

Acceptance and Commitment Therapy Enhanced Behavioural Therapy for trichotillomania in a
Group Setting: the Patients' Perspective

- A qualitative study of experience and meaning in eight respondents with TTM

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Now I can play again!

Abstract

Eight Norwegian participants in an AEBT-T group treatment study for trichotillomania were interviewed post-treatment about their experience as participants. Respondents' subjective understanding of central concepts in the manual were assessed with the aim to understand the participants constructed meanings. Several main themes were constructed from analysis: The disorder, Group, Seminar, Getting Well, Theoretical Understanding, Information, and The Arrangements. The conceptualisation of trichotillomania as a symptom-disorder or as an expression of underlying psychopathology was a recurring sub-theme across main- themes, and therefore explored in further detail.

Keywords: Trichotillomania, pathological hair-pulling, . AEBT-T, ACT, HRT, group treatment

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Hair is a natural part of the human body and most of us groom our hair in some way or another. In some cultures, such as the Western/European countries, trimming or removal of hair on different places of the body is common. The amount of hair removed and the locations where hair is removed or trimmed vary with fashion and cultural shifts, but generally speaking there has been a growing trend to remove more hair the last 30-40 years. Both men and women engage in these practices. Women have more areas on their bodies where hair is expected to be groomed, and may be experiencing a larger pressure to conform to hair removal norms (Brown, Trickleback, & Clarke, 2013) at the same time grooming practices for men have been on the increase (Elsner, 2012) possibly decreasing this gender gap. The cultural representations of hair or non-hair norms are abundant and several studies have explored their powerful normative influence on what people do with their hair (Brown et al., 2013; Fahs, 2013). People may struggle when faced with these normative demands of hairlessness and many individuals use a considerable amount of time and energy removing or manipulating their hair and worrying about satisfying hair related norms (Fahs, 2013). Nevertheless these practices are seen as normal in the context of western culture.

Pathological hair-pulling or trichotillomania in Latin is on the other hand defined as a mental illness. Individuals diagnosed with trichotillomania (hereby after referred to as TTM) differ from those engaging in “normal” hair-removal practices in several ways. American Psychological Associations Diagnostic Manual 5th version (DSM-V) include, in addition to recurrent pulling of ones hair, resulting in hair loss: That the individual have attempted to decrease or stop hair pulling without success, that the hair-pulling causes “significant distress or impairment in social, occupational or other important areas of functioning” (American Psychiatric Association, 2013, p. 251) as well as the hair-pulling behaviour not being better accounted for by other conditions, medical or mental (American Psychiatric Association, 2013). Empirical studies on people diagnosed with TTM indicate that it is common to have 2-3 regular pulling-sites and that the scalp, eyebrows,

eyelashes and genital area are the most common (although sites may be located anywhere on the body) (Christenson, Mackenzie, & Mitchell, 1991; Flessner, Woods, Franklin, Keuthen, & Piacentini, 2008). An individual may use tools such as tweezers to extract hairs, but using the hands is most common (Christenson et al., 1991). As to time spent on hair-pulling, the individual often engage in both longer bouts of “hair-pulling-binges” as well as shorter periods of pulling (up to 15 min). The shorter ones occur on average 5 times a day. A considerable amount of time is also used on resisting pulling, playing with hair or performing rituals associated with hair-pulling such as playing with the hair before and after pulling (Siwiec, 2010; Christenson, Mackenzie, & Mitchell, 1994; Mansueto, Townsley-Stemberger, Thomas, & Golomb (1997); Woods et al., 2006). In addition to this comes the time consuming task of hiding the consequences of pulling (Marcks, Woods, & Ridosko; 2005). Two styles of pulling are often described in newer literature: Automatic, where the individual is not really attentive to the pulling behaviour and one focused style where the individual are more aware of the pulling. These categories are not mutually exclusive, instead patterns of behaviour exist in different individuals (Flessner, Woods, Franklin, Cashin et al., 2008). Several studies exist based on pulling-profiles and pulling-styles possibly being connected with different triggers (see Siwiec, 2010 for a good overview).

Studies indicate that different forms of TTM are relatively common with a life-time prevalence of 1-3% (Christenson, Pyle, & Mitchell, 1991). In DSM 5 (American Psychiatric Association, 2013), TTM is sorted as an impulse-control-disorder with bodily manifestations. Pathological hair-pulling is often viewed as a symptom of or closely related to other mental illnesses. Often the hair-pulling is seen as an integrated part of an anxiety disorder, as self-harm behaviour or as an obsession and therefore treated as a secondary phenomenon that will be relieved if the primary condition is treated and indeed, co-morbidity is common. Estimates vary, but 55% - 82% of patients diagnosed with TTM will satisfy the DSMVI criteria for at least one axis 1 disorder,

in which mood and anxiety disorders were the most common (Woods & Twohig, 2008; Woods et al., 2006). In children diagnosed with TTM there are similar co-morbidity-rates; 50% had emotional disorder, 49% developmental disorders and 100% of the research-sample had environmental stressors (Hanna, G.L 1997, as in Woods et al., 2006). Individuals with TTM also show elevated levels of other body-focused repetitive behaviours (BFRBs) that include a range of conditions such as compulsive skin-picking and nail-biting (Stein et al., 2010, as in Siwiec, 2010). Even though it is commonly understood as integral to co-morbid conditions one might also understand TTM as autonomous to co morbid conditions or even as prior to them. Several facts may support this view:

Mean onset of the disorder in adult samples is 13 years of age (Woods & Twohig, 2008) and in samples with children as early as 18 months (Hanna, G.L 1997, as in Woods et al., 2006). As such it often precede at least the diagnosis of co morbid conditions. The symptoms of TTM often do not regress when co-morbid conditions are treated, leaving it a chronic struggle for the individual dealing with it (Siwiec, 2010). Patients with TTM are found struggling with emotion-regulation issues, obsessive tendencies and locked behavioural patterns that may be tied to biological feedback-loops that enforce the behaviour (Siwiec, 2010; Woods & Twohig, 2008; Woods et al., 2006).

TTM-sufferers often hide their illness and feel shameful of it and its sometimes visible consequences (Siwiec, 2010). Many of them never tell their therapists or physician about their problems related to hair-pulling and may develop avoidance behaviours such as social withdrawal and adapting the ways they dress to hide hair-loss, anxiety, depressive symptoms and issues with self-esteem and self-worth as well as a reduced quality of life (Woods et al, 2006; Woods & Twohig, 2008; Hersperger, 2012). There is a general lack of knowledge of TTM among helpers, which make it difficult to get sufficient help (Woods, Flessner, Franklin, Keuthen et al., 2006).

Theory

As indicated in the introduction there are disagreements in the field on how to understand TTM and how to best treat it (Woods et al., 2006). Empirical work on etiology and maintaining factors are somewhat limited and much of the research that have been done have small samples or suboptimal research-design (Woods et al., 2006). Different conceptualisations of TTM results from different perspectives within psychology as a discipline. Where the conceptualisations are academic in nature, therapies are applied psychology, what the clinical psychologist actually does in therapy. This text does not allow a full account psychological perspectives but I will briefly introduce some of the most important perspectives and try to outline possible implications for therapy (See Hersperger, 2012, for a fuller account).

Psychoanalytic or psychodynamic approaches. Psychoanalytic or psychodynamic approaches view hair-pulling behaviour as an expression of repressed emotions often outside of conscious control and often with theorised origins in childhood trauma or aversive experiences. Treatment will be targeted at bringing unconscious emotions or experiences in to consciousness and deal with them in a better way. This view have little empirical support although some indirect support may come from the fact that many children with TTM have co-morbid conditions and environmental stressors (Hanna, G.L. 1997, as in Woods et al. 2006).

Neuropsychological and biological approach. A neuropsychological or biological understanding looks at malfunctions in the biological make-up, brain-structures or functional systems in the brain and body that may be deviant. Imaging-techniques such as MRI, fMRI, PET etc. are often used to compare healthy controls with different diagnoses to find anomalies that might correspond with or account for the disorders. Logical target of treatment will be changing biochemical processes and functionality in one way or the other, for instance through medication,

bio-feedback og neurosurgery. Some research have found support for this view, some correlational data between TTM and brain anomalies exist, mainly done on patients diagnosed with Obsessive Compulsive Disorder who also engage in hair-pulling behaviours (Breiter et al., 1996; Jenike et al. 1996 and Robinson et al., 1995, as in Woods et al., 2006). Dysregulation of serotonergic, dopaminergic and opioid systems have some indirect support in that some studies show that medication affecting these systems may decrease pulling severity (Swedo et al, 1989; Stein et al., 1992 and Christenson et al., 1994, as in Woods et al., 2006).

Behavioural genetic approach. Behavioural genetics looks at the DNA- profiles of individuals and groups of individuals to try to determine which genes may be involved in different psychological expressions, such as traits, strengths, vulnerabilities and dysfunctions. Once with hopes of uncovering direct relationships between genes and behaviour The Human Genome Project completed mapping the human genome¹ in the early 2000's with sobering implications for psychiatry. Some mental disorders have proved to have a strong genetic component the discoveries of genes being able to be switched on and off; epigenetics, have complicated the matter. Today genes are considered one component amongst many, working in complicated transactional ways to “produce” human functionality. Some studies have suggested a genetic underpinning for trichotillomania (Greer & Capecchi, 1994, and Lenane et al., 1992, as in Woods, 2006) but as follows from the section above, these correlation al empirical findings must be understood in relation to other environmental and psycho-biological findings. Treatments that follow from this perspective is manipulation of genetic expression via epigenetic principles and preventive measures. But largely this perspective focuses on the inherited aspects of psychological disorder more directed towards understanding than treatment.

Behaviourist approach. Oppositional to the “inherent” perspective are behaviourist

1 A genotype is an individuals genetic makeup, whereas the human genome is the map of human genes in total

approaches, which focus on learning and how human psychology are moulded by experience. Principles of learning lie behind a behaviourist understanding of human psychology and psychopathology where so called S-R mechanisms make up the building-blocks. In its pure form it postulates that everything in the psyche can be reduced to associations and reinforcers (see beneath for a fuller description). A behaviourist approach to treating TTM will be looking for triggers and reinforcers of hair-pulling and try to find ways to extinguish learned associations tied to hair-pulling. The target of treatment based on this view would be mapping of learned associations and reinforcers and manipulate these to obtain the desired behaviour. Several studies confirm the power of triggers as well as reinforcers, both positive and negative, on hair-pulling behaviour (Miltenberger R.G et al., 1998; Rapp et al., 1999 and Rapp et al., 2001, as in Woods, 2006).

Evolutionary psychology approach. Evolutionary psychology is based on the understanding of humans as evolutionary products. Basic mental functions are seen as evolved as a response to the conditions early humans met, being passed on genetically by the laws of natural- and sexual selection. According to this perspective this “hard-wiring” of the human brain can explain propensity to learn different things faster than other, some parts of our social behaviour, development of some psychological disorders e.g. phobias, different personalities and some of the sex-differences we find in behaviour and psychology. The evolutionary psychologist will look at what function hair-pulling may have had in ancestral times and what hard-wired processes may be involved in the behaviour to try to manipulate it.

Social psychology approach. Social psychological approaches will focus on how socially constructed biases and social structural forces affect the individual and its possibilities for action. How behaviour is understood may result in psychological problems, not the other way around. The social psychologist will look at how individuals engaging in hair-pulling understand themselves and the behaviour and how societal structures such as norms regarding hair-removal affect

conceptualisations of self. Target of treatment: Analysing and understanding the social forces working on the individual and empower the individual to engage with it in another way or engage in a different construction of the actions considered problematic.

Cognitive psychology approach. Cognitive psychology understands mental illness as a result of information-processing in different ways. Cognitive schemas are created as the individual makes sense of their experiences and surroundings. These schemas will in turn colour further information-processing, memory, attentional processes etc., which will make a set of “goggles” the individual uses going through life. This will in turn affect behaviour, experienced emotions and thought. Target of treatment based on a cognitive understanding would be finding and challenging maladaptive cognitions changing schemas related to pulling hair. Mansueto et al. (1997) found that cognitions may trigger hair-pulling behaviour in some individuals diagnosed with TTM (Mansueto et al., 1991).

Interdisciplinary perspectives: Affect-regulation. Emotions, both negative and positive, have been found to correlate with hair-pulling behaviour (Siwiec, 2010). The affect-regulation paradigm in clinical psychology is based on the theory of optimal arousal originating in the Yerkes-Dodson law (Yerkes & Dodson, 1908). Yerkes and Dodson found an empirical relationship between performance and arousal that could be described as an inverted U-shape where both too much and too little arousal hinders maximal performance. This is used to build a theory of motivation. Given that it would be stressful for people to be both over-and under-aroused they would be motivated to regulate their level of arousal closer to the optimal level. Too much and too little arousal is experienced as negative and individuals use different means to regulate their level of arousal. An analogy might be that of a thermostatic air-conditioner set on a specific interval, when the temperature drops below a set limit it will use power to increase the temperature, if the temperature is too high it will use power to cool it down.

There is evidence that to what degree an individual is willing to experience certain emotions and/or cognitions may covary with hair-pulling behaviour in individuals diagnosed with TTM (Siwiec, 2010). Therapeutic angles of attack based on this view will be manipulating the ways the individuals regulate their emotions from a maladaptive one to a more adaptive one or making the individual able to withstand cycling of emotions without trying to manipulate them (making the interval or the distances between the thresholds for action greater).

