Introduction

This clinical guide describes an innovative, individualized approach to the treatment of body-focused repetitive behaviors (BFRBs), including hair pulling disorder (HPD) (also called trichotillomania) and skin picking disorder (SPD) (also called excoriation disorder). This treatment is derived from the Comprehensive Behavioral (ComB) conceptual model described more than two decades ago (Mansueto et al., 1997). In addition to the conceptual model, ComB treatment was first introduced in 1990 (Mansueto, 1990; Mansueto & Goldfinger, 1990) and has been refined by Mansueto and his colleagues at the Behavior Therapy Center of Greater Washington in the ensuing years (Mansueto et al., 1999; Mansueto, 2013, 2021; Mansueto, Vavrichek, & Golomb, 2019; Stemberger, Thomas, MacGlashan & Mansueto, 2000). Today, ComB is regarded as an established conceptual framework and as an assessment and treatment approach employed by scores of clinicians. ComB has served as the basis for the clinical training by the TLC Foundation for Body Focused Repetitive Behaviors' Professional Training Institute for over two decades; it was established as a favored treatment modality by that organization's Scientific Advisory Board; and it has influenced contemporary cognitive behavioral treatments of HPD, SPD, and other BFRBs since its introduction.

Who Should Use This Clinical Guide?

This clinical guide is intended for use by any mental health professional with a desire to help people who suffer with a BFRB. To utilize this manual most effectively, it is helpful but not essential for the treating professional to have familiarity with cognitive behavior therapy (CBT) techniques, the behavioral and cognitive principles that underlie these techniques, and experience in applying CBT to clinical problems. Although it is recommended that a therapist have some knowledge about or experience with CBT and the underlying principles thereof, it is not imperative. Anyone with an open mind and a desire to help those suffering with these disorders can benefit from reading and using this clinical guide.

Clinical Population Served by This Clinical Guide

ComB utilizes the fundamental principles of learning and cognitive theory, as well as a functional analytic approach to conceptualization and treatment of these problematic behaviors. ComB treatment was originally developed for HPD, although over the past decades it has been expanded to treat other body-focused repetitive behaviors such as SPD and those not listed individually in the fifth edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (2013), such as nail biting, nail picking, lip/cheek/tongue biting, and cuticle picking that are now classified collectively as "Other

Obsessive Compulsive and Related Disorders." This clinical guide provides a broad perspective on a range of BFRBs and is intended to provide the necessary information for the conceptualization and treatment for all such disorders.

Sometimes there is some diagnostic confusion, such as when a client's presenting concern can resemble that of a BFRB, when it is actually something else entirely. Clinical symptoms that can resemble those of a BFRB but are not served within the framework of this manual include obsessive compulsive disorder that infrequently manifests as repetitive preoccupation with, and excessive grooming of, one's hair; body dysmorphic disorder (an obsessive concern with the appearance of one's skin or hair that can lead to physical damage); delusional disorders such as parasitosis (a psychotic disorder where a person believes that their skin is infested with insects and may dig under their skin to remove them); or self-harm practices such as cutting or burning the skin where the damage to the body is the result of wanting to feel physical pain to divert from psychological pain. In cases such as these, it is important to differentiate these behaviors from that of a BFRB, because the treatment approach would be quite different. Diagnostic criteria for HPD and SPD, as well as how to tease out these differential diagnoses, will be discussed in greater detail in the next chapter.

How to Use This Guide

This clinical guide is designed to be a standalone tool for the conceptualization, assessment, and treatment of BFRBs. Because BFRBs are idiosyncratic behaviors in that they are experienced somewhat differently for each individual, understanding the unique clinical phenomenology of each BFRB sufferer is important and ultimately lays the foundation for the treatment plan. The rationales for the approach to conceptualization, assessment, and treatment in this guide will be offered, followed by descriptions of how to evaluate, understand, and intervene in cases that have their own unique underlying features and presentations. Clinical worksheets will be provided to assist in the evaluation process. Detailed descriptions of treatment strategies and tactical interventions will be offered. A complex case, "Emily's Story," will be introduced later in this chapter and returned to at numerous points throughout this guide. The case will be used to illustrate and highlight concepts and techniques of ComB treatment as applied to a complex case, from start to finish.

