**Mental Health Providers’ Knowledge of Trichotillomania and Skin Picking Disorder, and Their Treatment**

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**Abstract**

**Background**

In 2006, Marcks and colleagues assessed healthcare providers’ knowledge of trichotillomania and its treatment and found a general lack of knowledge of trichotillomania and limited experience in providing treatment. Due to growth in knowledge of and treatments for trichotillomania, we aimed to replicate Marcks and colleagues’ study and extend it to include skin picking.

**Methods**

In this study, all licensed mental health providers (e.g., social workers, psychologists; N=329) in Utah were contacted via email to complete an online survey assessing knowledge and treatment of trichotillomania and skin picking.

**Results**

Approximately half of participants had never treated a client for trichotillomania or skin picking. Participants had largely outdated or inaccurate knowledge of diagnostic criteria for trichotillomania and skin picking, and inaccurately identified evidence-based treatments (e.g., 30% noted psychoanalysis and 25% noted hypnosis as effective Participants reported feeling that their training had not prepared them to treat either disorder and expressed interest in additional education.

**Conclusions**

Provider knowledge of trichotillomania and skin picking remains limited, and a need for enhanced education and training on these disorders exists. Providers indicated interest in training opportunities (e.g., workshops on diagnosis and evidence-based treatments). Implications of these findings and future directions are discussed.

*Keywords:* trichotillomania, skin picking, body-focused repetitive behaviors, mental health providers, knowledge

**Mental Health Providers’ Knowledge of Trichotillomania and Skin Picking Disorder, and Their Treatment**

Trichotillomania and skin picking are body-focused repetitive behaviors (BFRBs) that are chronically undertreated disorders despite the severity of their impact on the individual (Walther et al, 2010; Capriotti et al., 2015). Trichotillomania is characterized by repetitive hair pulling that leads to notable hair loss and negatively impacts various domains of functioning (American Psychiatric Association [APA], 2013). Social impairment can include difficulties in close relationships, declining to pursue occupational or educational advancements, and interference in schooling (Grant et al., 2017; Woods et al., 2006). The prevalence of trichotillomania in the United States is 1-2% (APA, 2013). Although commonly believed to be more prevalent in women than men, more recent research suggests the disorder may be evenly disbursed across genders (Grant et al., 2020).

Skin picking disorder is characterized by skin picking that is repetitive, causes skin lesions, leads to clinically significant distress, and impacts both social and functional domains (Houghton et al., 2018; APA, 2013). Impairment caused by skin picking is similar to impairment found in those with trichotillomania (Keuthen et al., 2010). The prevalence of skin picking in the United States in 1-5% (Keuthen et al., 2010). Similarly, previous research suggested that women were disproportionately impacted by skin picking, but more recent research suggests that men and women are impacted similarly (Grant & Chamberlain, 2020). Trichotillomania and skin picking have high comorbidity with other mental health disorders including anxiety and depressive disorders, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and attention-deficit hyperactivity disorder (ADHD; Grant et al., 2020; Grant & Chamberlain, 2020).

Given the impact of trichotillomania and skin picking, there has been an increase in intervention research in this area over the last two decades. Most of this work has been on trichotillomania (e.g., Twohig et al., 2021; Lee, Homan, et al., 2018; Keuthen et al., 2012), but numerous studies have also been conducted for skin picking (e.g., Capriotti et al., 2015). These interventions include acceptance-enhanced behavior therapy (AEBT; Twohig et al., 2021; Capriotti et al., 2015), habit reversal training (HRT; Lochner, Roos, Stein, 2017; Teng et al., 2016), and dialectical behavior therapy (DBT; Keuthen et al., 2012). Additionally, intervention research has included pharmacotherapies, but these have often demonstrated conflicting results and have yielded less robust outcomes than psychotherapies (Jones et al., 2018). The medications that have shown some success in randomized controlled trials are olanzapine, N-acetylcysteine (NAC), and fluoxetine (Jones et al., 2018). While tested less rigorously than the other medications listed, clomipramine has shown some benefits for trichotillomania specifically (Hoffman et al., 2021). Despite the increased research, there is still a significant need for increased availability of treatments (Lee et al., 2018).

In 2006, Marcks and colleagues studied providers’ (medical and mental health professionals) knowledge of trichotillomania and associated treatments to better understand if providers’ knowledge was a barrier to treatment access. Marcks and colleagues found that healthcare providers in the midwestern region of the United States answered correctly to 61% of general knowledge information about trichotillomania and the efficacy of treatments (Marcks et al., 2006). However, most providers endorsed efficacy of non-empirically supported treatments and lacked knowledge of referral resources for treatment of trichotillomania (Marcks et al., 2006). These findings indicate that, in 2006, providers in this midwestern region of the United States had limited knowledge of diagnosis and treatment of trichotillomania. While causal statements cannot be made based on this study alone, lack of provider knowledge of diagnosis and treatment of trichotillomania could be a barrier to treatment access.