Combined models of understanding. Different therapies are constructed on the basis of different positions and sometimes different perspectives are combined. A well-known example of this is cognitive-behavioural therapy (CBT) where principles from both cognitive psychology and behavioural psychology are integrated. Mansuetos Comprehensive Model for Behavioural Treatment (ComB) developed by Mansueto et al. (1997) is an example of one such combined method used to understand trichotillomania as a response to emotional activation. This states that an environmental cue may give rise to certain emotions or increasing activation. With elevated activation comes the need to pull and the individual starts pulling. This can lead to an effective, but maladaptive regulation of the emotion. When the individual stops pulling, the emotion will rebound and be as intense as before. Furthermore, secondary feelings such as shame and guilt may lead to even higher levels of emotion and arousal, making pulling behaviour likely to reoccur. This cycling of emotion reinforces the hair-pulling behaviour because hair-pulling is associated with effective short-time relief from negative affect (Siwiec, 2010).

Context and Aim of the Study

In this study I take a look at one treatment for TTM: Acceptance and Commitment Enhanced Behavioural Therapy for TTM (AEBT-T) in a group format. The participants experiences from this treatment and the meanings they make from it is investigated from a social constructivist

perspective. The construction and negotiation of meaning is seen as the result of social interaction,. The individuals accounts of their experiences and reflections concerning the therapy are considered as parts of the social process of making sense of reality (Andrews, 2012). It is such processes and constructions that I set out to investigate (see epistemology beneath) and the study is not an evaluation of AEBT-T as a clinical intervention. Social constructivism differs from constructionism in a more explicit focus on language. Socially constructed meanings are seen as the basis of human understanding of the world and therefore sets the premises for action and interaction. The constructed meanings/ concepts are produced and reproduced through negotiating it in social contexts to the extent that they become “established truths” and feel “natural” to individuals and may be reproduced as part of socialisation to new generations. A social constructivist methodology is, well suited to investigate ACT-based therapy because ACT is explicitly focused on how language is fundamental elements to human psychology.

The AEBT-T treatment is based on a manual integrating Habit Reversal (HR) with elements of Acceptance and Commitment Therapy (ACT), a so called ACT-enhanced BT (AEBT-T) (Woods & Twohig, 2008) given in a group format. By interviewing the participants I wish to access their experience of participating in this therapy. I also seek the informants constructions of pathological hair-pulling and what they perceive as being therapeutic in AEBT-T in a group. My research questions guiding this work have been: (1) How do the participants' construct pathological hair-pulling? (2) How do the informants construct this therapy? (3) How do the informants experience participating in AEBT-T in a group-format? (4) What are the elements the informants find helpful in this treatment and why are they experienced as helpful?

The Norwegian TTM Project

The research project that made this possible is a result of a collaboration between three regional hospitals in Norway: St. Olavs Hospital, Oslo University Hospital and Sørlandet Hospital

called «The Norwegian TTM Project» (NTP) (B. Hummelen and E. Haseth, personal communication, autumn 2014)

The treatment model the participants had undergone was based on Woods and Twohigs manual «Trichotillomania– ACT- enhanced behavioural therapy » (AEBT-T) (Woods & Twohig, 2008) which consists of a therapists guide and a workbook for patients. Treatment was given in 3-hour sessions over 10 weeks during the autumn 2013. Homework was given between sessions, and participants were expected to prepare for sessions using their workbook. In the sessions two therapists met a group of 4-6 participants once a week at the same location. Each session started with a focus on progress or relapse from the week before, then a particular theme prepared beforehand was introduced according to the therapy manual and workbook. Practical and mental exercises were introduced by the therapists, as well as information about psychological theory concerning TTM. Group conversations took place. At the end of each session new home-assignments were given. A total of 3 booster sessions were given with the same therapists and participants during spring 2014, 3,6 and 9 months after the last session respectively. There were no arranged meetings outside of the sessions.²

This interview-study is made possible by collaboration with NTP and may be used within the context of the NTP for means of triangulation against quantitative data and to assess a user's perspective. It investigates the patients' experiences of participating in a group based 10 session AEBT-T, as well as their experiences of their illness, help-seeking and how they perceive the treatment and recovery processes. The aim of this study has been to grasp the participants' constructed meanings; their understanding of the treatment and their illness as explained in their own words to someone outside of the treatment-program.

In the following I will present the treatment in more detail followed by the methodology and results of the study.

² With the exception of the «Relatives Night» that were offered some of the informants, see p. 47 -

Habit Reversal (HR)

Habit Reversal is a behavioural-psychological treatment developed by Arzin and Nunn (1973; O'Connor, 2005) where the aim is to use knowledge of learning- mechanisms to change unwanted behaviour. In short learning-mechanisms can be understood as different things, such as actions, situations etc. that are paired together. This creates an association in the individual, either a positive or a negative one leading to the increase or decrease of certain behaviours, this is called conditioning. Classic conditioning states that stimuli presented together will create a new behaviour that is called the conditioned response (Nielsen & Raaheim, 2004). An example here would be the cat running to its dish when the owner finds the tin-opener which is usually used to open its food. Operant conditioning is an extension of this principle, with the addition of reinforcers. Positive reinforcement is when action A leads to positive consequences, hence the individual displays more of that behaviour. Negative reinforcement occurs when action A leads to an avoidance of something unpleasant and the individual therefore continues the behaviour. By repeating the associations the links become stronger, but one may also weaken these bonds by changing what is associated or the reinforcers (Nielsen & Raaheim, 2004). This process is known as extinction.

Based on these classical behavioural principles HR has five stages: (1) *Awareness training*, taking different steps to understand what precedes and follows the unwanted action often by keeping a written record of certain events or of a time-period; (2) *relaxation training*- decreasing muscle tension, breathing and using inner visual imagery; (3) *training in an incompatible response (antagonist action)* – finding an action that is incompatible with the unwanted behaviour and rehearse it; (4) *contingency management* – to keep reinforcers under control or manipulating them to obtain the desired effect; and (5) *generalisation of training*.- to apply the steps above on all pathological behaviour (such as all the tics an individual may have in Tourettes Syndrome) (Azrin & Nunn, 1973, as in O'Connor, 2005). This model has had success in reducing unwanted behaviours

in different disorders, amongst them tics in Tourettes Syndrome where some sufferers also engage in hair-pulling (O'Connor, 2005).

Douglas Woods and colleagues at University of Wisconsin have done research on what the active components of HR may be in children treated for tics. They developed an abbreviated version of HR with three major components: (1) *awareness training*; (2) *incompatible response*; and (3) *positive reinforcement /social support* (O'Connor, 2005).

Acceptance and Commitment Therapy (ACT)

ACT is rooted in behaviourist psychology through its foundation: Relational Frame Theory (RFT) which is a “functional contextual theory of human language and cognition” (Hayes, Strosahl, & Wilson, 2012, p. 39.) that harmonise in many ways with cognitive psychology in that it looks at the individuals' perception of the context in which they may act as a product of an inner construction both forming and formed by experience. Language, abstract thinking and problem-solving based on our verbal constructions does not only provide us with possibilities to reflect and think, but it is also a source of suffering related to thoughts and reflection. A healthy individual masters balance and flexibility in different modes of thinking and allows a critical distance between oneself, reality and ones own mental events. Being open to inner and outer experience of the here and now is seen as key elements to psychological health (Hayes et al., 2012).

ACT places psychological disorders on dimensions where normal functioning is included rather than in healthy/ non-healthy-categories. As it follows Hayes et al. (2012) voice a moderately critical stand to diagnoses (Hayes et al., 2012). Diagnoses are accepted as a necessary practical construct rather than something one should use to understand people with. Instead ACT provides a holistic approach where a clinician would seek to « make a map» of how the person is functioning on several dimensions. Flexibility is seen as the hallmark of psychological health while rigidity makes for bad functioning (see Kashdan & Rottenberg, 2010, for a review in support of this

perspective). Therapy thus should locate rigidities or maladaptive imbalances on the main dimensions and work with the individual to achieve greater flexibility and better balance. Hayes et al. (2012) suggest six main processes that can be used to understand psychological flexibility and six opposite/ dichotome processes for rigidity. These six core processes are often visualised in a model called “The Hexaflex” (See figure 1; and figure 2). There is no room in this report for an elaborate description, yet a short overview is provided. I highly recommend consulting figures 1 and 2 for a fuller comprehension of the following:

1. *Accept vs Experiential Avoidance* concerns to what degree the individual accepts different experiences, be it thoughts, feelings, situations both inside oneself and as an influence from one's environments vs a tendency to avoid or manipulate them.
2. *Flexible Attention to the Present Moment vs Inflexible Attention* concerns the individual's ability to flexibly apply attentional resources from moment-to-moment vs rigidity in attentional processes.
3. *Values versus Disruption of Values; Dominance of Pliant, Fused or Avoidant “Values”*. To what extent the individual has articulate internal values giving a meaningful direction to one's life vs lacking such or having “pseudo versions” of values.
4. *Committed Action versus Inaction, Impulsivity or Avoidant Persistence*. To what extent is the individual able to mobilise action and be active striving in a balanced manner towards whatever they find meaningful in their own life vs being inactive, active in unpredictable bouts or rigidly preoccupied to the extent of it being a means of avoiding something else.
5. *Self- as- Context versus Attachment to the Conceptualised Self*. To what extent the individual is able to feel that oneself is part of a bigger whole or feel

transcended/spiritual vs being rigidly preoccupied with creating and enacting the construction of oneself or one's own personal narrative.

6. *Defusion versus Cognitive Fusion*. To what extent the individual is able to relate in a flexible manner to what is “real” and what is their “conception of reality” versus being fused with their personal experience of reality.

These six processes can be paired to form three sub-domains: Openness (Acceptance, Defusion) illustrated on the left side on the Hexaflex figure, Centeredness (Present Moment, Self-as-Context) as illustrated in the centre of the hexaflex and Engagement (Values, Committed Action) as illustrated on the right side of the figure. It may also be sorted into two main processes: Commitment and Behavioural Activation (Acceptance, Defusion and Self-as-Context) the top and right side of the hexaflex and Mindfulness and Acceptance (Present Moment, Values and Committed Action) the bottom and left side of the figure (See Hayes et al., 2012 for a comprehensive account of the model).

Acceptance and Commitment Therapy is both a psychological treatment and a theory aiming at giving a comprehensive account of human psychology. In the last decade many therapies have been developed based on ACT-principles. ACT as a theoretical direction is openly expansive, seeking to encompass all theories and therapies contributing to psychological flexibility and thereby growing fast. As one of its founders Stephen C. Hayes (Hayes et al., 2012) put it:

Functionally defined, it consists of any method that reliably produces psychological flexibility; theoretically speaking, any method based on the psychological flexibility theory we have described here could be called “ACT” if those employing the methods choose to describe it in that way. (p. 97)

The manual - ACT Enhanced Behavioural Therapy (AEBT-T)

In its introduction the manual places itself theoretically as an ACT- enhanced behavioural

therapy, building on and extending from the Mansueto et al. (1997) cognitive model for understanding trichotillomania. Based on both HR and ACT the manual aims to help patients change/ reduce their hair-pulling behaviours, to understand their illness in new ways as well as relate to internal and external events in a new manner (Woods & Twohig, 2008). The manual consists of two books, namely a “therapists guide” and a “work book” for patients, both containing information about TTM and the theoretical background for the treatment as well as a “session- by-session” plan for therapy, homework assignments, metaphors and forms for assessment of progress and symptoms. While the therapists manual is more focused on theoretical background and practical guidance on how to organize therapy. The work-book is more focused on self-report and personal adjustment to the patient the content is largely the same in both books as it reflects the open/non-hierarchical nature of the therapeutic alliance in ACT.

Originally this manual is developed for use in individual therapy. The therapy investigated in this paper is however organised in group sessions. In the NTP the group format is intended to aid social support and counteract some of the issues concerning shame and self-hatred patients that with TTM suffer from (B. Hummelen.& E. Moen, personal communication, autumn 2014). There was good adherence to the manual as assessed with video-coding (Hummelen, 2015 personal communication).

Method

Epistemology

“Quantitative research is (...) concerned with the quantification (counting) of phenomena while qualitative research is that concerned with the qualities of phenomena” (Langdridge, 2004 p. 250). I chose qualitative methodology in this study because I wished to get a fuller account of the informants' perspectives of meanings and experiences of being diagnosed with TTM and going

through AEBT-T than traditional quantitative methods would allow. Qualitative approaches allow for a more inductive approach compared to hypothetical-deductive, positivist methods often used in psychological research (Silverman 2006; Rapley, 2011; Langdrige, 2012). The present approach is not aimed at “uncovering” the patients' true meanings, but is rather aimed at (re)constructing meaning as understood by the author in a dialectic process between what the informants' say, author's biases and background and what sort of questions she set out to answer. This amounts to a social constructivist position which holds that reality as perceived is always a social construction negotiated between individuals (Jorgensen & Phillips, 2002; Langdrige, 2012; Andrews, 2012). In effect everything is always a subject of interpretation and it is exactly those interpretations this study aims to assess. The process of answering questions in an interview is in itself a negotiation of meaning and the answers must be seen as constructed between interviewer and informants, situated in time and place not as “truths” held by informants or outside of the context they were asked. Social constructionism relates to reality as real, but it is the construction of knowledge and how reality is understood that is its focus, not the reality it self, making it an epistemological, not an ontological perspective (Andrews, 2012). Against this background I name my approach semi-inductive and social constructivist.