We will begin by providing an overview of BFRBs in Chapter 1, so that the reader has a basic understanding of the diagnostic, phenomenological, and clinical presentation of BFRBs. Chapter 2 will detail the clinical characteristics of HPD and SPD as related to the ComB conceptual model to provide a foundation for understanding how these behaviors are best understood. Chapter 3 will delve into the history of treatments for BFRBs and will describe current approaches to decreasing BFRB symptomatology, including an overview of ComB treatment. Chapter 4 provides a blueprint for getting started with a client utilizing ComB and setting the stage for successful ComB treatment. Chapter 5 will provide direction on conducting the assessment, functional analysis, and case conceptualization of an individual's BFRB practices. Chapter 6 addresses both the identification of relevant domains and the selection and implementation of targeted interventions. Chapter 7 will outline how to evaluate client progress, work toward treatment termination, and prevent relapse. Chapter 8 will provide self-care strategies to help support clients during their ongoing treatment and after termination. Chapter 9 will describe work with children and families

when BFRBs are present in younger clients. And finally, Chapter 10 will give an overview of working with comorbidities and other complicating factors that can influence treatment, and summarize the ComB approach and thoughts about moving forward in light of recent research findings. We anticipate that readers will find this clinical guide to be the most comprehensive resource available for treating individuals struggling with BFRBs.

Now we will introduce you to Emily, a young woman who has suffered with a complex problem that involves a combination of hair pulling and skin picking features. This combined form of BFRB disorder is not typical but also not uncommon in the population of people with BFRBs. Please read it carefully as it will contain many of the critical pieces of information that will illustrate points covered in the ensuing chapters. Plan to return to Emily's story from time to time as you read relevant sections of the guide to reconnect with information provided in her initial case description. As you will see, the experience of living with an established BFRB encompasses suffering across a broad range of human dimensions with highly complex interconnectedness. Now meet Emily and share in her life's story.

It was everything that Emily thought she wanted, the start of a new life at college, with her own private room and all the freedom to shape the next phase of her young life. But just three months into her college career, things had gone terribly wrong. Instead of the joy and freedom she had hoped for, she spent much of her time alone, flooded with sadness, sobs, and tears so deeply felt that she was constantly exhausted from crying, fatigue, and growing despair. Instead of sleeping and living a normal college life, she was pulling out her hair and picking her skin for hours each day and night. Not long after freshman orientation she had withdrawn from socializing. Soon dormmates gave up on her and stopped inviting her to join them in routine college activities. Worse yet, she was no longer attending classes, and, to her horror, she had to accept the possibility that she might have to admit to failure to her parents and return home in disgrace. Things had gone terribly wrong in what seemed no time at all.

She knew that she had problems before she left home. As an only child, she had resented her mother's intense scrutiny and daily comments on all aspects of her behavior and appearance. It obviously had some advantages, Emily had to acknowledge, because without those intrusions and with so much time alone, her "attacks" on her body now went unchecked and were occurring with a vengeance. She was trapped in her single dorm room, afraid to show her face to her dorm mates, or anyone else for that matter – a pretty face, now bruised, swollen, and oozing blood and lymph fluid. Only weeks ago, she had arrived on campus with excitement and great hopes for her new life. The blackheads around her nose and cheeks, and the few unremarkable zits on her chin and forehead bothered her some, but with a little makeup she could almost forget about them most of the time.