Since the study by Marcks and colleagues (2006) was published, there has been an increase in treatment research and dissemination of treatments through telehealth (e.g., Lee et al., 2018) and website interventions (e.g., Storch et al., 2014). Therefore, it is likely that there is an increased awareness of treatment options and knowledge of trichotillomania. However, there are no current data available on providers’ knowledge of trichotillomania and its treatment. The present study seeks to replicate the work of Marcks et al. (2006) and extend it to include skin picking as a way of better understanding how providers’ knowledge may have improved or changed in the last two decades. Specifically, we assessed mental health providers’ knowledge of trichotillomania and skin picking diagnoses, treatment options, resources, and referral options. Additionally, we assessed if education level or job title related to knowledge in these areas. If differences are found between education level and job title, this would impact the target of dissemination efforts (e.g., targeting specific types of programs). This information will inform current need for education and training opportunities for mental health providers on trichotillomania and skin picking treatment, resources, and referral options.

**Methods**

Participants (*N*= 329) were mental health providers licensed to practice within the state of [removed for masked review]. To participate in the study, participants had to be social workers, therapists, psychologists, or another type of mental health provider licensed in the state of [removed for masked review]. Participants were recruited from the entire Division of Professional Licensing email list of state licenses for individuals holding the following licenses: Certified Social Worker, Social Service Worker, Certified Social Worker Intern, Licensed Clinical Social Worker, Associate Clinical Mental Health Counselor, Clinical Mental Health Counselor, Associate Marriage and Family Therapist, Marriage and Family Therapist, and Psychologist. The survey was sent to 14,214 individuals, 187 emails were undeliverable to the email on file, 329 individuals completed the survey. The survey was closed after four hours from the launch of the emails as the desired sample size was obtained. There were no exclusion criteria for the study. Participants were predominantly White (85.4%) and women (72.9%), with an average age of 38.6 years. The providers mostly held masters level degrees (e.g., M.A., M.S., M.S.W) and had been practicing for between 2-5 years. See Table 1 for more details on participant demographics.

Study participation involved completing a 10–15-minute survey that included demographic questions, as well as a brief assessment about trichotillomania and skin-picking diagnoses and treatment. Participants were asked to respond to the questions to the best of their ability without looking up the answers. Following completion of the survey, participants were compensated with a 10-dollar gift card.

**Measures**

The survey contained four major sections: demographics, experiences with trichotillomania and skin picking, general questions about trichotillomania and skin picking, and treatment. Please see Supplemental Table 1 to view the entire survey.

***Demographics***

Participants were asked to report their gender, birth year, and racial and ethnic identity. They were also asked about the highest educational degree they have earned, along with their general job title and the length of their practice with a license. Participants also were asked to select whether the majority of their clients were children/adolescents, adults, older adults, or across the lifespan.

***Experiences with Trichotillomania and Skin Picking***

In this section, participants selected the approximate number of persons they had treated for trichotillomania, skin picking, OCD, or other body-focused repetitive behaviors (e.g., nail biting) respectively. They also selected the approximate number of persons they have treated who have trichotillomania and/or skin picking as a secondary concern. Participants were asked to report on the following scale: 0, 1-2, 2-5, 5-10, 11-20, 20+.

***General Questions about Trichotillomania and Skin Picking***

Participants were asked to select *agree, disagree,* or *don’t know* in response to a list of six statements regarding the specific criteria necessary to receive a diagnosis of trichotillomania (e.g., “a person must experience gratification or relief when pulling out the hair”) and skin picking (e.g., “a person must experience clinically significant distress or impairment due to picking”). Both accurate criteria from DSM-V and inaccurate criteria from DSM-IV TR were included. Participants used the same response options to then respond to 10 questions about trichotillomania and skin picking (e.g., “Trichotillomania can result in medical problems,” “The average onset of skin picking is during adolescence”). Lastly, participants were given a list of statements that are accurate about the diagnosis of trichotillomania and skin picking. They were asked which of the statements they were aware of prior to completing the survey. Seven true statements about trichotillomania (e.g., “individuals with trichotillomania may use devices like tweezers to assist in pulling”) and six true statements about skin picking (e.g., “individuals with skin picking disorders may manipulate the skin after picking it) were listed.