Discourses can be understood as the ways in which we talk/write/express ourselves about something or as “A particular way of talking about and understanding the world (or an aspect of the world)” (Jorgensen & Phillips, 2002, p.1) . They are at the same time the frames in which construction of meanings may occur as well as the results of such processes. There are many different definitions of discourse, but they all «share the starting point that our ways of talking do not neutrally reflect our world, identities and social relations but, rather, play an active role in creating and changing them» (Jorgensen & Phillips, 2002, p.1). In that way discourses are relevant to many fields of knowledge, amongst them psychology. In this work I am interested in the

discourses relevant to the informants; affecting them and being affected by them in their construction of meaning. My method to explore such discourses is to engage in face to face interviews with individual informants, using thematic analysis to investigate the data (Brown&Clarke, 2006). Discourse analysis on the other hand is a method of analysis specifically evolved to understand discourses per se and is not attempted in this work (Langdridge, 2012; Jorgensen & Phillips, 2002).

The Author and the Interview-guide

The author and interviewer is a graduate student of clinical psychology with partial background in sociology. The author's clinical training will influence the process of gathering, analysing and reporting data even though some measures are taken to balance this: Guidance is obtained from both a non-clinical and a clinical psychologist, feedback from non-psychologists have been sought in the process and the author has tried to be openly reflective about her position throughout the process. A semi-structured interview-guide was used in this study to ensure that all themes were covered with all informants. The guide was formed like a list of themes with probes to assess certain concepts (for the full guide, see appendix 3).

In preparing the interview-guide I only gathered enough information on the topic to get a sufficient overview in order to ask meaningful questions. I avoided engaging in literature about TTM and AEBT-T before the interviews in order to keep a genuine curiosity and open mind. Acknowledging the cooperative nature of constructing meaning in social constructivism I wanted to limit my own knowledge to prevent constructing meanings too close to theory. A clinical psychological training involves competence in talking to people in a one-on-one setting about sensitive topics and is therefore a method of assessment I am familiar with. The clinical interview is a key skill in therapy often used to gather information and plan therapeutic interventions that has several overlapping features with the semi-structured interviews used for research purposes (Davey,

2008).

Interview as Means of Assessment

Interviews were chosen as means of gathering data because they give rich data. A semi-structured interview allows informants as much time as they like to think through each question/theme. There is room for both short and elaborate answers and follow up questions one to one. Interview settings allow conversation about sensitive topics such as mental illness or shame-related behaviour. A question specifically asked for the participants to add anything they wished to probe, topics that the author had not thought of.

Recruitment and Participants

A broad range of participants in the treatment groups from 2013 were informed by their therapists and later the interviewer about the interview-study and given the opportunity to attend the interview-study. 13 participants initially voiced their interest but due to practical issues some were not able to make it to the interview appointments. A total of 9 informants were actually interviewed; 6 female, and 3 male, all of seemingly Norwegian ethnicity. Age of the 9 informants in question was not assessed but the mean age of the participants in the groups total were 32, ranging from 20 to 54 with a standard deviation of 9,7. No measure of socio-economic status or sexual orientation were obtained.

The Interviews

The interviews took place when the treatment was terminated around the time of the first booster session and the participants were free to choose the location that suited them best. One pilot interview was conducted at a university campus with a participant from the spring 2013-group around the timing of the first booster session. This interview was not included in further analysis,

but helped refine the interview-guide and the practicalities around interviews. Most interviews were conducted at the location where treatment sessions were given in association with the first booster session, one interview was conducted at the informant's home address and two interviews were conducted at a university campus around the time the first booster session were to take place. The interviews were audio-recorded in a digital format. They lasted between 60 and 75 minutes.

Data Analysis

Transcriptions of the recorded interviews were done by the author using a simple transcriptional method focusing mainly on semantic content, even though long pauses, laughter, special gestures and voice-manipulations were noted. The data was analysed with a semi-inductive driven thematic analysis (Brown & Clarke, 2006), using the content in the informants' answers as the basis for structuring the material and constructing themes. At the same time I acknowledged the interview-guide as directing the answers and to some extent making some deductive processes present in the analysis. The analysis was done at a semantic level informed by an epistemological view close to “critical realism” (Brown & Clarke, 2006). This means that I accept the informants' statements at a semantic level, without interpreting “true” or “hidden” meaning based on non-semantic cues. Some form of interpretation is seen as an inherent part of human communication; no measures was taken to interpret more or less than in any normal conversation. Critical realism holds that there is such a thing as reality and that we can get to know something about the “real” world, but that our means of assessing it will never be 1:1. Furthermore, in human sciences human beings inherently impose meaning on reality. Reality is thus construed differently in different individuals, groups, cultures and so on and what we may assess are our constructions of these constructions leading to the position of social constructivism (Jorgensen & Phillips, 2002; Andrews 2012).

The Process of Analysis

The transcripts were coded both manually and with the use of the software nVivo 10 for Windows. nVivo is a tool for organizing qualitative data such as text, sound and video. The coding was done in a “three-step-fashion” moving from a more descriptive to more interpretive coding using a constant comparative method down to the transcribed level to ensure continuous dialogue with the data. The two first steps were done in the author's mother tongue (Norwegian) and the third level in English.

The first step was to make a written transcript out of the audio-files from the interview. The author listened to the interviews several times and wrote down what was being said using earphones and a laptop with a text-editing program. Once the transcripts were done they were transported as whole documents in to the nVivo software.

The second step involved making coarse labels describing the observed content of small pieces of text with short key-words or codes using the software. This was done one interview at the time reading each transcript several times. When all interviews were coded I read all the transcripts again and compared the answers given by each participant to the same questions, looking for similarities and differences regarding similar topics. Then I reviewed all of the codes and compared the most frequent ones with the transcripts to see if they were descriptive of several transcripts or confined to a few.

After settling with a set of codes I found representative of the data, I started grouping these together in meaningful groups manually. I did this in three steps using coloured pen: (a) First I wrote down all of the codes from the last step on a piece of paper starting to group the ones I considered associated somehow together before assigning one colour to each group making circles, arrows and lines to indicate relatedness; (b) On a new piece of paper I wrote all the codes again, this time organised in colour and placement according to the last step, leaving the codes I felt

ambivalent about “hanging” with some arrows in several directions: (c) I tried to find a suitable name for each category of codes, creating themes. This process involved engagement with sheet a) and b) as well as consulting the transcripts and the codes in nVivo again. Finally (d) I wrote all the themes on a piece of paper, sorted by colour and with the associated codes beneath and then adjusting the numbers somewhat (see appendix 4, 5 and 6).

Next I made one document per theme, drawing out the most central points and finding quotations that support the view in question. These documents were compared with the transcripts and each other in a dialectical process. This was done still at a fairly descriptive level, but using more of my own words. Then more condensed versions were developed and I started writing in a document where all results were to be presented. This involved translating Norwegian quotes to English which was done by the author under guidance of the academic mentors Johannesen and Vogel. There were several rounds of editing and concentrating the text, all the time keeping a close eye at the transcripts while doing interpretation, resulting in the themes presented beneath.

Even though full bracketing was never attempted, the author abstained from reading the manual until analysis was done to limit the manual's influence on the data.

From the point of transcription and onwards to the writing of the report gender-neutral pronouns like “s/he” and “oneself” have been used. Whilst sympathising with arguments from queer and feminist- psychology of not excluding minorities that define themselves between traditional gender-categories (Feinberg, 1996) this matter the main reason for using gender-neutral pronouns in this thesis stems from the fact that research and theories on disorders too frequently are framed as “masculine” or “feminine” due to the majority of diagnosed patients being of one gender (Hartung & Widiger, 1998). The minorities are made invisible too often, which may contribute to the reproduction of stereotypical biases in diagnosing and treating them. By using gender-neutral pronouns the reader is challenged on the use of ones own stereotypes of the patient. See Milles

(2013) for a recent account of the use of gender-neutral pronouns in Sweden. In reporting the results I use numbers to identify which informant said what. In quotes “..” indicate a slight slow-down of speech where as “...” indicates a longer break, (...) indicates that the quote have been shortened by the author.

Methodological and Ethical Considerations

Using interviews as means of assessment may have been not only stressful for the informants (Siwiec, 2010) it may also have influenced informants' social desirability-bias so that fewer negative or critical statements came forth (Crowne & Marlowe, 1964, as in Spector, 2004). At the same time the very use of interviews combined with the fact that the informants knew that I am trained as a clinical psychologist bound by ethical guidelines for maintaining confidentiality may have provided a zone of confidentiality making it possible to share shame-related material. In line with a social constructivist understanding this may also have affected the way informants talked about their issues as well as the constructed meanings themselves.

The interview study is reported to the Regional Ethical Committee and have been approved as an additive study to NTP as of 10.28.2013. The interviews were anonymised during transcription and the original recordings were deleted in accordance with the norms for ethical treatment of personal data. The participants were able to withdraw their consent of participation and their data from the study at any time throughout the process. Some phrases in the quotes are rewritten as to avoid identification of informants and therapists. In some quotes the informants use the word “trich” as an abbreviation or slang for trichotillomania. The informants will get access to this report by email and the possibility to communicate with the author about it per email or phone.

Results

Main Themes

As a result of the thematic analysis based on the interviews, eight main themes were constructed: Group, Seminar, Getting Well, Theoretical Understanding, The Disorder, Information, and The Arrangements. The analysis has been guided by the research questions: (1) How do the participants construct pathological hair-pulling? (2) How do the informants construct this therapy? (3) How do the informants experience participating in AEBT-T in a group-format? (4) What are the elements the informants find helpful in this treatment and why are they experienced as helpful? The interaction between these questions and the data have been dialectical in nature, affecting each other reciprocally in line with the constructive nature of thematic analysis (Brown & Clarke, 2006). In the following I present the themes relevant to answering these questions. Even though headlines indicate the themes relations to the research-questions there is considerable overlap in what themes are relevant when answering the different questions.

How do the Participants Construct Pathological Hair-pulling?

The disorder -“The inner itch”. The first main theme might be the one closest to answering the research question: (1) How do the participants construct pathological hair-pulling? Informants are not asked this question directly, but they describe their urge to pull and they therefore indirectly describe the effect of hair-pulling in their life by describing what changes as they get better.

The urge. Informants describe the urge to pull hair in different ways. They experience it in different modalities: As a thought, as a feeling and as a bodily sensation. For example; a thought that they want to get rid of certain strands of hair, some informants feel emotional or they feel a

tingling sensation in the scalp or a need to touch their hair. The urge is experienced in different degrees of conscious control in so that it is experienced as more or less available to them as a precursor of hair-pulling. Many informants feel a psychological and psychomotorical uneasiness coupled with the need to pull hair and/or the belief that pulling hair will resolve the uneasiness.

Informant 3 uses a bodily based metaphor when describing the urge to pull:

3: For me it is like, it's sort of an uneasiness, an inner itch . Eh, and then I think that the only way to make it disappear, to curb it is to pull a hair. But you know, it doesn't go away it just gets worse and worse (...) But then it gets even worse when you say to yourself; «You've got to stop it.»

S/he describes the urge as something that seems to be a solution or giving a relief from the unease s/he feels, but that results in the opposite. Also typical for the informants is that it gets stronger as s/he tries to make it go away. One informant does not feel any urge at all, but the majority have a distinct feeling of an urge that is almost like a desire or a want.

Relation to emotions. Stress and other expressions of arousal affect the hair-pulling behaviour. Some informants experience symptoms mainly when aroused in a negative way, such as being stressed or experiencing negative emotion. They experience the urge more frequently and at greater intensity when they are going through tough times in their life although some report feeling the urge when positively aroused too. One informant describes a need to pull when in a confused or indecisive mood. Others also feel a rise in their urge when feeling under-aroused, when they are feeling bored or when trying to read a book or riding as a passenger in a car.

What trichotillomania is. Most informants hold that emotions affect the frequency and intensity of the urge to pull, but have different conceptions with regard to whether TTM is best understood at a symptom-level, as an illness on its own or as a result of some underlying issue. Some informants have changed their views of TTM through the AEBT-T. Several informants report

having had little information about hair-pulling and that they lack a sufficient vocabulary to talk about it or any conception of the problem as a diagnosis before treatment. «3:(...) we just thought that this is a terribly bad habit that we've got(...)». Others have understood their hair-pulling as self-harm-behavior, compulsive behaviour or as related to anxiety.

The majority of informants describe their new understanding of TTM as «the way it really is».

«7: because I thought that at first too, right, when I got here and that book tells us it is it is not an act of compulsion, we are not, that's not what... it's a habit! Thats really what we.. yeah, there is a difference there»

While some still hold on to their former conception. «5: In the beginning I looked at it as self-harm-behavior (...) but we got the impression on the seminar that they didn't think it belonged in that category, self-harm. But I think it does»

Even though they vary in their conception of TTM all informants agree that the label the hair-pulling is assigned (the diagnosis and how this is understood) is important to them. It affects how they view themselves and also their outlook for change. To be offered long-time treatments as some have experienced earlier make them feel as though there is something seriously wrong with them. At the same time not being offered any help leaves them thinking it is just a bad habit they need to get rid of without help. One informant describes how the therapists estimated the time needed to treat the hair-pulling affected how s/he felt about her/himself. When meeting a former therapists s/he was told after a very brief assessment that long-term therapy twice a week was needed. Upon learning that the present treatment-program offered 10 weeks of treatment once a week, s/he felt it changed the way s/he felt about oneself. 2: «And then I think that's a whole different (...) view of who people are when you do it in a way.»