In middle school and high school, it wasn't her complexion that was most challenging. At first it had been her eyebrows that she had fussed with. She hadn't a clue why, but she would occasionally pull out eyebrow hairs, one by one, that is, until her mother noticed the damage and responded with intense emotion and disapproval. That was enough to end that behavior quickly. Her eyebrows quickly grew back and were never a problem again. But she had a secret. Though she had stopped pulling from her eyebrows, instead she was targeting hairs on her legs, mainly from her thighs, where the damage could be more easily hidden. But soon a complication became apparent, because many of her leg hairs were frustratingly hard to grasp, especially the short ones and ingrown ones that caused her the most bother, she began to use tweezers to dig beneath the skin to pull them out. She would go at the more deeply buried hairs with the sharp tweezer points, causing irritation, bleeding, and unsightly lesions. Scabs began to multiply on her legs, and they became irresistible targets for picking and scraping with her fingernails.

Before college, her chronic hair pulling and skin picking clearly was an inconvenience, and shaving her legs became very difficult with all of the irregularities on her skin. She wasted a lot of time engaged in secret and shameful activities of hair removal, and a lot more time than that in efforts to keep the damage concealed from others. Wearing shorts, bathing suits, and other clothes that bared her legs were impossible when the damage was at its worst – and that meant missing out on some fun events. Still, partly out of fear of her mother's wrath if she knew, Emily managed to limit the damage she caused and to keep it mostly concealed from others as best she could. Now her world had crumbled in a matter of weeks. What had been an inconvenience was now a crippling condition that dominated her life.

Maybe all of this privacy, freedom, and excitement about college was just too much for her to handle. It was during orientation week that she realized something that she should have thought about and taken more seriously. Having chosen a college in New Orleans meant hot, humid weather, and that translated to revealing outfits as de rigueur in the local scene. Moreover, she had met a nice guy, Josh, who under any other circumstances would have been a major plus in her life. But after three straight days of getting together with him, she realized that things had moved too fast. She was blind-sided by his insistence that she be his date for a swim party being thrown for new students. Scrutiny of her legs via her wall mirror made it clear that she wasn't nearly ready for daylight exposure of her tortured limbs. In fact, she was so distraught in her realization that not only going to the party but more intimacy with Josh was out of the question. Worse yet, the self-examination of her bared legs had led to the most severe incident of pulling and picking that had ever occurred up to that point. More damage than ever, more invitations turned down, and a call to Josh in which she ended their involvement. She lied when she had told him that she "just wasn't into him in that way". That pushed her into the deep pit of despair in which she now felt trapped. Emily wondered at what point she should return home and end her college dream that now felt like a nightmare. She dreaded having to face her mother and admit that it was her own weakness that led to this humiliating circumstance.

With her mother phoning her daily, it was increasingly difficult to pretend that everything was fine. She was always probing and intrusive, insisting on providing Emily with unwanted advice. The phone calls just added fuel to the fires that ignited Emily's shameful activities. During these calls, her frustration would mount, and her composure would wane. Her tension would increase as the conversations became more one-sided. It was after one of those calls that she realized to her horror that, for the first time, she had pulled out hair from her scalp. Within a week, she had a growing bald spot the size of a fifty-cent piece behind her left ear. Now there was enough hair missing from several spots on her scalp that it became challenging to camouflage them, even with clever hairstyling. That's what led Emily to begin to skip classes, to start eating alone in her room, and to give up on any involvement with potentially friendly dorm mates.

Desperate and alone, after a terribly damaging episode where she attacked her legs and scalp with unchecked pulling and picking, Emily tearfully searched online for any kind of help. She discovered an organization, the TLC Foundation for BFRBs. With information from their website she found a therapist trained to treat hair pulling and skin picking right in New Orleans. She quickly scheduled an appointment in the hopes of finding a way out of her horrible dilemma. She felt a flicker of hope.

Throughout this book we will return to Emily's case and describe her experiences throughout the course of her treatment.