***Treatment***

Participants were first asked to select *agree, disagree,* or *don’t know* in response to four general statements about the available treatments for trichotillomania and skin picking (e.g., “There are evidence-based psychosocial treatments for trichotillomania”). Participants also selected “true” or “false” in response to “Trichotillomania and skin picking are treated differently.” Additionally, participants were asked to select what roles they believed a psychologist/therapist could play in treating people with trichotillomania: treating hairpulling, treating comorbid depression, treating comorbid anxiety, treating comorbid substance use, treating relationship problems, educating about the disorder, and/or other.

They were then asked to select whether of the following medications are evidence-based for the treatment of trichotillomania and skin picking: N-acetylcysteine, Clomipramine, Olanzapine, Clonazepam, and Lithium. Participants were similarly provided with a list of eight psychotherapies (e.g., psychoanalysis, dialectical behavior therapy, habit reversal) and asked whether the treatment was evidence-based (*agree, disagree, or don’t know*) and whether they knew how to implement the treatment. Respondents were not provided with a formal definition of “evidence-based” in an effort to decrease the potential that respondents would research or look up the correct answer. They were also asked to rate their perceived competence and training in the treatment of trichotillomania and skin picking (0 = *not competent*, 10 = *very competent*).

Lastly, participants responded yes or no in response to 14 questions regarding their awareness about various resources for individuals with trichotillomania and/or skin picking (e.g., “Do you know of any self-help books for persons with skin picking?” “Does your clinic have any informational material about trichotillomania available to clients?”).

**Data Analyses**

All analyses for the present study were conducted in R version 3.6.3 (R Core Team, 2020) in R Studio (R Team, 2020). The following packages were used: tidyverse (Wickham, 2017), lme4 (Bates et al., 2015), texreg (Leifeld, 2013), and furniture (Barrett & Brignone, 2017).

Descriptive statistics were used to understand the sample characteristics and knowledge of trichotillomania and skin picking and their treatment. To assess the moderating effect of variables like education level and job title on knowledge of trichotillomania and skin picking, multilevel models (MLM) were used because of the hierarchical nature of these data (e.g., level 1 education level or job title and level 2 individual). For each outcome, we compared four nested models to find the best fitting model. Each outcome was fitted first with the null model (i.e., only random intercepts for individual participants), and then we added additional fixed effects of job title-only, then education-only, then both job title and education in one model.

To identify the best-fitting model, each model was nested to compare the last best-fitting model with the new model. A likelihood ratio test (*p* < .05) was used, and maximum likelihood criterion was fitted for the final models.

**Results**

***Experiences with BFRBs and OCD.***

Descriptive analyses were conducted to assess how many participants had worked with individuals with trichotillomania, skin picking, BFRBs generally, and OCD as either a primary or secondary concern. Most participants reported working with adults. Approximately half of the participants reported to working with 1-2 or fewer patients with trichotillomania or skin picking. Approximately 38% of participants reported working with 1-2 participants with skin picking as a secondary concern. Most participants reported having worked with someone with OCD (93%) and many (approximately 24%) had worked with 3 or more patients with OCD. Additionally, 42% of participants reported never working with someone with a BFRB. Of participants who had served individuals with BFRBs, nail biting was the most common diagnosis. See Table 2 for more details on provider experiences treating trichotillomania and skin picking.

***General questions about trichotillomania.***

Descriptive statistics were conducted to assess the percentage of participants who correctly identified current diagnostic criteria and could differentiate the current criteria found in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-V) from criteria in DSM-IV-TR. Of the current criteria for trichotillomania, the majority (approximately 70%) of participants accurately stated that an individual needs to have tried to stop pulling and approximately 80% accurately stated that the pulling must cause clinically significant distress. Additionally, 90% of participants correctly identified trichotillomania as an obsessive-compulsive related disorder.

Of the DSM-IV-TR criteria, the majority (approximately 58%) of participants inaccurately stated that to diagnose trichotillomania there needed to be as sense of gratification after pulling, 65% inaccurately stated that pulling must have an associated feeling of tension, and 48% inaccurately reported that there must be obsessive-type thoughts associated with pulling. Notably, 25% of participants did not know the average age of onset for trichotillomania symptoms, approximately one-third of participants inaccurately identified that there is a known cause of trichotillomania, and one-third did not know if there is a known cause. When asked if trichotillomania typically begins following a traumatic event, 25% inaccurately identified this as true and 34% reported that they did not know. See Table 3 for more details on correctly identified diagnostic criteria. These findings show notable inaccuracies in providers understanding of trichotillomania.

MLM was conducted to assess if education level (associates, masters, doctoral) or job title (social worker, psychologist, mental health counselor) moderated these findings. The findings indicated that neither job title, nor education level significantly moderated general knowledge of trichotillomania, indicating this is a problem across professions.