Informants differ in their understanding of TTM as a symptom-disorder or as part of an

underlying problem and individually they also express ambivalence regarding how to understand their hair-pulling, especially in relation to other problems in their life. Whether just a bad habit, a symptom disorder or a sign of childhood trauma, meanings are constructed and negotiated with the use of existing theoretical ideas on how to explain human actions. The informants reflect on the implication of the different views of TTM for effective treatments. Two main views are constructed from the informants' accounts: Symptom-disorders call for «serial treatments». Here one problem may be addressed at the time with a specialised treatment, before moving on to the next. Questions informants raise within this understanding is: « When should I stop taking courses? What happens after a seminar is ended? What sort of other treatments are available? Who is responsible for answering the questions above?». Understanding TTM as part of the underlying problem calls for a treatment that «changes the fundamentals». This can be done by localizing the underlying problem and by working directly with the problem or trying to influence the «expressions» of it and affect different problems through generalising effects.

How do the Participants Construct Therapy?

“To accept it as it is. It could be a lot of different things”- Theoretical understandings.

The treatment-program the informants have participated in is based on a specific theory which main components are introduced in their workbook and discussed in the group. In this setting the informants' conceptions of theory are created, making joint construction or meaning possible. The informants have understandings of some concepts such as “values” and more homogeneous understanding of others like “acceptance”. In the interviews, informants were asked to describe central concepts to someone who knew nothing about the treatment. In contrast to the other questions in the interview they were given specific keywords to talk about. Although some concepts were easier than others to verbalise, most participants conveyed an understanding of the concepts

through practical examples or at other times in the interview.

Acceptance. There is a uniform agreement that “acceptance” is an important component of the therapy. Simultaneously informants seem to have two different constructions when given the keyword “acceptance”. The first is (a) “to accept that you have TTM and that it is a disorder that will not go away by itself”. The other is (b) “the mental act of accepting the urge to pull hair when it arrives without trying to make it go away or giving it too much attention”. Informants focusing on (a) acceptance of the condition, point towards learning about the disorder and meeting other people with the same problem as crucial for acceptance to occur.

6: Some of the others were very..very, emb..not embarrassed, but they had some issues with them doing it and we noticed throughout the seminar that, like (...) they learned more about what it was, why they had it and that several others had it and stuff like that and that led to like, eh, from non-acceptance of, not the act, but of the problem

Informant 6 describes how some participants found it easier to accept that they have a problem with pathological hair-pulling after learning more about it as well as meeting others with the same problem in the treatment-program. Several informants describe how this placed them in a better position to work on behavioral change.

Informants focusing on (b) *acceptance as a mental act*, often describe it in a practical manner; how they use it. 3 has found a way to interact with the urge to pull hair where s/he accepts its presence but not engaging with it, much like a polite, but noncompliant host:

3: It has been of great help to me to accept that the urge could be treated like a, I have like treated it like an uninvited guest in a way. The thought arrives, but I don't want anything to do with it. I have stopped, I sort of try to stop arguing with it, because then it disappears for a while.

In addition the informants who focus on acceptance as a mental act, point to towards ACT

– theory to a greater extent. “6: (...) and then you got to feel a little how your brain works. That it just comes with, like these suggestions all the time, but, like you don't have to do what it says”.

Some informants describe both acceptance of the condition and acceptance as a mental act as a response to this keyword. Some also describe these processes elsewhere in the interview.

Generally informants speak easily and vividly about this concept such as retelling exercises they have done in the AEBT-T group to illustrate how it works. Informants describe acceptance both as an acceptance of the condition and as a mental act as empowering.

Values. When given the keyword “values” many informants seemed puzzled. Several found it difficult to articulate an answer to this keyword and in contrast to “acceptance” there were heterogeneity in conceptions and the alleged importance of it, across the interviews. Some informants see “values” and “goals” as synonymous while others define “values” as deliberately utopic goals. 4: (...) looking at a specific value like, not like a goal in itself that can be difficult to achieve, but things that I, eh, would like to strive to.. follow” or as traits they would like to encompass.

Commitment. The informants have different constructions of “commitment”. Several informants focus on committing to ones goals “1: I will keep agreements with myself (...) it is important to me to keep a commitment to myself. Just as important as keeping any other agreement.” Others speak of a more “practical commitment”, related to complying with the treatment program like committing to attending the group and doing the assignments. The informants differ both in (a) how easily they can articulate and define several theoretical constructs to the interviewer, what we may call a “semantic understanding” and in their description of (b) how theoretical constructs work, “procedural understanding” as well as (c) the distance of a) and b) from the therapeutic manual as understood by the author.

How Do the Informants Experience Participating in AEBT-T in a Group-format?

Group – Empowering and Therapeutic? The group is something every informant mentions spontaneously throughout the interview. It is homogeneously held as an important feature of the treatment-program. There are some contradictory constructions within this theme where the group is seen as important but not as contributing to reducing hair-pulling behaviour per se.

Positive effects of the group. Most informants spontaneously point out normalisation as one of the central therapeutic effects of the group.

1: If I were to sit there alone, maybe I would have felt a little more abnormal. So sitting there with several others and being able to recognize the different features and discover that in fact you are not alone. That it was the majority that was abnormal. Then you're all of a sudden not so abnormal anymore

This normalisation led to reduction of shame: “7: Maybe it was the biggest and the thing I have struggled the most with and then it just went away like «poff» by itself after the first meeting and to get, to get it like, into the light..” Simply meeting other people with the same issues and talking out loud about the hair-pulling reduces feelings of shame drastically. By listening in on the other participants describing how they felt about their hair-pulling many informants felt like the others put something into words that they themselves were not able to.

3: (...) it is all about, of course you hear other people talk about a problem that you've got and just through that something happens through accepting it. Because I think the most of us, having trich, we have gone about believing «This is something only I struggle with» and it, I had never even heard of TTM before, before maybe two years ago.

Informant 3 points to the common point made by the informants that there is no public discourse about TTM and until they attended the treatment-program they could not discuss it freely

with other people. The group makes construction of such a discourse possible and this joint construction of what it means to have TTM is experienced as empowering to the informants.

Finally: Getting validation from the other participants and hearing how things went with their recovery is seen as important both for motivational purposes and for providing a reference point for themselves.

1: (...) I haven't got any competitive instinct, but it has been like sort of nice to see that I have had a really good week and then I can come there and I can tell everybody about it. We can compare a little and we can support each other a little and we can give each other positive feedback, share some, share some experiences that you have worked with yourself. So... maybe it has been like.. eh.. like.. I can compare myself to someone. In that way I think it has had a very big impact.

Clearly the group is important to the participants. At the same time none of them have had contact outside the group setting and most were not interested in that sort of contact either.

4: On a personal level? Nyeah, well I have got to know parts of their life that I wouldn't necessarily get to know if I wasn't that close to them, but I still feel that it has been some sort of professionalism in the way we have shared different things, but eh..eh.. I don't feel like, eh.. I don't know quite what to say... I feel that we have been there for each other, but not necessarily to establish, to establish a relation

«It didn't make much of a difference, but it was really nice» (Informant 8). People construct two effects of the group separately: the “therapeutic” and the “nice/empowering”. Answering the question: “Do you think the contact with the other group-members have helped you master TTM?”. Informants generally do not think the other group-members have influenced their recovery, but appreciate the social and emotional benefits of the group. The group as supportive and “nice” is constructed as separate from their own recovery in that they felt the group was supportive,

but not directly influential on their own process of recovery. As opposed to a construction where the supportive/empowering effects of the group were seen as a therapeutic effect in and of itself, it is seen as a framework wherein the “therapeutic” work may be done.

This might relate to the discourse of the treatment-program as a seminar (see below). In such a frame the individuals act toward each other as they would do at class, having a mutual supportive relationship, like colleagues or fellow students contributing to their learning. In this discourse they construct their recovery as an individual accomplishment, much as you would have individual marks based on your work in a seminar or class setting.

Not attributing the success to the group, but to oneself is also in line with the broader discourse of progress and success held in the ideal of an individualistic self-construction project in the Western/European cultures. It further resonates well with the social psychological principle of the self-serving bias stating that humans will tend to attribute their own positive accomplishments to themselves and negative ones to others (Campbell & Sedikides, 1999, Duval&Silvia,2002).

At the same time as informants do not attribute their recovery to the group, they describe it as a very important part of treatment- pointing towards it being seen as related to therapeutic effects in some way. Informants acknowledge the significance of normalisation, shame reduction and validation, but does not link these processes directly to their own recovery. In light of this it is possible to understand the apparent contradiction of the group as being very meaningful to the informants, but not having any effect in helping them master TTM, as a construction of two separate processes. The processes of “empowerment” and “mastering symptoms”, mutually supporting each other instead of the group-format being ineffective.

“You need to do the job yourself” - Seminar. Informants emphasise learning when they talk about the treatment-program. The words they use when describing what they have experienced resembles those used in other learning-settings, such as in a class or at a seminar. This discourse

have implications for the way the other participants and the therapist are seen as well as the informants' view of effort and responsibility for treatment outcome.

Therapy versus seminar. The informants generally speak of AEBT-T as a seminar and the material as curriculum. “5: If I start to pull hair I almost automatically think about the seminar, about what we learned there.” In their experience they have learned something rather than being treated for something which reflects an experience of being an active participant in AEBT-T. Yet many informants' initially expected something else than what they got from the treatment. Their expectations were different both in terms of how fast they would get better and to what extent it required continuous effort from themselves as well as the role of the therapists.

In many cultural expressions depicting psychotherapy, the patients are portrayed as passive recipients of a treatment from an expert. A categorical, rather than continuous understanding of mental illness is often implied. The “problem” gets “fixed” and after treatment the patient does not have to deal with the issue anymore. In many ways the public discourse surrounding psychotherapy is influenced by medical and psychoanalytic myths. The therapists are depicted as interpretative experts and does not share their knowledge with the patient or involve patients in active work. Furthermore, group therapy as portrayed in cultural expression is often all about sharing feelings and a retrospective focus. This discourse surrounding psychotherapy may have contributed to the informants initial expectation entering AEBT-T. Informant 7 describes how the expectations s/he had about recovery changed promptly the first session

7: And of course, even though I didn't get over it like «boom» (snaps fingers) like I had hoped, I realised after the first session really that this is something you're supposed to work with for a very long time. But I have hopes that there will come a day, but it takes a lot of effort, it does

Effort-driven learning and personal responsibility. Informants feel responsible for the

outcome of AEBT-T to a great extent, like you would as a student in a seminar. This seems to contrast with the initial expectations of what therapy would be like “6: My expectations were quite low really and.. eh, I was actually pleasantly surprised, but, then it's like, then it demands a sort of continuous effort”.

The “seminar-form” of therapy is perceived by informants as both liberating in the way that they are seen as competent and rational, but also giving them a greater burden of individual responsibility that sometimes weighs them down. “2: There are some practical stuff that I have thought maybe, like I think has a very good effect, but that I've maybe been a bit bad at doing too (laughs a little). Sort of.. ehm.. yes, well its quite a big task to go through with changing ones habits”. 2 illustrates the feeling shared by many that there is a lot of work to be done and that they sometimes feel they are not doing a satisfactory job. When something did not quite work for them or when they had a hard time grasping certain concepts they generally attribute this to their own lack of effort, rather than faults in the materiel or bad explanation from the therapists. Attributing progress to effort is in line with a seminar-like discourse making them responsible for getting as much as possible out of the treatment at the time allotted, much like the students are responsible for their own learning in a seminar. In addition this understanding makes them feel responsible when not learning.

Seminar-leaders and colleagues. The relationship with the therapists is influenced by the conception of AEBT-T as seminar. Informants speak of them as “seminar-leaders” rather than “therapists”. They are perceived as straight forward and somewhat confronting something that might be in contrast with a discourse of psychotherapy in the society at large .

2: (...) like, you recognize some things, like when it comes to what it is and how one does stuff and how one relates to, both one self and the world around that you get very, like confronted with, I feel, in a group like that or at large in that kind of therapy. It has, sort of

been quite, yes, you have to go there, but off course it is demanding to, so both useful and informative, but also demanding.

Again the relationship to the other group-members is described as collegial, supportive and confined to the group setting. Some informants use the word professional in describing the sort of relationship they have to co-participants. This corresponds with the group being a place where individual ways of recovering are facilitated but that is not conceived as therapeutic in and of itself, as described above.

What are the Elements the Informants find Helpful in this Treatment and Why are They Experienced as Helpful?

«I deal with things in a better way now» - Getting better. We have seen in the themes above that informants have described how the habit and the urge of TTM may be like. We have also seen how they understand the theoretical underpinnings of the treatment-program in both homogeneous and heterogeneous ways. We have looked at how they experience the group-format as very important yet somewhat ambiguous as well as how they conceptualise the treatment as a seminar. So far research question (1) How do the participants construct pathological hair-pulling? (2) How do the informants construct this therapy? And (3) How do the informants experience participating in AEBT-T in a group-format? have been addressed. In the following section research question number (4) What are the elements the informants find helpful in this treatment and why are they experienced as helpful?" will be illuminated. Most informants feel the treatment has had a positive impact on them one way or another. Below we look at how the informants describe getting better

Dealing with things differently. Informant 6 says:

(...) maybe when it comes to the urge to pull and stuff. I've got, like a more rational way of

dealing with it maybe. Or a more analytic, so that you are able to evaluate.. yes, you think it through more maybe, you don't just necessarily throw yourself at the feeling that emerges

Informants describe improvement in terms of change in the way they relate to inner events or as secondary effects, not in terms of hairs pulled or frequency of pulling-episodes. Related to the theme above, many informants use the concept of “learning” to describe how they changed rather than “getting well” or “recovery”, words that may be more in line with a common psychotherapy-discourse.