Chapter 1

Overview of Body-Focused Repetitive Behaviors

The subject of BFRBs is relatively new to psychology and psychiatry, but it is likely that these problems have been personal issues for as long as humans have had hair to pull and skin to pick. Accounts in the Bible and other ancient sources such as Hippocrates suggest that BFRBs are a universal human phenomenon, occurring across time and cultures (Christenson & Mansueto, 1999). Theoretical views of BFRBs suggest that similar self-damaging patterns related to grooming behavior exist among different species such as mice, birds, cats, dogs, and monkeys as well (Moon-Fanelli, Dodman, & O'Sullivan, 1999). This clinical guide focuses on the two varieties of BFRBs that have now been identified as legitimate psychiatric disorders by the American Psychiatric Association: hair pulling disorder (HPD), also known as trichotillomania, and skin picking disorder (SPD), also known as excoriation disorder. We prefer SPD and HPD to the alternative nomenclature, and we will use these throughout this clinical guide.

What Is Hair Pulling Disorder?

In DSM 5, the current edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 2013), HPD is classified as an Obsessive Compulsive and Related Disorder, and the diagnostic criteria are as follows:

- The recurrent pulling out of one's hair results in hair loss.
- The person has made repeated attempts to decrease or stop hair pulling.
- The hair pulling cannot be better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder).
- The hair pulling or hair loss cannot be attributed to another medical condition (e.g., a dermatological condition).
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In addition to moving HPD from the classification of Impulse Control Disorders to Obsessive Compulsive and Related Disorders, several notable changes in the diagnostic criteria for trichotillomania were also made from the fourth (American Psychiatric Association, 1994) to the fifth edition of the DSM. First, criterion A requiring "noticeable hair loss" was changed to "hair loss." This change was made because many people pull from areas that are not outwardly visible, while others are very careful to hide hair loss. This means that hair pulling individuals without noticeable hair loss had not met criteria for the diagnosis prior to that change. Second, in the fourth edition, criterion B required "an increasing sense of tension immediately before pulling out hair or when attempting to

resist the behavior." While most people may report experiencing some form of "tension" prior to pulling at least some of the time, most people with HPD may report other experiences such as boredom, anxiety, sadness, frustration, excitement, suspense, guilt, or no notable emotion or tension prior to hair pulling. Criterion B was left out of the fifth edition as it excluded people from being diagnosed who most definitely had a hair pulling problem, just because they did not experience the tension-reduction phenomena. Finally, criterion C from the fourth edition requiring "pleasure, gratification, or relief when pulling out the hair" was also removed from the fifth edition because, like "tension prior to pulling," many people report a wide range of other sensations or emotions, or no particular sensation or emotion at all, prior to pulling out their hair. The changes made in the fifth edition were designed to allow clinicians to more accurately and rationally identify all individuals who warranted inclusion in this diagnostic category.

Hair pulling can occur on any part of a person's body from which hair grows. The most common sites for hair pulling include the scalp, eyelashes, eyebrows, pubic area, arms, legs, and face (for men). Although it may seem awkward to ask specifically about pulling pubic hair, it is important to solicit this information from all clients when doing an intake evaluation. Many people will not report pulling from the pubic area if they are not asked directly about it, most likely because of misguided concerns about presumed sexual connotations associated with that practice. Asking direct questions in a compassionate, nonjudgmental manner serves to reduce shame and embarrassment in clients by helping them feel understood and validated. It is important to uncover the details of the individual pulling styles and behaviors (focused on in Chapter 2) so that an individualized, comprehensive treatment plan can be developed. If key factors that support continued performance of BFRBs go unaddressed, treatment outcome is likely to be disappointing.

What Is Skin Picking Disorder?

Prior to the release of DSM 5 in 2013, skin picking was not included in the American Psychiatric Association's diagnostic system. In this latest iteration of the manual, skin picking, also termed "excoriation disorder," is included among Obsessive Compulsive and Related Disorders with the following diagnostic criteria:

- Recurrent skin-picking, resulting in skin lesions.
- Repeated attempts to decrease or stop skin picking.
- The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The skin picking cannot be attributed to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
- The skin picking cannot be better explained by the symptoms of another mental disorder (e.g., delusions or tactile hallucinations [a psychotic disorder], attempts to improve a perceived defect or flaw in one's appearance [body dysmorphic disorder], stereotypies [stereotypic movement disorder], or intention to harm oneself [non-suicidal self-injury]).