***General questions about skin picking.***

Descriptive statistics were conducted to assess the percentage of participants who correctly identified current diagnostic criteria and could differentiate the current criteria found in DSM-V from criteria in DSM-IV-TR. Of the current criteria needed for diagnosis of skin picking, the majority (approximately 60%) of participants accurately stated that an individual needs to pick frequently leading to skin lesions, approximately 72% accurately stated that the individual must have made repeated attempts to stop picking, and approximately 85% accurately reported that a person must experience clinically significant distress or impairment caused by picking. Additionally, 85% of participants correctly identified skin picking as an obsessive-compulsive related disorder.

Of the DSM-IV-TR criteria, the majority (approximately 52%) of participants inaccurately stated that to diagnose skin picking there needed to be as sense of gratification after picking, 49% inaccurately stated that picking must have an associated feeling of tension and 20% reported that they did not know. Approximately 48% inaccurately reported that there must be obsessive-type thoughts associated with picking. Notably, 30% of participants did not know the average age of onset for skin picking symptoms.

MLM was conducted to assess if level of education (associates, masters, doctoral) or job title (social worker, psychologist, mental health counselor) moderated these findings. The findings indicated that neither job title, nor education level significantly moderated general knowledge of skin picking.

***Treatments.***

Descriptive statistics were conducted to assess if participants knew about the treatment of trichotillomania and skin picking. When asked if the treatments for trichotillomania and skin picking are different, approximately 50% stated that they were different. Most participants identified that there are evidence-based psychosocial and pharmacological treatments for trichotillomania and skin picking. However, participants were not aware of which medications were evidence-based.

Participants were asked to identify which psychosocial treatments were evidence-based and if they knew how to implement the treatment. Approximately two-thirds of the participants inaccurately identified psychoanalysis, hypnosis, and exposure and response prevention (ERP) as evidence-based treatments for trichotillomania and skin picking. Approximately two-thirds of participants accurately identified habit reversal training (HRT), dialectical behavior therapy (DBT), and cognitive behavior therapy (CBT) as evidence-based treatments for trichotillomania and/or skin picking. Approximately half of the participants accurately identified acceptance and commitment therapy (ACT) as an evidence-based treatment. More than 50% of participants reported that they could implement ACT, psychoanalysis, CBT, DBT, and ERP. See Table 4 for more details on correct identification of evidence-based treatments.

Participants were also asked how competent they felt in their ability to treat trichotillomania and skin picking. Responses varied widely on a scale of 0 to 10 (0= not competent, 10=very competent). For treatment of trichotillomania the median competency rating was 3-4, and for treatment of skin picking the median competency rating was 4-5. When asked if participants felt that their training effectively prepared them to treat trichotillomania and skin picking, the median rating was 2-3 for trichotillomania, and the median rating was 3 for skin picking. Most notably, 81% of participants reported that they would be interested in receiving training to treat trichotillomania and 82% reported interest in training to treat skin picking.

Participants were asked to identify their knowledge of treatment resources and self-help options available for clients with trichotillomania and skin picking. Most participants were not aware of support groups, self-help programs, or self-help books for either trichotillomania or skin picking. Additionally, under 30% of participants knew what referral options were available for individuals with either skin picking or trichotillomania and had previously heard of the TLC Foundation for BFRBs. These findings are notable as there are multiple publicly available web-based interventions and bibliotherapies on the treatment of trichotillomania and skin picking. Also, the TLC Foundation for BFRBs is the leading referral resource in the USA, making these findings striking.

Finally, participants were asked what role they believed psychologists or therapists should play in the treatment of trichotillomania. Over 80% believed therapists should treat hair pulling, comorbid depression, anxiety, substance use, relationship problems, and provide psychoeducation.

**Discussion**

The current study was based on Marcks and colleagues (2006) paper on providers’ knowledge of trichotillomania and aimed to similarly address knowledge of trichotillomania and skin picking. The purpose of the present study was to assess current Utah-based mental health providers’ knowledge of trichotillomania and skin picking, treatment options, resources, and referral options. This is the first study since 2006 that assessed provider knowledge of BFRBs generally. The findings of this study demonstrated a lack of knowledge of diagnosis and treatment of trichotillomania and skin picking. Despite the amount of research since the Marcks and colleagues (2006) study was published, providers had limited awareness of evidence-based treatments, resources and referral options for trichotillomania. The gap in providers’ knowledge speaks to a larger issue of the speed of dissemination of research to practice. It highlights the need for education and training opportunities in this area.