Most informants describe that they still feel the urge, but that they have now learned how the urge works and how to deal with it. “6: So that you see what's going on and are able to. It is much easier then, to react, then when you.. yes, when you just don't understand what's happening.” At the same time they are conscious of individual differences and have their own understanding of *their* urge and the tools that are working for them to change their behaviour. Generally they experience that their inner events, such as the emotions or thoughts themselves have not changed, it is their relationship with their inner events e.g. the ways in which they relate to them that are different.

Secondary effects – generalisation. Many informants describe generalizing effects out of and above reduction-, control and awareness of hair-pulling. 4 illustrates the construction of several different ways of getting better. There are hair-pulling related changes but also other important effects. “4: Even though I don't consider my self totally over it, then at least it is not something, eh, that I go about feeling ashamed of.” Being more confident is a clear effect that most of the participants agree on. “1: I have discovered that maybe I am stronger then I thought I was and that I can master more than I thought I could”. Some informants feel as they are more in control of themselves and being able to stay committed to goals one has set on different life arenas is mentioned by many participants. Informants describe better relations with others in several

different ways, such as speaking in a group setting, communicating better at work and in their personal life “5: (...) to be able to meet the opposite sex for instance”. Last, but not least a great deal of informants express a feeling of relief finding a way to understand and handle their pathological hair-pulling. “8: I feel very free, relaxed (laughs)”.

«You are supposed to learn from your patients» - Information. Being part of this particular treatment has also meant being part of a research program. This involves systematic gathering of data about the participants. The informants feel they have answered many questionnaires and seem to sometimes be in doubt of what is part of the treatment per se and what is purely research-driven. They wonder what their information will be used for and express that they hope it will be used to improve treatments and provide information about TTM. The majority of the informants have negative experiences related to a lacking knowledge of TTM or a misunderstood conception of it amongst health-care workers. They also hope that the information they have provided will be used to the benefit of help-seeking people with the same problems and to establish a more available and enlightened discourse of TTM in the public.

The use of information. Informants are curious about why they had to give up so much information at the pre-treatment evaluation and during the treatment-program. There is also a curiosity and concern for what it will be used for. The following expression from informant 2 illustrates the concern of many informants with regard to the use of their personal data

2: (...) Is there something about me that they are like sitting there thinking; «You should really talk to someone about that or maybe you should have had some help or it would be useful for you and stuff», but, but I understand, sort of the side of it, that it, that it has to be my choice to come and sort of ask for that perhaps, but maybe like. By the very fact that they may be sitting on a lot of material and looking at it with professional eyes in a way, it could have been comunnic... it may be that they do just that, but not to me (...)

They generally want their information to come to good use. “4: Cause I hope that, because we have like filled out seventy billion forms so I hope it will be used for something, if not I will feel really cheated”. Some informants voice a concern for possible spreading of information by way of the other participants and miss some sort of a treaty of confidentiality in the group.

Ignorance hurts. Informants want to spread information about TTM. “1: The more who know the better really. (...) I wish more people sort of knew about it, that I knew about it earlier maybe.” Informant 1 illustrates the frustration most informants feel of not having had access to a public discourse of TTM before. The empowering effects of normalisation and shame-reduction as described above are seen as possible positive effects of such a discourse being publicly available. The informants have many experiences of not being understood. “5: This has been an unknown problem for me since I was little and I have been to a lot of people. For instance child- and adolescent psychiatry; no one knew what it was “ and other peoples lack of knowledge have hurt them. Their shame has grown rather than shrunk as a consequence of some encounters with helpers.

8: (...) I've been to a psychologist once before ehm, I was almost sort of ridiculed probably because s(he) didn't understand what it was. And then it makes a stronger barrier for making contact again, and you feel a little, you feel, like, a little silly «can't you just stop it?» .

Several informants tell stories from when they have felt humiliated and scorned by physicians and psychologists.

1: Well I have, I have an experience with a physician who... He laughed right, he thought it was just silly.. and I sat there, right.. I was there twice and asked for help and I just got a list of psychologist and were told to call them myself. «Tell them about your problems, don't come to me about them». You can't meet people that way, and not with scorn because that's what he did.

Information about what works. Informants describe a feeling of having wasted time and energy on pulling hair because of ignorance among helpers. Many informants have experienced different approaches to the understanding and treatment of TTM and find that AEBT-T focuses more directly on the hair-pulling compared to other approaches. The following quotes from informants 7 and 2 are illustrative of what many informants have experienced:

7: At that time I had been going to this psychiatric nurse or psychologist or, I'm not quite sure what s/he is. Been going there for over a year without us working with the main problem and I was like.. (...) because the main problem was my life partner. s/he thought. It wasn't necessarily like that. Maybe we were having a hard time because I was ill right.

Here 7's therapist clearly has a different opinion of what is "the real problem" than informant 7.

Informant 2 has not got such a hierarchical understanding of the problems but sees this treatment-program as more directly targeting the hair-pulling than former therapy has done.

2: You are met with some expectations from the therapist about what will do me good in a way, but eh... without it really focusing on the hair-pulling in a way, but here you, like go straight at the hair-pulling and then you look at, in a way a little bit in the shadow of it that also the other stuff I've been into before as well, that they too are made visible in a way, you, but.. (mumbles) the trich gets elevated in a way, but in a way it gets to be, like, what's important here

Informants call for information about how different treatments work and information about what sort of help is out there. "5: What is available for your diagnosis?" Informant 5's quote also points to the responsibility informants feel for their recovering-process as well as the discourse of treatment as a seminar. Informants want to be informed about what sorts of treatments work for TTM to be able to choose. Some informants describe the ethical issue of people getting treatments that are not proven to be effective, whilst evidence-based treatments exists, but are not known about

or not adhered to by helpers.

2: I think, like, there are loads of people just waltzing about in that system, year out and year in in a way. Maybe they could have had a lot in return for just 10 weeks that would have done them good in a way, even though stuff might surface that sort of.. but it can be a good, sort of angle of attack to the problem or to that of getting better(...)

In sum they want to spread information about effective treatment for TTM to helpers and the public to help others in their position. “2: For it's that I'm thinking that why isn't there more, why don't they meet up to a greater extent and say that it (short laugh) «Most likely» (short laugh) (...) «this is what's working»”

«I'm sure they thought it through» - The arrangements. Going through the treatment informants have had the first hand experience of how the treatment-program works in practice. They have made observations of the arrangements and how the treatment is organised. The informants' experiences are interesting because a treatment, however promising on paper, is never better than the way it is perceived by the participants. Informants' experiences may be translated in to possible improvements to the treatment-program. The informants' experiences help shed some light on research question (3) How do the informants experience participating in AEBT-T in a group-format? And not least: (4) What are the elements the informants find helpful in this treatment and why are they experienced as helpful? In the following these sub-themes are described; Assessment, Relatives Night, Practicalities – the sessions, Therapists in the group and the Road ahead.

Assessment. Many informants have had negative experiences from the interviews and assessment with the therapists that took place before joining the group. They feel evaluated and tested without getting enough feedback on what was tested and how they performed. Several informants found the questions asked scary, wich made them feel accused of being crazy.

3:(...)I was so scared when I saw all the strange questions I had to answer I was here for this interview before I joined the treatment and it was so many questions that I thought «Like, oh my God, do they think I am like totally crazy or what?» that's what I thought. And I think that is why I thought «what sort of group is waiting for me?» as well. If everybody else answered yes to all those questions where I answered no or 0-10, it was a lot of that, then I thought «this must be a bunch of loonies» so I thought that was kind of scary. Because I couldn't relate to 90% of those questions and I thought «why on earth do they ask me about such things?»(...) One could have had information about that before filling them out.

Because I felt that that scared me

On a similar note informants feel they are missing accurate information on why they are asked to fill in plentiful forms during the ten weeks of AEBT-T. “4: I haven't got o much information about the ones that I fill out in the sessions (...) I just think that. I just put my trust in that there is some reason...”

Relatives' Night- Activating Social Support. “The relatives' night” is an arranged meeting outside the sessions one night during the ten weeks the treatment-program lasted. Informants were allowed to invite loved ones to this event to get information and meet therapists and other families affected by TTM. Relatives night is a subject many informants mention spontaneously and held as very important to the participants that were invited to one, but it appears, however that not all treatment groups arranged a relatives' night. Furthermore it is not mentioned in the manual and I did not know anything about this before I conducted the interviews. Informants participating in this event describe it as a very important part of therapy. The impression is that the provision of psycho-education to the relatives from therapists as “experts” give the informants credibility as sufferers of “something real” and that participating at Relatives' night enabled communication between the informants and their family and/or close ones. The reported result of Relatives' night is increased

social support and involvement of kin and/or friends.

1: (FAMILY MEMBER)(...) s/he has never understood my, s/he hasn't understood quite what this is all about. S/he got an epiphany. When we got home or in the car back home, s/he was, yeah, almost like : «Wow, what is this, I should have known this». Now all of the sudden s/he started understanding my little fascination with hair (...). So after that like, this has been sort of a breakthrough for me. So that (Relatives' night) is something, I recommended dearly, «you have got to continue doing it».

Practicalities – the Sessions. Practical issues, like not having access to the course books on time, have influenced treatment and made it difficult for some participants to prepare for the first sessions.

The content of sessions and the pace in which they are undergone is commented on. “2: (...) The use of terms and stuff like that is very, like it fits well in a way to the eh, to like, the process you are in in a way and the things you do (...)” Mostly informants are satisfied with the content, but some informants feel the pace is too rapid and that there are problems with setting the agenda of the sessions beforehand. In some informants' view there should be less focus on keeping schedule and more focus on open discussion and exploration of participants' stories as well as alternative treatments.

5: (...) so they were arrogant enough to hold that exactly what they had done research on and written a book about and... but eh, that is just like a little information. Because it may be that this seminar doesn't fit us all, maybe someone needs something else.

6: (about medication) But it has been very much a focus on not to talk about it. It has been a bit like «no, that doesn't help and bla-bla». I don't think it is that simple really.

Therapists in the group. The relationship to the therapists is experienced as different in a group versus individual treatment in that the plan for each session is more “to the point” and there are less focus on each participant.

2: (...) the relation takes on a somewhat different shape in a way when you're in a group.

Maybe you get to the core of the matter faster when it is a group, because the time and the mode of treatment is like that. Like «we are here because of that» you are not to attend to needs so much. Maybe it can be a little.. I don't know if it might be a little different if it just...if it were just,like, the two of us.

Some informants look at this as a disadvantage because they have less time to engage in their personal issues, but the majority are positive to the “different patient-therapist relationship”.

Therapists are described as both invisible, warm and controlling. The therapists are invisible in that most informants describe the other participants as most important in the group.

6: (...) One has a sort of an informal relation to them being there, just to say that «we have to get through some stuff, but we are quite free to choose how to work with each subject».

So, so that you sort of get to say what you want and discuss what you want to discuss, but that one sort of makes sure that the curriculum in a way is covered

Therapists are described as warm in that they are supportive, genuine and sympathetic. This is somewhat contrasted with several informants description of them as arrogant in the way they relate to other treatments and theories of etiology of TTM. The therapists sticking to the planned agenda in sessions is experienced as both positive in that they are efficient and to the point, but also at times as arrogant or inconsiderate.

5: When we started talking in the group and people started opening their feelings right, because there is a lot at stake, then we were quite promptly directed in to their schedule.

They had like this (making sounds and gesticulating many fast sounds quickly succeeding

each other) it was quite negative in a way because when people first open up their emotions then...and then someone did that right, then they got like withdrawn right.

The road ahead. Even though they come through as empowered by the group and my the treatment, informants' still would like some more guidance. Both regarding how they are doing and guidance on what to do after treatment has ended. They express doubt about when to consider themselves well or they want to hear the therapists' expert opinion of the extent of their problem.

2: (...) maybe some guidance in it anyway like would be, or I'm thinking that that also would have been... if they with the competence they possess could say something qualifies about, sort of. That it is sort of within their sort of (laughs) commission. A little bit like, they are not physicians and stuff, it is sort of their field and in a way to be able too, on the basis of that, all the forms I have filled out and then I could have made choices on that background without me taking to much lead there, but I don't like know how it works in a way, in a world like this one (laughs).

Finally although most informants are satisfied with the treatment being intensive/short term, several informants wish the seminar had lasted for a longer period of time or that it would be possible to have more repetition of what they have learned.

“5: (...) should have lasted for longer. And now we're having this booster-session tomorrow so I hope there will be more, that it won't, that it won't just end there. But quite possibly, I'll participate in another seminar for instance. A refreshment seminar”

Discussion

Brief Summary of Results

In this study we have seen that seven themes have been constructed on the basis of the interviews: The disorder, Group, Seminar, Getting Well, Theoretical Understanding, Information

and The Arrangements. Informants experience the urge in hair-pulling in different ways, but agree that the urge increases when trying to make it disappear. They define the disorder in different ways, and most informants have changed their understanding of trichotillomania through AEBT-T. Informants construct two separate conceptions of “group”. One empowering and one therapeutic influencing each other. The group has made the construction of a discourse of trichotillomania possible. Informants use a discourse when they describe AEBT-T that resembles the ones used in seminars or courses, making therapy about effort-driven learning. Getting well concerns much more than reduction in hair-pulling and the theoretical understandings of the concepts acceptance, values and commitment are somewhat heterogenous across the informants. Acceptance is understood as “acceptance of having trichotillomania” or “acceptance as a mental act”. Values are understood as synonymous to goals or as a deliberately utopian goal and commitment is understood in either a practical commitment or as a commitment to inner values. Informants are in doubt as to how their personal information is utilised. They want it to come to good use and wish to spread knowledge about TTM. Informants request guidance founded in information about them. Several practical issues were voiced about the arrangements, Relatives' night was seen as an important part of the therapy.

