et al., 2013) or the therapist guide for A-EBT (Twohig & Woods, 2023).

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Table 1
Patient's scores on standardizes measures over course of treatment

	Intake	Session 1	Session 2[a]	Session 3	Session 4	Session 5	Session 6[b]	Session 7
AAQ-4TTM	N/A	29	N/A	18	15	21	N/A	18
GAD-7	5	2	N/A	2	1	6	N/A	4
PHQ-9	3	1	N/A	2	1	1	N/A	0
MGH-HPS	N/A	6	N/A	0	4	5	N/A	4

[a]Surveys were not administered by clinic staff by mistake.
[b]Surveys were not administered due to telehealth format
Note. AAQ-4TTM = Acceptance and Action Questionnaire for Trichotillomania; GAD-7 = Generalized Anxiety Disorder 7; PHQ-9 = Patient Health Questionnaire 9; MGH-HPS = Massachusetts General Hospital Hairpulling Scale.