***Experience with BFRBs and OCD.***

The majority of participants reported that they worked with adults but had limited experience with trichotillomania and skin picking specifically. Almost half had never treated a BFRB. This is interesting given the prevalence rates of these diagnoses and that the typical age of onset is during early adolescence (APA, 2013; Grant et al., 2020). Individuals with BFRBs may not be seeking out treatment, or perhaps the lack of reported expertise may limit what providers are being contacted for treatment for picking and pulling specifically.

***General Questions about Trichotillomania and Skin Picking.***

Of the current diagnostic criteria for trichotillomania, most participants correctly identified that, in order to diagnose trichotillomania, the person needed to have tried to stop pulling and that the pulling needs to cause clinically significant distress. However, most participants also identified many inaccurate diagnostic criteria. For skin picking there was more variability in knowledge. Over half of the participants correctly identified that skin picking must lead to skin lesions, the person must have tried to stop picking, and that it causes clinically significant distress and impairment. Approximately half of the participants identified many inaccurate diagnostic criteria. Some of these criteria were from previous versions of the DSM, and others were simply inaccurate. Despite our prediction that education level and job title would moderate knowledge around diagnosis of trichotillomania or skin picking, the findings were null. This is interesting because training models in different types of degrees and programs place greater or less emphasis on diagnosis and it would be expected that there would be a difference in knowledge based on educational background. However, given that all providers in this study are mental health providers, we may see fewer differences between groups. Additionally, our sample consisted mostly of master’s level clinicians, and it is possible that the sample did not fully capture other degree levels knowledge. It is also possible that doctoral programs have less emphasis on and limited clinical training experiences with BFRBs so despite the longer program, opportunities for experiences with BFRBs may not differ from masters programs.

***Treatments.***

Participants were asked about treatment options for trichotillomania and skin picking. Approximately half reported that the treatments are different for trichotillomania and skin picking. Most participants identified that there are evidence-based psychosocial and pharmacological treatments available for both. Half of the participants correctly identified that HRT, DBT, CBT, and ACT were evidence-based treatments for trichotillomania and skin picking and felt competent to implement these treatments. However, approximately two-thirds of the participants incorrectly identified psychanalysis, hypnosis, EMDR and ERP as evidence-based treatments for trichotillomania and/or skin picking. Self-reported competence varied across all interventions. Nevertheless, the majority of participants reported feeling that they were not competent to moderately competent to treat trichotillomania and skin picking. Further, most participants reported feeling that their training had not prepared them or had moderately prepared them to treat trichotillomania and skin picking. Finally, most participants were unaware of resources, support groups, and self-help opportunities for trichotillomania and skin picking. This lack of knowledge of resources and treatment options could potentially impact individuals who are receiving support and treatment for BFRBs. However, approximately 80% reported interest in education and training opportunities should they be made available to better be able to serve individuals with BFRBs.

***Clinical Implications.***

These findings indicate a need in Utah for additional education and training for trichotillomania and skin picking in mental health graduate programs and broader continuing education options for licensed providers. These trainings should highlight current diagnostic criteria (e,g., impairment and distress caused by picking or pulling), presentations of these disorders (e.g., frequency and location of picking and pulling), evidence-based treatments (e.g., HRT, ACT, DBT, combined interventions), and referral options (e.g., self-help websites, bibliotherapy, and referrals through the TLC Foundation for BFRBs). Providers have limited experience with and knowledge to effectively provide treatment and feel that their training had not prepared them to do so. Given the level of interest in training opportunities, it appears there is an untapped need. By increasing training and general knowledge, it is possible to increase the number of people who are receiving evidence-based treatments and support for their pulling and skin picking. Training and education could include continuing education workshops or conference workshops from expert clinicians on how to deliver acceptance enhanced behavior therapy (ACT + HRT), combined DBT and HRT, or HRT alone to increase the training experiences providers have had in treatment of trichotillomania and skin picking. Additionally, these workshops could include information on how to diagnose pulling and skin picking as well as resources and referral options available within and outside the United Sates. These types of workshops will increase accurate diagnosis of these disorders, dissemination of evidence-based treatments, and improve accessibility of care for individuals with trichotillomania and skin picking.