Relation to Other Empirical Work

In general the way informants describe the urge to pull harmonise well with other empirical work done on pathological hair-pulling. As in Mansuetos ComB- model informants emphasise emotions as related to pulling, and as Sewici (2010) holds, both positive and negative emotions or boredom/indecisiveness may trigger the urge to pull. Further in line with previous studies, several informants point to a reinforcing dynamic where the pulling feels like a solution, but ends up leading to a stronger urge to pull.

This study concerns the collectively constructed and personal meanings of the participants

and indeed the informants describe changes in the way they consider hair-pulling after having attended AEBT-T. As they have shared experiences, recognized the descriptions of others and learned about the psychological models underlying AEBT-T, a new understanding has emerged. This new understanding is a result of group processes, moderation and discussion. Psycho-education from the therapists, the workbook and the discussions in the group have laid the foundation for this transition of meaning from pre-treatment to post-treatment. This process can be described as a joint construction of meaning or a negotiation of meaning. The majority of informants feel that the transition from their pre-treatment- belief has been empowering and speak of it as learning something useful and «finally understanding how it is». Other informants are critical of the new meaning and says they prefer a different understanding of their problem or the initial understanding. The informants who describe the therapists as arrogant or too focused on the preplanned content of the session were largely the same informants who did not change their conception of trichotillomania or asked for more information about other perspectives than the one presented in this therapy. These informants felt that their perspective was moderated by the therapists or not recognized by the others as being in line with the joint new meaning and therefore disqualified.

With regard to the theory in question the three concepts of «acceptance», «values» and «commitment» yielded interesting answers in this study. Acceptance was by most of the informants held as the most important concept. Yet taking a closer look I constructed two different meanings from the informants' answers: Acceptance of trich and acceptance as a mental act or skill. While both of the understandings of acceptance were held as important to the informants, the acceptance of trich was more related to the therapy being in a group-format through the processes of normalisation and shame-reduction. This in turn affected how the individuals looked at themselves.

Acceptance as a mental act however was aided by the «curriculum» in the manual.

Excercises done in the group under therapist guidance, the workbooks explanations and the discussion in the group aided this form of acceptance and it affected the way they practically dealt with the urge to pull. The first construction of acceptance is interesting in that it may be directly affected by the format therapy is delivered in. It may be that the common meaning of «acceptance» is made salient by the early experiences in the group. Some individuals describe both forms of acceptance, others only one of them, but regardless of which understanding the informant focuses on it is seen as an effective part of therapy. Several informants also describe how the acceptance of having the trich makes it easier to work with the handling of the urge as it reduces secondary emotions. This resonates well with Mansuetos model of affective-cycles that keep reinforcing pulling-behavior. According to this model removing or reducing secondary emotions such as shame and guilt may weaken the urge to pull (Mansueto et al., 1997). This may point to therapeutic effects that might be unique to the group-format. It also reveals a possible (psycho-)educational challenge distinguishing the concept of «acceptance as a mental act» from «acceptance of having trichotillomania».

Informants disagree on to what degree «values» is an important therapeutic concept. Some informants find it difficult to articulate what values are to them and quite a few do not see a connection between reducing hair-pulling behaviour and defining values. Some of those who construct values as synonymous to «goals», also ties values to mastery of hair-pulling in that way. All informants mention it being on the «curriculum» and that they have talked about it. Yet it seems to be considerably less salient and vivid in their memory than “acceptance”. Another explanation may be that the informants are afraid of giving «wrong» answers as many of them conceive of this concept as highly theoretical or abstract. The construction of therapy as a «seminar» might enhance this effect, leaving the individuals feeling like they have failed to understand something on the «curriculum» if they cannot easily verbalize a concept learned in therapy. Informants who have

found the concept of «values» valuable typically speak of their own reflective work amounting in an understanding of the concept. In sum it looks like the joint negotiation of meaning has not culminated in a common understanding of «values», but it is left up to the individuals to figure it out themselves. This might be because it is considered a more «personal» topic and hence up to the individual to think about on their own instead of discussing it in group. This bereaves the individuals from a shared negotiated meaning being constructed on this topic.

There are two main understandings of commitment being communicated in the interviews; One practical and one theoretical understanding much in parallel with the two main constructions of «acceptance» where one is more closely connected to the commonly used understanding of the concept and the other is a theoretical concept within ACT. The informants who focus on the practical understanding speak of commitment to the group and to the other participants, whereas the informants focusing on the theoretical understanding speak of commitment to ones goals and to oneself.

Especially «keeping commitments to oneself» is something many informants hold as an important change. The informants have more respect for themselves post-treatment, as they make commitment to what is important to them a priority whereas commitments to others was seen as more important before. In the theme «getting better» increased self-esteem and experience of mastery of one's own life is regarded as important secondary effects of the program seen as separate from the reduction of hair-pulling behaviour. The increase in self-respect can be seen as a consequence of the empowering effects of the group and the «acceptance of trich» - again positive effects of the group-format. In addition, the experience of mastering the tools given in AEBT-T and seeing a reduction in hair-pulling behaviour is attributed to oneself and not the group. This can also be seen as strengthening self-respect. In line with both an individualistic culture's conception of the self-made-self and with the «therapy as seminar»-discourse the individuals reject the others having

a direct influence on their hair-pulling behaviour. Instead the normalisation and shame-reducing effects are attributed to the group-format while «getting better» is attributed to personal effort.

Effort-driven learning means personal responsibility, this responsibility combined with the tools learned in therapy makes for mastery experiences attributed to the self, promoting an inner locus of control. This gives the effect of the individual feeling more in control of their life. This feeling of mastery or being in control is somewhat paradoxical to the content of theory and the nature of the tools informants have learned in therapy. After all, acceptance as a mental act is all about *not* trying to control mental events, but letting them be. By giving up control they paradoxically gain a sense of mastery. The informants describe this effect as one of the most important, if not *the* most important effect of treatment. This understanding of «how the mind works» validates the «seminar» and gives credibility to the rest of the «curriculum». The combination of learning a new principle and experiencing a change is powerful. This may account for the fact that «values» are seen as less therapeutically relevant, most informants only have the theoretical, personal understanding of this concept. The ones that have constructed it as a more practical concept, and made it relevant in their day-to-day living generally describe it as more important and therapeutic.

Constructions from this Study

In describing the urge to pull hair, the ways they get better, information and arrangements, the informants touch in on the nature of trichotillomania as a symptom-disorder versus a result of an underlying problem. There are heterogenous views in the data and each individual may be highly ambivalent on the matter. Some informants feel that there has been too little focus on understanding the «Why-questions», etiology and how to place trichotillomania in relation to co-morbidities and former experiences. The contrast between a clear psycho-educational element and «getting to know how it works» and not getting any answers to these questions puzzle some informants. In the

session there is not given opportunities for the informants to debate and discuss these topics, thereby bereaving them of the opportunity to construct cooperative answers to the «why-questions». Instead initiatives to start such a debate is rejected as «off topic». The focus of therapy is confined to getting well or better from the pathological hair-pulling, not placing the issue in time or space or really providing any etiological account- it does not allow each individual to place this treatment or the hair-pulling in their personal narrative, rather it openly «just» teaches the tools to handle the hair-pulling regardless of cause and relation to experience. This underscores the informants' view of the AEBT-T as a seminar, not as a therapy. The construction of therapy as a psychodynamic myth-like makes AEBT-T not seem like «therapy» and the therapists not seem like «therapists» as the common discourse held in our culture creating a breach between their initial expectations and the experience of going through AEBT-T. Informants are for the most part very happy with this «differentness» which make them feel empowered and in charge of their own recovery, rather than a recipient of treatment. Yet when the groups have ended informants' have many questions. They feel alone in their effort trying to place what has happened in to their personal narrative, both of the past and in guiding what to logically do next. In this landscape questions of how trichotillomania is best understood becomes important. Informants construct two main understandings; TTM as a symptom-disorder that might relate to other mental conditions as one in a line of other symptom-disorders or TTM as part of an underlying issue that has different ways of affecting day-to-day-living with TTM being one of them.

In openly reflecting on this subject, the informants' place themselves in the middle of an important grand debate in clinical psychology as a field of knowledge. How to best understand mental illnesses and their etiology is an ongoing tug-of-war between the position where something pathological or maladaptive often called «underlying» or «deep» may manifest itself in different forms in peoples life versus a view that the behaviour only in the present is the object of therapy

and is thus to be changed.

As outlined in the introduction different perspectives within clinical psychology vary in their understanding of trichotillomania (and mental disorders in general) as a result of something “underlying” or “symptom-based”. Most therapeutic directions will place themselves somewhere in-between these extreme positions. The recognition of the complexity of etiological questions is great in clinical psychology today, but even if theorists and therapists from different psychological backgrounds now accept and acknowledge the other's contributions to understanding humans psychology and psychopathology there are still disagreements in what ways to best solve problems people are faced with. Interestingly the informants in this study openly reflect on the pros and cons of different understandings of TTM from their perspective. Isolating TTM as a pathological habit and giving it 10 weeks of intensive focus has enabled many of the participants to understand the dynamics of this problem in depth themselves and to work actively and thoroughly through different aspects of hair-pulling problems, guided by the workbook and manualized sessions. On the other hand no, or little attention is given to whatever other conditions informants' may have and informants' are left with no answers to why they had this problem in the first place or what relations this problem may have to other issues in their lives. Informants' are generally unsure of whether they need more treatment or not and that they do not know what to do next.

Several informants have had former experiences with therapists who have tried to treat the «underlying» issue first, hence hypothesising that this will affect the TTM positively. These informants are sometimes in disagreement with these therapists as to what the «underlying» problem is and feel like they have been focusing on answering the «why-questions» without being shown a way out of their issues. Furthermore, they felt frustrated with not seeing or feeling any progress in their behaviour. They miss an insight into the therapeutic rationale from these therapists and ask specifically for research-driven or evidence-based therapies. To sum up: Specific treatment

for an isolated problem is experienced as providing good progress and it feels like their own project being their own main responsibility. Treatment for an underlying problem is experienced as providing answers to more questions but lacking impact on behaviour.

The therapists role are constructed to take more responsibility in the «underlying problem»-therapies, as they also give an indication as to when patients are considered well and have an «expert opinion» on how the patient is doing regarding this «underlying issue» of which the therapist is an expert. In the «specific» therapy the patient is the expert, knowing and feeling themselves when they need more therapy or not. This is a responsibility some of the informants do not feel qualified for. At the same time they appreciate the egalitarian style of therapy experienced in AEBT-T. Informants explicitly address the need for guidance and a more interpretative therapist when it comes to understanding themselves and what to do next. Especially the fact that therapists gather so much detailed information on them without giving an «interpretation» back feels strange to the informants. This study being done on groups attending a research-program where there is a lot of gathering of information may exaggerate this effect. At the same time registration and keeping a diary is part of the manual and systematic gathering of information is more common in «specific/symptom focused» therapies than in «underlying focused» therapies.

Most informants seem to attribute the egalitarian aspects of therapy to the group-format and not to the manual. This may be due to the contrast between expected therapy and the experience of this therapy at large, or it may be due to the group feeling more egalitarian than an individual therapy.

As a whole, informants illustrate the pros and cons of «symptom focused» versus «underlying focused» therapies from the patients' point of view. Several informants feel that the symptom-focused treatment has had generalizing effects and that the “practical” part of this therapy has given them tools that they use when trying to resolve other issues in their life, somehow tapping

into an «underlying» mechanism through a «specific focus». Clues to what the informants' experience as such possible underlying therapeutic mechanisms may lay in the theme «getting better». Many informants hold that their relationship with emotions has changed and some feel that their overall content of emotionality has changed in the direction of more positive emotions. Informants feel a greater sense of mastery of their own lives and have better self-esteem. They feel less ashamed of themselves and respect themselves more. Informants' say they deal with challenges in their life in a different way than before and that they have a greater understanding of how their mind works and they feel more able to change their own behaviour if they so will. To what degree the tools learned in this treatment-program contributes to recovery from other co-morbid mental illnesses or better daily functioning would be an interesting empirical question to answer in further research.

Informants are keen to spread knowledge about TTM. Having experienced the liberating and empowering effects of normalisation and shame-reduction that came with knowledge and meeting others with TTM they wish to ensure more people struggling with pathological hair-pulling get this information too. Informants are generally very positive to the AEBT-T and want helpers and sufferers to know about it and make this treatment available to people struggling with TTM. Even the informants who have voiced the most criticism recommend the treatment as a step on the way of getting better, but first and foremost they wish for research to keep evolving and for evidence-based treatments to be available throughout the country. When it comes to critique of the arrangements, maybe the most important point to note is that the way information is handled is crucial. Informants want information both about why questions are asked, what the information will be used for and not least what the information means. Feedback is about getting help to make sense of the information that is gathered about them so that they may use this information themselves.

Many informants have had negative experiences with seeking help, only to be left without a

treatment alternative, misunderstood or even ridiculed or humiliated. It is a homogeneous wish from informants that helpers, doctors, nurses and therapists learn about what trichotillomania is and how to meet these patients respectfully and to provide them with the help they need.