There are a host of other BFRB manifestations that are not identified in the DSM 5 classification. These include biting and/or picking of nails, cuticles, lips, the insides of cheeks, severe nose picking, and the grinding of teeth. These behaviors, though not specifically recognized in DSM 5, can be construed as "Other Obsessive Compulsive and

Related Disorders." Therefore, they may be formally diagnosed and treated, and the ComB approach described in this clinical guide can be easily adapted to treat all these BFRB types.

Differential Diagnoses

Historically, BFRBs have been confused with obsessive compulsive disorder (OCD) or considered to be a symptom or subtype of OCD. Because of this, it is worthwhile to clearly distinguish between the two disorders and to educate clients and other caregivers who may be conflating them. Although OCD and BFRBs have important features in common (they both involve unwanted, repetitive patterns of behavior), there are several notable differences:

1. Obsessive compulsive disorder is typically characterized by obsessions (intrusive thoughts, e.g., "Something bad might happen to me or my loved ones") that increase anxiety, and compulsions (repetitive, voluntary, overt or covert behaviors, e.g., hand washing, checking, mental reassurance, etc.), which serve to reduce the distress associated with the obsession and perhaps belief in the likelihood of harm. In contrast, hair pulling and skin picking are repetitive behaviors that are not likely to be driven by obsessive thoughts (e.g., "If I don't pull my hair something bad will happen to me or my loved one"), and these behaviors are unlikely to function as harm-reduction mechanisms and are less likely to function primarily as anxiety reducers.
2. People with OCD generally abhor their rituals, but they feel compelled to perform them to prevent the feared negative outcome. Conversely, people with BFRBs may experience greater degrees of pleasure or satisfaction from the act of hair pulling or skin picking, but, of course, they are distressed by the longer-term results of their behavior (e.g., baldness, scarring, shame, etc.). Body-focused repetitive behaviors are for many, comforting, soothing, or otherwise rewarding activities that help them feel better, at least in the short term.
3. Treatments for OCD and BFRBs are quite different. The treatment of choice for OCD is exposure and response prevention (ERP). This therapy involves exposing the person to the feared stimuli while requiring them to refrain from performing rituals. The general assumption is that with practice, a person will experience less anxiety with repeated exposure to those stimuli and, as a result, is less inclined to engage in rituals. The expectation is that over time, the obsession will become weaker and functional behavior will increase. Treatment for BFRBs, on the other hand, de-emphasizes ERP and, instead, employs a wider variety of cognitive behavioral techniques designed to provide each individual with capabilities to *decrease their self-damaging practices by substituting adaptive alternatives in their place* (Franklin & Tolin, 2007). Sometimes ERP is included in the framework of ComB treatment when it is deemed appropriate by the clinician; however, it is not the first line intervention for the treatment of BFRBs.
4. Medications that are widely considered as effective for the treatment of OCD typically do not have similar effectiveness for BFRBs. Studies show that the antidepressants known as selective serotonin reuptake inhibitors (SSRIs) are not consistently helpful for people with BFRBs (Chamberlain, Fineberg, & Odlaug, 2012). However, for some individuals, reductions in anxiety, stress, or depressive symptoms may have indirect benefits for people with BFRBs, since these conditions can exacerbate BFRBs for many people. In cases such as these, reducing anxiety or depressive symptoms can have a positive impact on the BFRB. Recent interest has turned to an over-the-counter antioxidant supplement,

N-Acetyl Cysteine (NAC), that is presumed to impact neurotransmitters through the glutamate system and has shown promise in reducing BFRB severity (Grant, Odlaug, & Kim, 2009). A more comprehensive discussion of medication and nutraceutical interventions for the treatment of BFRBs can be found in Chapter 3.