***Limitations.***

While the results of this study are important, there are limitations. First, the survey was distributed to mental health providers in Utah and as a result these findings may not generalize to providers across the United States. In Utah, there are research experts in treatment of trichotillomania and this may have impacted the results in that providers may have greater knowledge than in other regions of the United States. It is also possible that education and knowledge in Utah is lower than in other areas and regions of the United States. These factors may also explain a lack of difference between providers sampled in this study compared to the findings in the Marcks et al (2006) study. However, fully screening all licensed professionals in Utah allowed recruitment of a more representative sample rather than using a convenience sample. There is not research currently that looks at regional differences in treatment availability. Additionally, it is important to assess availability of treatments and provider knowledge of trichotillomania and skin picking outside of the United States (e.g., Europe, South America) to assess if these findings are generalizable. This is an area of future research and may impact the generalizability of the current study. Another limitation is that the data was collected rapidly, reaching the target sample size within four hours of launching the study. While all mental health providers in Utah were contacted before the target sample size was reached, it is possible that some providers did not have the opportunity to participate due to the rapid time frame. This may have biased the sample because of financial incentive, interest in trichotillomania or skin picking, and work setting. However, the results of this study show that the training and educational needs are great and therefore increased availability would likely be beneficial. Furthermore, most participants reported having never worked with someone with trichotillomania and/or skin picking. It is possible that this biased the findings, as limited experience with these disorders may be a reason for less knowledge. However, given that approximately half of the participants reported having worked with someone with either trichotillomania or skin picking as a secondary concern indicates that the need for treatment trainings is present in Utah] and the people in our sample. Another limitation worth considering is while the researchers asked participants to not research correct answers and to answer based on their current knowledge, it is possible that participants did look up correct answers which may have impacted the results. Given the current findings, however, it would appear that knowledge of diagnosis and treatment of trichotillomania and skin picking is low.

***Conclusion.***

The findings from this study indicate a need for increased training and education on trichotillomania and skin picking for mental health providers with all educational backgrounds and current positions in Utah and likely the United States. Future directions include exploring best methods for disseminating current (and emerging) information regarding these disorders in hopes to increase provider knowledge and competency to treat trichotillomania and/or skin picking. Additionally, future research should assess knowledge of diagnosis and treatments for other disorders to elucidate whether these findings are unique to trichotillomania and skin picking.

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Table 1

*Demographics for the Entire Sample*

|  |  |
| --- | --- |
|  | Entire Sample  (*N* = 329) |
| Age (*SD*) | 38.6 (8.70) |
| Gender (%) |  |
| Man  Woman  Non-binary/ third gender  Other  Prefer not to say | 88 (25.20)  254 (72.80)  3 (0.90)  1 (0.30)  3(0.90) |
| Race (%)  White  Black or African American  Asian  Hispanic, Latino or Spanish Origin  American Indian or Alaska Native  Middle Eastern or North African  Native Hawaiian or Other Pacific Islander  Another Race Not Listed | 299 (85.40)  6 (1.70)  13 (3.70)  21 (6.00)  2 (0.60)  1 (0.30)  1 (0.30)  5 (1.40) |
| Education (%) |  |
| M.S./M.S.W.  M.D./ D.O.  Ph.D./Psy.D.  Other | 290 (83.10)  1 (0.30)  50 (14.30)  8 (2.30) |
| Job Title (%) |  |
| Social Worker  Counselor  Psychologist  Marriage and Family Therapist  Other  Years Practicing (%)  Less than 1 year  1-2 years  2-5 years  6-10 years  11-15 years  16+ years | 169 (48.40)  83 (23.80)  37 (10.60)  35 (10.00)  25 (7.20)  12 (3.65)  58 (17.60)  100 (30.39)  78 (23.70)  49 (14.89)  66 (20.01) |
|  |  |

*Note.* M.S. = Masters of Science, M.S.W= Masters of Social Work, M.D.= Doctor of Medicine, D.O. = Doctor of Osteopathic medicine, Ph.D. = Doctor of Philosophy, Psy.D. = Doctor of Psychology

Table 2

*Reported Clinical Experiences*

|  |  |
| --- | --- |
|  | Entire Sample  (*N* = 329) |
| Age (*SD*) | 38.6 (8.70) |
| Age of clients (%) |  |
| Children/Adolescents  Adults  Older Adults  Across the Lifespan | 87 (26.40)  168 (51.10)  6 (1.80)  68 (20.70) |
| Clients treated for Trichotillomania (%)  None  1-2  2-5  5-10  11-20  20+ | 170 (51.70)  86 (26.10)  50 (15.20)  11 (3.30)  6 (1.80)  4 (1.20) |
| Clients Treated for Skin Picking (%) |  |
| None  1-2  2-5  5-10  11-20  20+ | 149 (45.30)  107 (32.50)  37 (11.20)  17 (5.20)  7 (2.10)  6 (1.80) |