Conclusions

This study has been explorative in that it broadly has tried to encompass the patients' constructed meanings and experiences of participating in AEBT-T in a group-format. Being semi-inductive the thematic analysis done on the interviews has been constructed in a dialectical manner between the interview-guides' themes, what the informants' answer and the understandings imposed from the author. The following four research-questions have loosely guided this work: (1) How do the participants' construct pathological hair-pulling? (2) How do the informants' construct this therapy? (3) How do the informants' experience participating in AEBT-T in a group-format? (4) What are the elements the informant's find helpful in this treatment and why are they experienced as helpful? These questions are all partially answered in the section above. At the end of the day, however, the most important concern in this work was to make the informants' perspective and some of their hard-won experiences available for those who wish to learn. Hopefully the patients perspective can enlighten further work in optimising treatment for TTM and the therapies conducted on the basis of it.

Critique of the Study and Further Research

Thematic analysis used in this work, is best suited to get an overview of themes in the data. This is done on the expense of the level of detail in the analysis. The discourses in themselves are not investigated and no single theme is studied exhaustively. Instead thematic analysis gives insight in to what main themes the author construct from what comes across as most salient in the interviews. In that, some information is lost and considered less important during the process of

analysis. The semi-inductive approach gives room for themes that were not prepared in advance to be studied and understood. It also makes sure that all informants' are asked the same questions, thereby getting different perspectives on the same matters. This is an attempt get the best out of both approaches. But using a semi-inductive approach rather than a purely inductive or deductive approach means missing out on some of the benefits as well. A purely deductive approach would have given more clarity in individual differences making it easier to compare informants' answers to each other. A purely inductive approach would have made it possible for informants' to elaborate more on what they found most important, with less lead from the author.

A qualitative methodology with a low N (=8) will not yield generalizable results, but may help us to understand a subject more fully. It may also be informative as a starting-point, generating new research questions to guide investigations that will generate generalizable results. As intended in NTP triangulation, using qualitative and quantitative data together might give a fuller understanding of a phenomena than either of them alone.

Further research may investigate the individuals' answers to the "Why"-questions (Why do they pull hair? Why did they develop pathological hair-pulling?). Many theories have been developed on the etiology of trichotillomania, but few studies have investigated the patients' perspective as to why they pull hair. The differences between the AEBT-T given in individual sessions or in a group-format should be further investigated. The informants in this study hold that the group is one of the most important aspects of the treatment. The role of social support and sharing in relation to trichotillomania at large and in relation to AEBT-T and recovery might be another. For example; Informants describe what may be therapeutic effects of "Relatives Night", an added element to the manual, as activating social support, reducing shame and making communication about trichotillomania easier. Informants in this study say that the diagnose they are given in combination with the type of- and length of treatment they are offered not only affects

their outlook for recovery, but also influence the way they see themselves. Possible placebo or nocebo effects of being offered different sorts of treatments and of being understood / diagnosed in different ways is an empirical question and an important one to answer for the field of clinical psychology. When it comes to conceptualizing theory, any therapist using a manual containing psycho-educational material would be interested in how the patients construct their own personal understanding of theory and how they internalise it. This being said, not many studies have explored this by giving the informants' the possibility to describe central aspects of the theory in their own words. In a time where clinical psychology witness an increase in manualised therapies (often including work-books or psycho-educational material), further work should be done on the patients' understanding and conceptualisation of theory and the way different understandings influence therapeutic processes.

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Appendices

Appendix 1

The semistructured interview-guide, translated to English

Interview-guide

Thank you for doing this interview. My name is Lene Paulsen Walderhaug and I am a student of psychology at NTNU. The backdrop for this investigation is that we wish to know how it is to be a patient at the therapy-study that you have been invited in to. One way of doing that is to interview the participants about their experience. This interview will be like a conversation where some subjects and questions will be given in advance, but where there will be lots of room for your personal experience. The interview will be recorded and then written down. It is nice if you talk as freely and detailed as possible. Your data will be anonymized. This means you will get a number attached to your interview. If you want we can send you a copy so that you can make corrections or additions. **You can withdraw your consent at any time, also during the interview and ask for your information to be deleted.** The interview will take between an hour and 90 minutes.

Your therapists will not get to know who said what. What you say has no consequences for the relationship between you and your therapists or between you and the other participants or for further treatment.

A written report will be made on the basis of this investigation and the interviews may be used in an academic assignment. You may be quoted on some of your statements in this assignment, but we will take measures so that it will not be possible to identify you. I will also ask you if you think it is OK to be contacted by me on a later occasion if I have any questions.

Before I start I will go through this statement of consent with you and ask you to sign it.

Have you got any questions? I will start the recorder now.

Open reflection

- On the whole, how has it been to participate in the project? Negative perspectives are just as valuable as positive ones.

HRT?

- Negatives?
- Positives?

ACT?

- Negatives?
- Positives?

Anything else?

- Negatives?

- Positives?

How do you think has it been to work with your problems in a group-setting?

Exploring social benefit/ social support

- Did you get to know the other participants in the project?
- have you had any contact afterwards?
- do you think the contact with the other participants have made a difference to how you master your hair-pulling?

Exploring quality of life and the experienced level of wellness today

- At large; How are you doing now?
- (How are you doing when it comes to hair-pulling these days?)

Values

- Have you got any values you find important in life?
 - Has this project changed the way you think about values?
 - Have you changed the way you live your life according to your values in any way?
- Since you started this project: Have you discovered new sides of yourself?

Emotions

- How would you describe your relationship with your emotions?

- have your feelings changed in any way after joining the project?

(in what ways?)

- Has your relationship with your feelings changed in any way after joining the project?

(in what ways?)

«Value for money» / «Usefulness»

- Do you find stuff you have learned in the treatment useful?

(what do you find useful?)

- Do you use things you have learned in in the treatment in your everyday life?

(what do you use?)

Theoretical understandings

- Imagine talking to someone with no concept of what ACT or HRT is. Could you please give a short explanation to what the following concepts are about?

- acceptance?

- commitment?

- alternative response?

- practice

- urge

Closure/ feedback

- Have you got any advice for patients considering getting treatment for trichotillomania?
- Have you got any advice for therapists working with treatments for TTM?

Closure/ formalities

We are getting close to the end of this interview, so I would like to ask you if you would like to add anything before we get to the end. Maybe you have some thoughts that have popped up along the way or important things we haven't talked about?

Is there anything else you would like to say?

No? I will turn of the tape-recorder then.

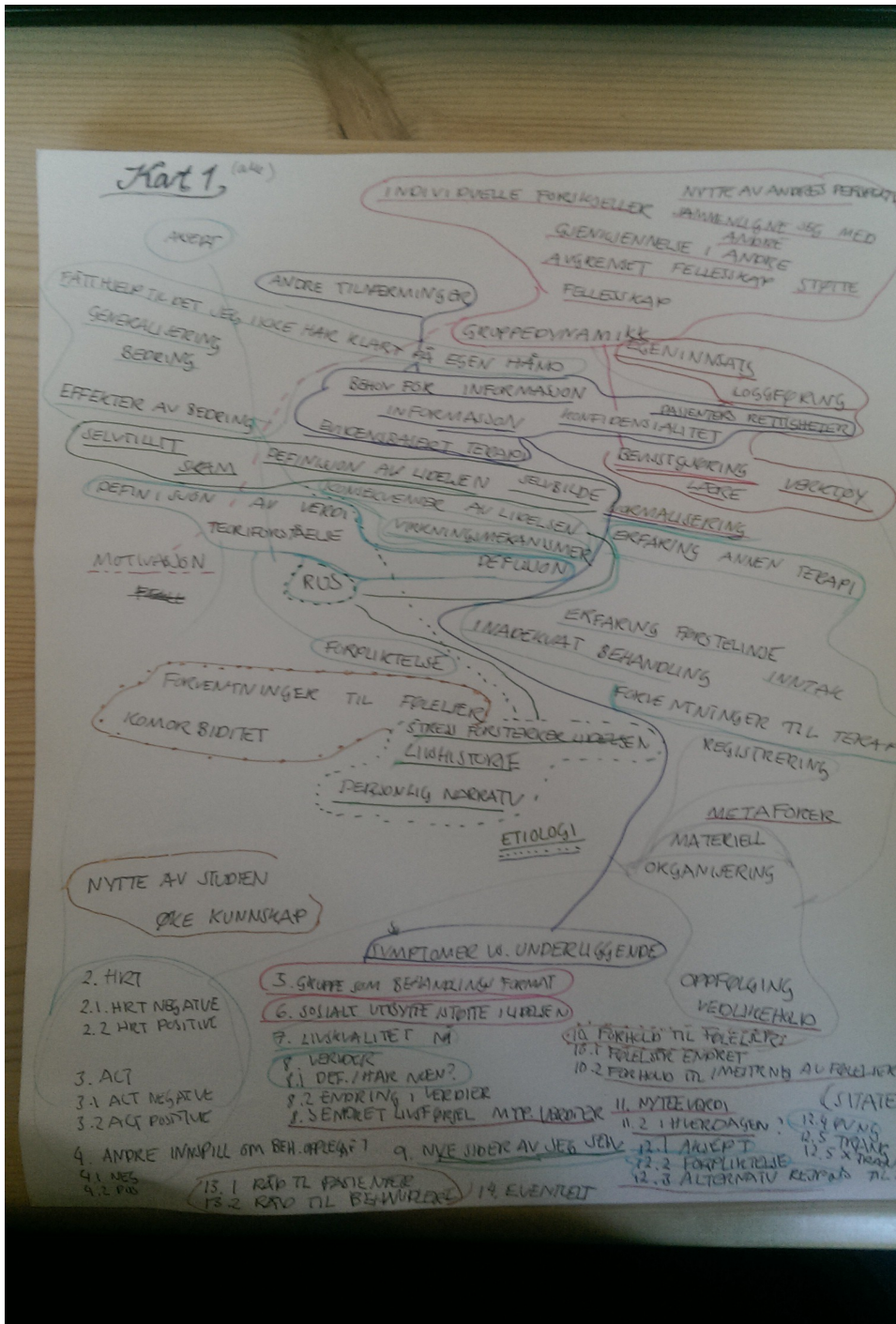
Have you got any other questions about this investigation?

If you have any questions about this study or wish to withdraw your consent you may contact me at lenewalderhaug@gmail.com. Do you think it is OK for me to contact you if something may be unclear at a later time? If so would you like me to call you or mail you?

Thank you so much for taking time to do this interview! You have been of great help!

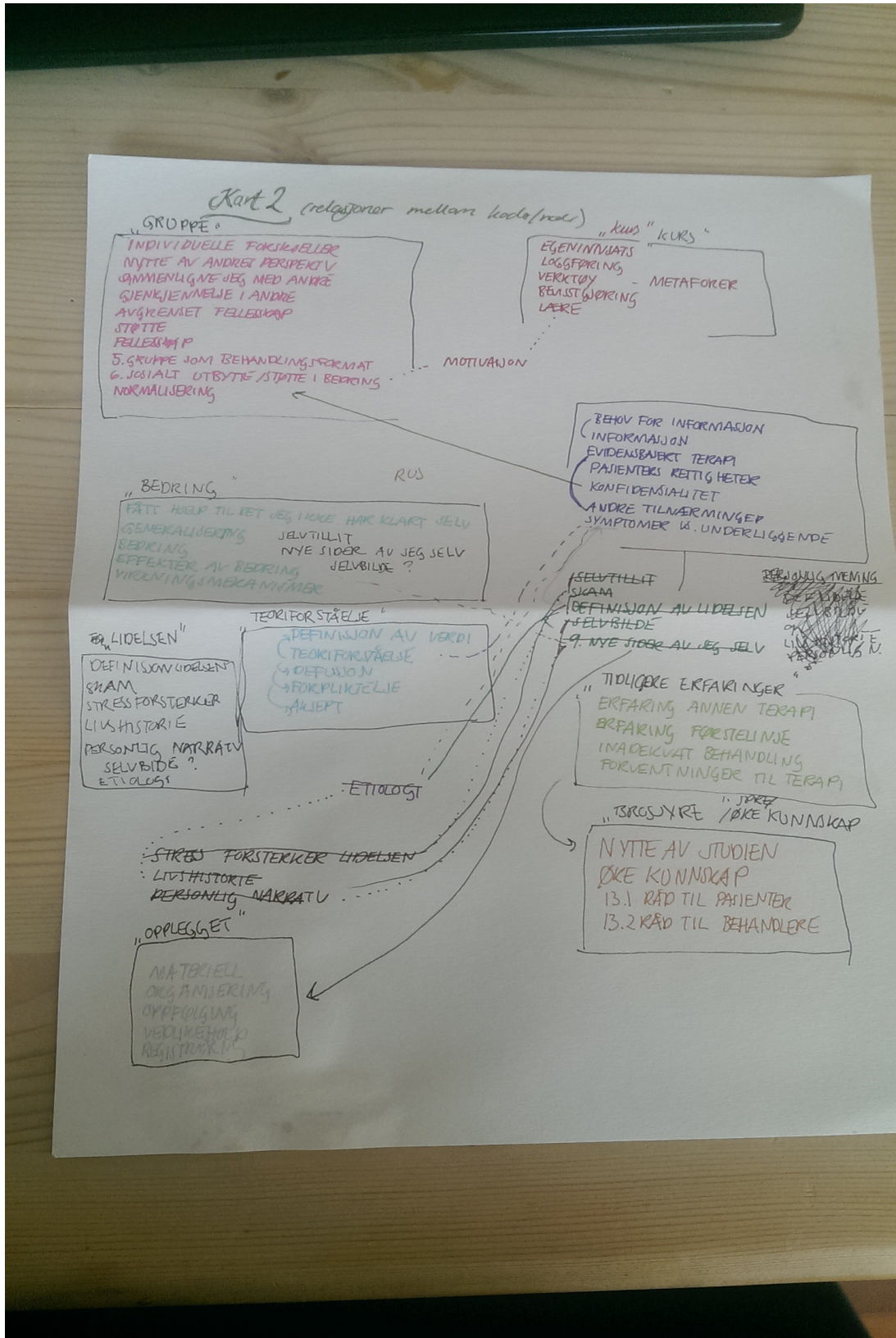
Appendix 2

Thematic map no 1 : Written notes from the stages of conceptualizing main themes in the material