That said, there is a smaller subset of people with BFRBs who do seem to have a more compulsive "flavor" to their practices. Such individuals may, for example, want to remove every coarse or bumpy hair or they want all pores to be cleaned free of dirt or excoriate. Although these cases are still considered to fall under the purview of BFRBs, they can seem to be more akin to OCD than more typical BFRB forms. In these cases, exposure and response prevention (ERP) can be incorporated into the ComB therapy protocol to help the client become more accepting of unwanted features of the hair or skin. When ERP is employed, it is within the context of the standard ComB assessment and clinical decision-making process that guides the choice of individual treatment components. When and how to incorporate key elements of ERP into the treatment of BFRBs will be discussed in Chapter 10.

Another type of case that may provoke diagnostic confusion would be that of a person who pulls hairs or cuts their hair toward the goal of "evenness" or symmetry (e.g., "Both eyebrows must be identical in form" or "All hairs must be exactly the same length"). In cases such as these, it is important to understand what motives drive the behaviors. What does the person believe will happen or fear will happen if the hair is not all the same length or if the eyebrows do not match? If the answer is something like: "I don't like the way it looks," or "I just want them to match," from the ComB perspective, this is likely to be a form of BFRB that is influenced by factors within the Cognitive and Affective domains ("domains" are integral to the ComB approach and they will be discussed in detail in later chapters). It is common for people with BFRBs to have perfectionistic tendencies about the hair or skin, but sometimes there exists a more generalized personality feature that may require clinical attention and intervention. Moreover, if a person believes that something bad will happen, such as: "A terrible event will occur if my hair isn't all the same length," then the possibility of a primary or comorbid OCD component should be addressed. (Guidance for dealing with comorbidity within the context of ComB treatment will be discussed later in this chapter and at other points throughout this guide.)

Body-focused repetitive behaviors are sometimes confused with body dysmorphic disorder (BDD), and there actually may be some overlap in symptomatology for some BFRB clients. Some individuals report feeling disgusted by the look of certain hairs or by perceived imperfections of the skin and may be convinced that these are so ugly and so intolerable that they must try their best to eliminate them. In some cases, conceptualizing the client as having primary BDD with BFRB features may be warranted. Appropriate treatment would take this into account. Although less common, some hair pulling and skin picking does, in fact, have a more "BDD feel." The ComB model of treatment provides a viable, comprehensive framework with enough latitude and flexibility to accommodate these variations. Appropriate techniques for these purposes are described in Chapter 10.

It is possible that a small subset of people who pick their skin do so with the goal of harming their body, but intentional self-harm is not found within the context of BFRBs. As we will emphasize throughout this guide, BFRBs are viewed as self-regulatory mechanisms that are employed in efforts to *feel better* by meeting an individual's needs on some level – sensory, emotional, or cognitive – not with the intention to

cause harm or to damage their body. The unfortunate outcome of the BFRB is, of course, damage to the hair or skin, but that is not the intention. Quite the contrary, often an individual pulls or picks with the belief that by engaging in their BFRB they are improving their appearance, even after past experiences have shown otherwise. If, during assessment, it becomes apparent that an individual's skin picking or hair pulling is done with the intent to cause harm to their body, clinical approaches not included in this clinical guide may be required.

Finally, and very rarely, delusional clients may develop a focus on their hair or skin that can masquerade as a BFRB. Hallucinations that involve the belief that insects live under their skin or delusions that there are foreign bodies under their skin can result in attempts to remove these unwanted elements by digging into the skin. Other kinds of delusions can involve beliefs that the removal of, or damage to, some part of the body is necessary, leading to body-damaging practices of various severities. Making the distinction between a BFRB and potentially psychotic conditions is critical in ensuring that treatment is appropriate. As with any differential diagnosis, it is important to conduct an in-depth clinical assessment to determine the true nature of the problem and to follow through with a well-conceived therapeutic plan. Making a premature diagnosis based upon obvious symptoms without performing an adequate functional analysis can lead to improper diagnosis and treatment, and ultimately, frustration for the client and the therapist. As may seem obvious, the broader clinical skills and knowledge of the therapist are often brought to bear in the treatment of BFRBs when there exist complications that the ComB approach is not designed to address.