Table 3

*Percentage of providers who accurately identified if diagnostic criteria is or is not relevant in the diagnosis of trichotillomania and skin picking*

|  |  |
| --- | --- |
|  | Entire Sample  (*N* = 329) |
| To receive a diagnosis of trichotillomania a person must (%)  Experience gratification or relief after pulling (Inaccurate)  Have repeated attempts to stop pulling (Accurate)  Experience increasing tension before pulling (Inaccurate)  Experience clinically significant distress or impairment (Accurate)  Have obsession like thoughts linked to pulling (Inaccurate)  Pulling may occur outside of one’s awareness (Accurate) | 101 (30.70)  229 (69.60)  63 (19.10)  261 (79.30)  104 (31.60)  304 (92.40) |
| To receive a diagnosis of skin picking a person must (%) |  |
| Experience gratification or relief from picking (Inaccurate)  Pick skin frequently leading to skin lesions (Accurate)  Must have repeated attempts to stop or decrease picking (Accurate)  Experience obsession-like thoughts linked to picking (Inaccurate)  Experience clinically significant distress or impairment (Accurate)  Have a dermatopathological diagnosis (Inaccurate) | 110 (33.40)  199 (60.50)  236 (71.70)  100 (30.40)  278 (84.50)  236 (71.70) |

Table 4

*Percentage of providers who accurately identified if a treatment is or is not evidence-based for trichotillomania and skin picking*

|  |  |
| --- | --- |
|  | Entire Sample  (*N* = 329) |
| Evidence-based treatment (%)  Psychoanalysis (Inaccurate)  Eye Movement Desensitization and Reprocessing (Inaccurate)  Hypnosis (Inaccurate)  Exposure and Response Prevention (Inaccurate)  Dialectical Behavior Therapy (Accurate)  Habit Reversal Training (Accurate)  Cognitive Behavioral Therapy (Accurate)  Acceptance and Commitment Therapy (Accurate) | 129 (30.40)  66 (20.10)  81 (24.60)  27 (8.20)  201 (61.10)  206 (62.60)  272 (82.70)  173 (52.60) |

Supplemental Table 1

*Full survey that providers were asked to complete.*

Background Information:

What is your gender? female male other\_\_\_\_ What year were you born? ­­­­\_\_\_\_\_\_\_\_\_\_\_\_

With which racial and ethnic groups do you identify? (select all that apply)

American Indian or Alaska Native

Asian

Black or African American

Hispanic, Latino, or Spanish origin

Middle Eastern or North African

Native Hawaiian or Other Pacific Islander

White

Another race or ethnicity not listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest educational degree you have earned? M.S./M.S.W. Ph.D./Psy.D. M.D./D.O. Other \_\_\_\_\_\_\_\_\_\_\_

What is your general job title? (please specify)

Social Worker Psychiatrist. Psychologist Marriage and family therapist Counselor Other\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been practicing in your field with a license? \_\_\_\_\_\_\_\_ years

The majority of your clients/patients are (please check one):

\_\_\_\_\_children/adolescents \_\_\_\_\_ adults \_\_\_\_\_\_older adults \_\_\_\_\_\_\_\_\_\_\_\_ across the lifespan

Experiences with Trichotillomania and Skin Picking

Number of persons you have treated specifically for trichotillomania 0 , 1-2, 2-5, 5-10, 11-20, 20+

Number of persons you have treated specifically for skin picking 0 , 1-2, 2-5, 5-10, 11-20, 20+

Number of persons you have treated with trichotillomania as a secondary concern: 0 , 1-2, 2-5, 5-10, 11-20, 20+

Number of persons you have treated with skin picking as a secondary concern: 0 , 1-2, 2-5, 5-10, 11-20, 20+

Number of persons you have treated with obsessive-compulsive disorder: 0 , 1-2, 2-5, 5-10, 11-20, 20+

Number of persons you have treated with other body-focused repetitive behaviors (e.g., nail biting): 0 , 1-2, 2-5, 5-10, 11-20, 20+

If yes, which ones?

# General Questions about Trichotillomania and Skin Picking

(Please respond to the following questions to the best of your ability without looking up the answers)

To receive a diagnosis of trichotillomania…

a person must experience gratification or relief when pulling out the hair. Agree Disagree Don’t Know

a person must have repeated attempts to stop or decrease pulling. Agree Disagree Don’t Know

a person must experience increasing tension before pulling or when attempting to resist pulling. Agree Disagree Don’t Know

a person must experience clinically significant distress or impairment due to pulling. Agree Disagree Don’t Know

a person must have obsession-like thoughts linked to pulling. Agree Disagree Don’t Know

a person’s pulling must lead to hair loss . Agree Disagree Don’t Know

To receive a diagnosis of skin picking….

a person must experience gratification or relief from picking. Agree Disagree Don’t Know

a person must pick skin frequently leading to skin lesions. Agree Disagree Don’t Know

a person must have repeated attempts to stop or decrease picking. Agree Disagree Don’t Know

a person must experience obsession-like thoughts linked to picking. Agree Disagree Don’t Know

a person must experience clinically significant distress or impairment due to picking. Agree Disagree Don’t Know

a person must have a dermatopathological diagnosis. Agree Disagree Don’t Know

Trichotillomania is categorized as an obsessive-compulsive and related disorder. Agree Disagree Don’t Know

Hairpulling may occur out of one’s awareness. Agree Disagree Don’t Know

Trichotillomania can result in medical problems.