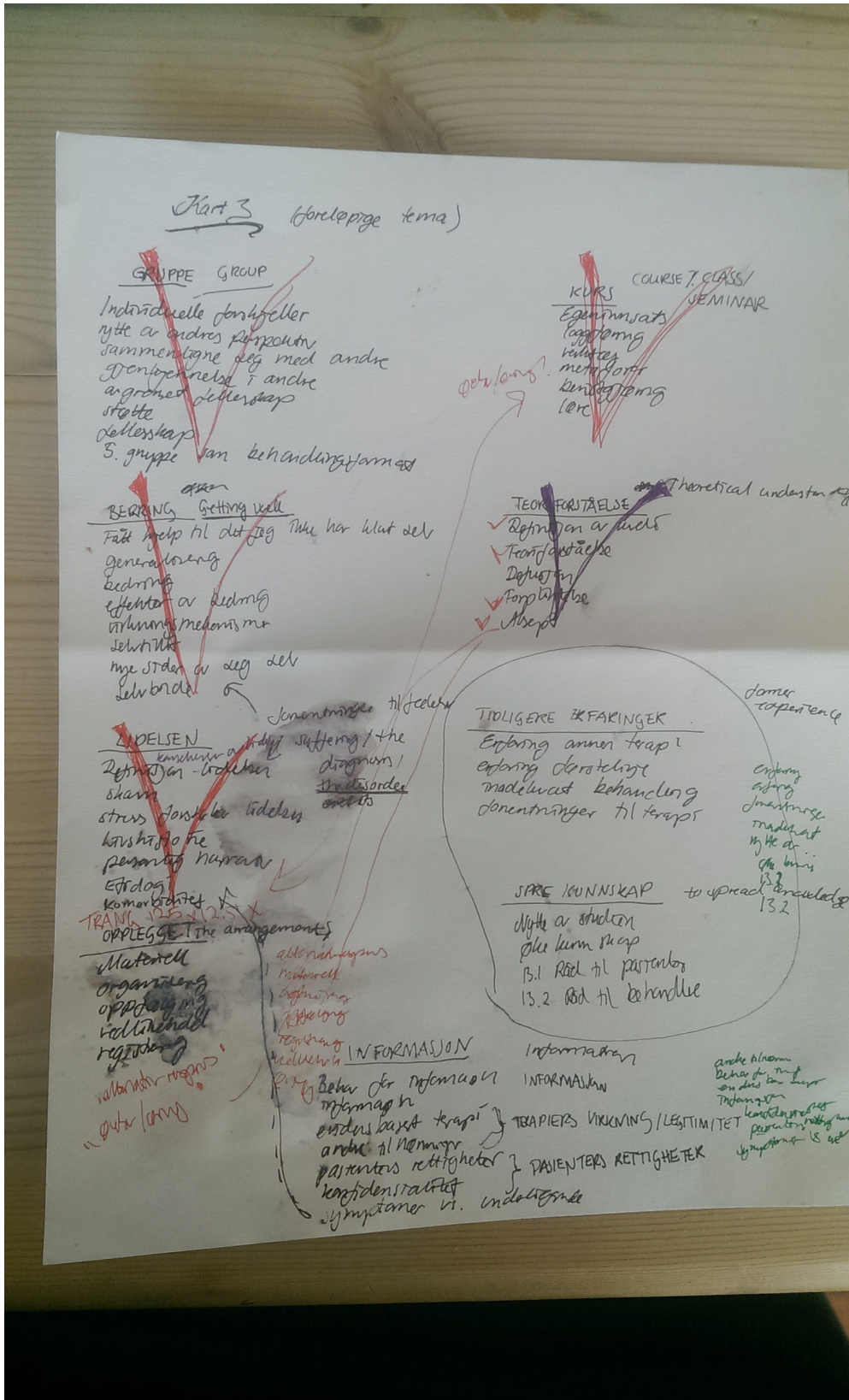
Appendix 3

Thematic map no 2



Appendix 4

Thematic map no 3



Appendix 5*Table 1 Broad themes and sub-themes*

Broad themes	Catchy heading	Sub themes
The Disorder	<p>«The inner itch»</p> <p>«A bubbling desire to do something I know I shouldn't»</p> <p>«Its not a compulsion, its a habit»</p>	<p>Informants have changed their view of TTM through AEBT-T</p> <p>What sort of label they are assigned for their problems is important for their self-image and self-esteem</p> <p>Informants describe «the urge» differently. They experience it through different modalities and in varying degree of conscious control/ automaticity.</p> <p>Arousal (too much or too little) is related to the urge emerging</p> <p>Informants differ in their view of TTM as a single standing disorder or as a consequence of an underlying problem. Several informants describe a synthetic view of these positions which supports dual target treatment.</p>
Seminar	<p>«You need to do the job yourself»</p> <p>«It's been useful and informative»</p>	<p>Informants speak of the treatment as a seminar and view the material as curriculum</p> <p>Informant expected something else than what they got from treatment</p> <p>Therapeutic result depends on effort (akin to a course/seminar), this gives opportunities but also responsibility</p> <p>The relationship to the therapists are different in a seminar vs in treatment</p> <p>(the relationship between group members are</p>

<p>Theoretical constructions /understandings</p>	<p>«To accept it as it is. It could be a lot of different things»</p> <p>«It was an 'aha-moment' to me»</p> <p>«I think I got it...»</p>	<p>different in a seminar vs a group treatment?)</p> <p>There is uniform agreement that «acceptance» is important</p> <p>The informants have different constructions of «acceptance»</p> <p>The informants have different constructions of «values»</p> <p>The informants have more uniform constructions of «acceptance» than of «values»</p> <p>The informants have different constructions of «commitment»</p> <p>The informants differ both in</p> <p>a) how easily they can articulate and define several theoretical constructs to the interviewer («semantic understanding») and in their description of</p> <p>b) how theoretical constructs work («procedural understanding»)</p> <p>as well as</p> <p>c) the distance of a) and b) from the therapeutic manual as understood by the author</p>
<p>Group</p>	<p>«Where the majority is abnormal, you're not abnormal anymore»</p> <p>«It didn't make much of a difference, but it was really nice»</p>	<p>Normalisation, reduction of shame and usefulness of others experiences are important effects of the group</p> <p>Social pressure to perform and attend</p> <p>Informants' don't think the others influence their recovery, but appreciate the social and emotional benefits of the group</p>

		<p>The relationship to the therapists are different in a group vs individual treatment</p> <p>Therapists as both invisible, warm, confronting and controlling</p>
<p>Getting better</p>	<p>«I deal with things in a better way now»</p> <p>«I'm stronger than I thought I was»</p>	<p>Informants' describe improvement in terms of inner change or outer secondary consequences, not in terms of quantities of hairs pulled or frequency of pulling-episodes</p> <p>Informants' still feel the urge. They now know how the urge works for them and what they can do with it.</p> <p>Informants' have learned tools they can use to change habits</p> <p>The ways informants' have changed their thinking and behaviour varies between individuals and in how they map on to the manual as the author sees it</p>
<p>Information</p>	<p>«You are supposed to learn from your patients»</p> <p>«We know more then them, you can see how little they know»</p>	<p>Informants' are wondering why they have had to give up so much information and what the information will be used for</p> <p>Informants' feel deprived of feedback</p> <p>Other peoples lack of knowledge have hurt them</p> <p>Different approaches to understanding and treating TTM have affected informants' in a negative way.</p> <p>Informants' call for evidence-based treatment and information about evidence for different treatments.</p>

		<p>Informants' wish to contribute to science and to spread information about TTM and the treatments available to laypeople, patients and health-workers.</p>
<p>The arrangements</p>	<p>«I'm sure they thought it through»</p> <p>«I put my trust in that there must be a reason»</p> <p>«Logistically it could be better»</p>	<p>«Relatives' Night» has been important for several respondents. Social support, and involvement kin/friends. Psycho-education from «experts» give the informants' credibility as sufferers of «something real».</p> <p>The pretreatment evaluation and questioning have been an adverse experience for many informants'.</p> <p>Practical issues have influenced treatment.</p> <p>The agenda and topics in treatment session are commented on. Most informants' are positive to the way this is organised, but all agree that it seems to be that way for a reason (albeit one they might not understand)</p>

Figures

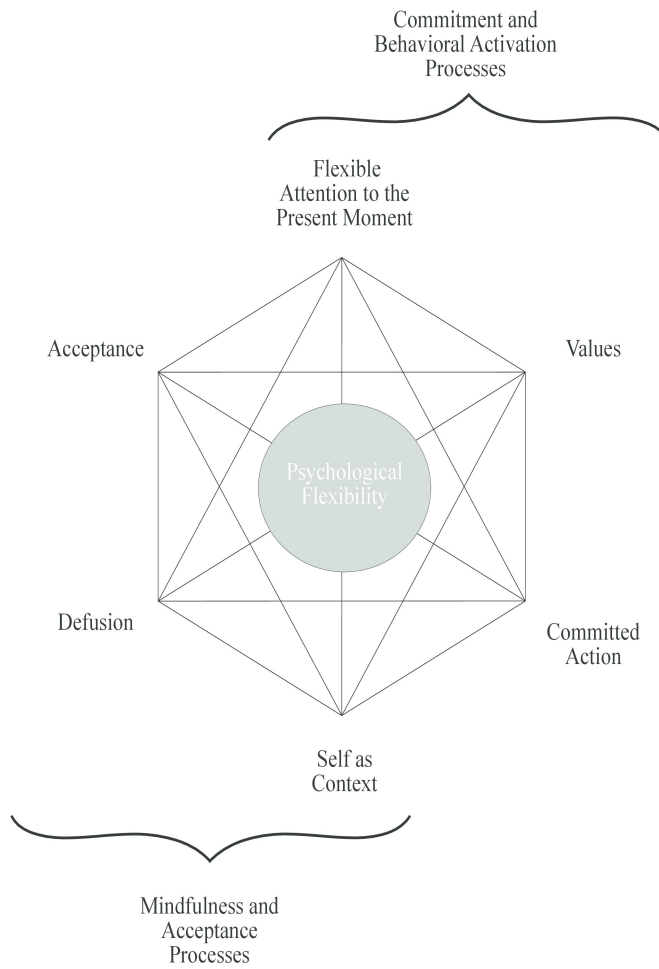


Figure 1: The hexaflex of flexibility (ACT) Copyright Steven C.

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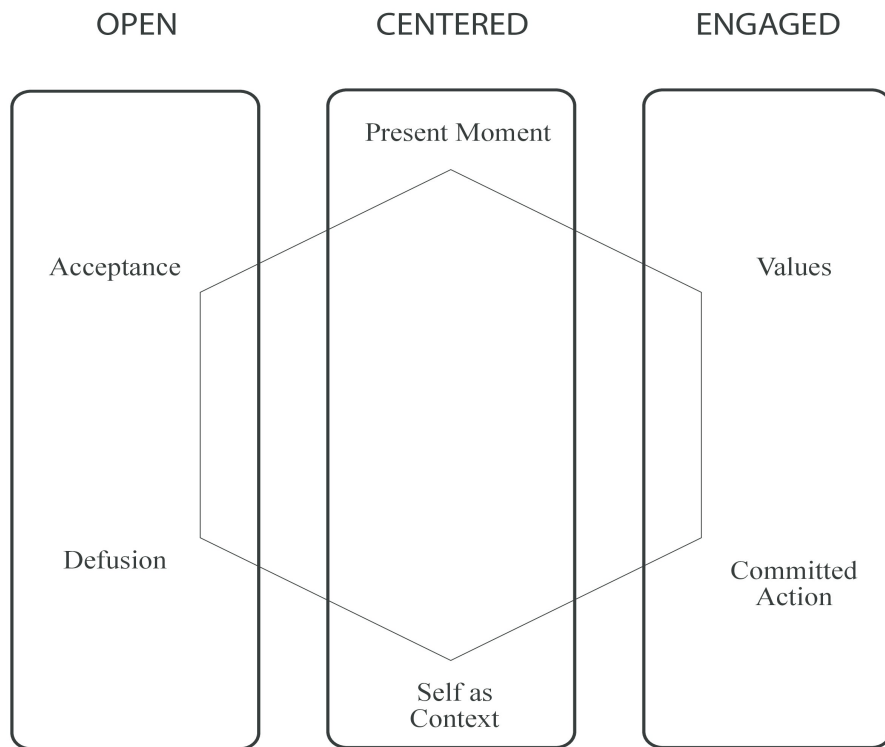


Figure 2: Response styles that make up psychological flexibility. Copyright Steven C. Hayes, printed with permission