What We Know about Body-Focused Repetitive Behaviors

As with virtually all legitimate psychological disorders, the assumption is that biological vulnerabilities interact with life experiences to produce the pathology. That is true of BFRBs as well. Here we will briefly cover the research examining genetic components of BFRBs, and also describe the clinical characteristics of hair pulling and skin picking.

Genetic Basis

Although research examining the heritability of HPD and SPD is barely underway, there is some preliminary evidence suggesting that BFRBs have a genetic component. In a family study conducted at Harvard University (Keuthen et al., 2014), researchers reported the incidence of HPD in first-degree family members of their subjects with HPD was 10 percent, while it was just 1–2 percent in first-degree relatives of those without HPD. In addition, rates of skin picking and other BFRBs were higher in relatives of people with HPD. Thus, even if a person with HPD does not have a family member who pulls hair, they are more likely to have someone in their family who bites nails, picks cuticles, bites lips, or picks at acne or scabs than chance alone would allow. It is useful to mention these other BFRBs during client education, as they are generally perceived as less pathological than HPD and therefore place their disorder in a less stigmatized context. More family and genetic research is needed in order to conclude the degree of hereditability of BFRBs. It is useful, however, to present BFRBs as genetically facilitated behaviors, since it changes the perception from that of "willful" practice, to a condition with a biological basis. This kind of information can be helpful in reducing unwarranted shame and embarrassment.

Age of Onset

The average age of onset for BFRBs is around twelve years old, although these behaviors can begin as early as infancy or much deeper into adulthood. It is not known if this clustering of onset is related to puberty itself and the hormonal changes associated with this period of extensive transformation or due to other factors. Perhaps the emotional turmoil that is common in early teen years may play some role in triggering BFRB symptoms. In people who report a later onset, perhaps in their twenties or thirties, many report having experienced other BFRBs earlier in their lives. For example, a woman who presents for treatment of hair pulling that began when she was 35 years old may also report that, in her early adolescence, she bit her nails and picked at her cuticles. So, although the hair pulling did not start until adulthood, her history with BFRBs actually began in early adolescence, which is in accord with current understanding of BFRB onset.

Another phenomenon to be aware of is a somewhat common form of hair pulling that begins in early infancy and is sometimes referred to as "baby trich." This early manifestation of hair pulling is, in many cases, a more benign and self-limiting variety. However, in some cases, infant hair pulling may persist into childhood, adolescence, or adulthood. Baby trich and the treatment thereof will be discussed in more detail in Chapter 9.

Comorbid Diagnoses

Research suggests that depression and anxiety are commonly coexistent with BFRBs. These and other comorbid conditions may complicate treatment of BFRBs, and the therapist is advised to use good clinical judgment to evaluate the overall impact of comorbid features on a client's functioning. If it seems that the BFRB is secondary to other, more pressing concerns, these other matters should be addressed first. For example, when depressive symptoms are present to the extent that the client's general functioning is poor, or renders them unable to benefit from BFRB treatment, prioritizing treatment of the depression seems sensible and may facilitate successful treatment of the BFRB. If a person is picking their skin in times of stress, worry, or anxiety, then addressing those conditions in treatment is appropriate, since therapeutic progress is likely to be impeded if the anxiety is left unaddressed. Of course, there are cases where comorbid conditions are severe enough to prioritize in treatment. Decisions must be made whether these can be handled by the BFRB therapist or whether they should be referred to another professional.

Prevalence

The prevalence of HPD in adults has been estimated to be as low as 2 percent and as high as 5 percent in community and in clinical samples. However, small sample sizes, varied inclusion criteria, and other factors may account for the discrepancies (Mansueto & Rogers, 2012). For SPD, reported prevalence rates have an even wider range in various studies, but overall, an incidence of about 5 percent in the general population seems plausible (Odlaug & Grant, 2012). Because individuals with these disorders often conceal them from others, it is possible that BFRBs may be underreported in the general population. What seems certain is that BFRBs are far more common than was thought only decades ago and that prevalence rates are similar to those of OCD and anxiety disorders.