Agree Disagree Don’t Know

Skin picking is conceptualized as an obsessive-compulsive and related disorder. Agree Disagree Don’t Know

Skin picking can result in medical problems. Agree Disagree Don’t Know

Pulling may occur across many parts/sites of the body. Agree Disagree Don’t Know

The average onset of trichotillomania is during adulthood. Agree Disagree Don’t Know

The average onset of skin picking is during adolescence. Agree Disagree Don’t Know

The cause of trichotillomania is unknown. Agree Disagree Don’t Know

The onset of trichotillomania generally occurs after experiencing a traumatic event. Agree Disagree Don’t Know

The following statements are accurate. Please select the ones that you were aware of. (Select all that apply)

Individuals with trichotillomania…

Usually pull from their scalp,

May use devices like tweezers to assist in pulling.

Often look for a specific type of hair (coarse texture, has a bulb).

May manipulate the hair after pulling it.

May ingest the hair after pulling.

Often pull to regulate mood.

Experience difficulty in dating and work.

Individuals with skin picking disorder…

Usually pick from the face .

May use devices like tweezers to assist in picking.

Look for imperfections in their skin.

May manipulate the skin after picking it.

May ingest the skin after picking.

Pick to regulate mood

# 

**Treatment**

There are evidence-based psychosocial treatments for trichotillomania Agree Disagree Don’t Know

There are evidence-based psychosocial treatments for skin picking Agree Disagree Don’t Know

There are evidence-based pharmacological treatments for trichotillomania Agree Disagree Don’t Know

There are evidence-based pharmacological treatments for skin picking Agree Disagree Don’t Know

Which medications are evidence-based in the treatment of trichotillomania and skin picking?

1. N-acetylsysteine
2. Clomipramine
3. Olanzapine
4. Clonazepam
5. Lithium

Trichotillomania and skin picking are treated differently. True False

I know how to implement this treatment Is an evidence-based treatment.

Psychoanalysis…

Agree Disagree Don’t Know Yes No

Eye Movement Desensitization and Reprocessing (EMDR)…

Agree Disagree Don’t Know Yes No

Hypnosis…

Agree Disagree Don’t Know Yes No

Exposure and Response prevention…

Agree Disagree Don’t Know Yes No

Dialectical Behavior Therapy

Agree Disagree Don’t Know Yes No

Habit Reversal…

Agree Disagree Don’t Know Yes No

Cognitive-behavior therapy…

Agree Disagree Don’t Know Yes No

Acceptance and Commitment Therapy

Agree Disagree Don’t Know Yes No

I feel competent in the treatment of trichotillomania

slide scale (0= not competent, 10=very competent)

I feel competent in the treatment of skin picking

slide scale (0= not competent, 10=very competent)

I think my training is where it needs to be to effectively treat trichotillomania

slide scale (0= not competent, 10=very competent)

I think my training is where it needs to be to effectively treat skin picking

slide scale (0= not competent, 10=very competent)

Would you be interested in learning about effective psychosocial treatments for trichotillomania? Yes No

Would you be interested in learning about effective psychosocial treatments for skin picking? Yes No

Do you know of support groups for persons with trichotillomania? Yes No

Do you know of support groups for persons with skin picking? Yes No

Do you know of self-help programs for persons with trichotillomania? Yes No

Do you know of self-help programs for persons with skin picking? Yes No

Do you know of any self-help books for persons with trichotillomania? Yes No

Do you know of any self-help books for persons with skin picking? Yes No

Do you know where to refer clients with trichotillomania? Yes No

Do you know where to refer clients with skin picking? Yes No

Do you know how to teach your clients about trichotillomania? Yes No

Do you know how to teach your clients about skin picking? Yes No

Have you ever heard of the TLC Foundation for Body-Focused Repetitive Behaviors? Yes No

Does your clinic have any informational material about trichotillomania available to clients? Yes No

What role do you believe a psychologist/therapist could play in treating persons with trichotillomania? (Please select all that apply)

treating hairpulling

treating comorbid depression

treating comorbid anxiety

treating comorbid substance use

treating relationship problems

educating about the disorder

other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_