Ina Jahn • Linda Hollatz • Sonja von Rimscha
Hildegard Goletz • Christian Stierle • Stella Schmotz
Carola Hennig • Antonia Peters

Guidelines for the Treatment of Body-Focused Repetitive Behavior Disorders (BFRBDs)

Basic Information for Patients, Relatives, and Healthcare Professionals



Psychiatrie Verlag

Initiated and recommended by the German Society for Obsessive-Compulsive Disorders (e.V.)



Ina Jahn is a licensed clinical psychologist specializing in behavioral and systemic therapies. She serves as the psychological lead of the specialized outpatient clinic for obsessive-compulsive disorder at Helios Park-Klinikum in Leipzig. For many years, she has treated people with obsessive-compulsive disorder and related disorders, as well as their family members.



Linda Hollatz, Dr. phil., conducts research on body-focused repetitive behavior disorders as a psychologist, a hair expert, and someone with lived experience. In her dissertation, she examined hair-related disorders and hair care, focusing on experiences and intervention options.



Sonja von Rimscha, M.D., is a psychiatrist and psychotherapist who practices in Mainz. Specializing in behavioral therapy, she had extensive experience in the outpatient treatment of obsessive-compulsive disorder and related obsessive-compulsive spectrum disorders.



Hildegard Goletz, Dr. rer. medic., is a psychotherapist and has worked at the University Hospital of Cologne since 1999. Until 2020, she headed the specialized outpatient clinic for anxiety, obsessive-compulsive, and tic disorders at the Educational Institute for Child and Adolescent Psychotherapy at the University Hospital of Cologne (AKiP). She has since led the outpatient clinic for internalizing disorders. Her focus is on the diagnosis and treatment of anxiety and obsessive-compulsive disorders in children and adolescents.



Christian Stierle is a psychotherapist and behavioral therapy supervisor. He is a professor of clinical psychology at Fresenius University of Applied Sciences in Hamburg. Previously, he worked at the Schön Klinik Bad Bramstedt as a senior psychologist, where his responsibilities included treating obsessive-compulsive disorders. He serves as vice-chair of the Psychosomatic Dermatology Working Group.



Stella Schmotz, M.Sc. in Psychology, is pursuing a Ph.D. on body-focused repetitive behaviors and is in training to become a psychotherapist. She conducts research in neuropsychology and psychotherapy at the University Medical Center Hamburg-Eppendorf.



Carola Hennig, M.A. in Education, M.A. in Social Pedagogy, and child and adolescent psychotherapist, has been in private practice in Buchholz since 2009. Her professional focus is on integrative cognitive behavioral therapy, with an emphasis on treating body-focused, repetitive behavior disorders.



Antonia Peters, a former patient, has served as president of the German Society for Obsessive-Compulsive Disorders (German Society for Obsessive-Compulsive Disorders e.V.) since 2004. She heads the Trichotillomania Information Center, provides free telephone counseling, and has authored the guidebook *Trichotillomania*. In Hamburg, she leads an in-person support group and moderates online groups focused on OCDs and BFRBDs. In 2021, she founded the Working Group on BFRBDs. Contact: TrichoHH@t-online.de

Ina Jahn, Linda Hollatz, Sonja von Rimscha, Hildegard Goletz, Christian Stierle, Stella Schmotz, Carola Hennig, Antonia Peters

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Preface to the English-Language Version

The present English-language version of the treatment recommendations is a translation that follows the German original as closely as possible. The content, structure, and professional statements are therefore closely aligned with the German version.

As the original recommendations were developed within a German-speaking professional and healthcare context, certain terms, diagnostic references, care structures, legal frameworks, or country-specific aspects may not apply in the same way across all English-speaking countries. Readers are therefore asked to interpret the recommendations within their respective national, professional, and institutional contexts and to adapt them where appropriate.

We would like to express our sincere thanks to Aneela Idnani and Laureen Alger for their careful review of the English version and for their valuable linguistic refinements. Their support has contributed greatly to the readability and clarity of this translation.

Working Group on Body-Focused Repetitive Behavior Disorders (BFRBDs)

Germany, August 2026

Preface

With these treatment recommendations finally available, a long-held wish of mine has come true. When I started pulling my hair in 1970, it was simply considered a "bad habit" I should stop. Nearly three decades later, I learned that this behavior has a name: trichotillomania. With the help of outpatient behavioral therapy, I overcame this disorder.

Since then, I have been dedicated to supporting those affected by trichotillomania and their families. In the meantime, other BFRBDs have been added, such as skin picking (dermatillomania), nail biting (onychophagia), and lip and cheek biting (morsicatio). Over the years, through conversations with those affected and their families, I have repeatedly learned that it is not only difficult to find a suitable therapy form, but also that many therapists are largely unfamiliar with these behavioral disorders and therefore cannot offer therapy.

Through my volunteer work as chair of the German Society for Obsessive-Compulsive Disorders (German Society for Obsessive-Compulsive Disorders e.V.), I met many dedicated professionals. Their knowledge and experience were instrumental in developing these treatment recommendations. I would like to extend my special thanks to the Working Group on BFRBDs, from which the focus group was formed:

Dipl.-Psych. Dr. Hildegard Goletz, Köln,
Dipl.-Päd. Carola Hennig, Buchholz,
Dipl.-Psych. Linda Hollatz, Hamburg,
Dipl.-Psych. Ina Jahn, Leipzig,
M. Sc. Stella Schmotz, Hamburg/München,
Prof. Dr. Christian Stierle, Hamburg,
Dr. med. Sonja von Rimscha, Mainz.

We hope that these treatment recommendations will help foster understanding and encourage therapists to help patients find a way out of their behavioral disorders.

Antonia Peters, Chair of the Board, German Society for Obsessive-Compulsive Disorders (e.V.)

Hamburg, June 2025

Introduction

> *"Isolation and intense feelings of shame are among the possible consequences of this condition. This makes it all the more important to talk openly about it and raise awareness."*
>
> Tino, affected by BFRBDs

Body-Focused Repetitive Behavior Disorders (BFRBDs) occur in children, adolescents, and adults alike. BFRBDs include hair pulling, skin picking, as well as other behaviors such as cheek chewing, biting the lips or cuticles, and cracking the joints and knuckles. The quality of life of those affected is often significantly impaired. Without adequate treatment, BFRBDs tend to become chronic.

Fear of stigmatization, shame, long wait times for psychotherapy, and a lack of awareness about the importance of treatment can lead those affected to seek therapeutic help only at a late stage. Even specialist therapists often do not recognize BFRBDs until pronounced psychosocial and physical secondary problems are already present.

These treatment recommendations aim to provide an overview of the symptoms and diagnosis of BFRBDs, highlight challenges in differential diagnosis, and present key findings on the course, epidemiology, and etiology of these disorders. In addition, evidence-based interventions are presented, along with practical guidance on treatment. Behavioral therapy methods, including Habit Reversal Training (HRT), habit replacement, decoupling, and "insensu" decoupling, are described in detail.

Whether these recommendations are implemented as part of therapy or through self-management, the following applies: Everything has its time. Therapy takes time.

The Different Types of BFRBDs

The following body parts may be affected by body-focused repetitive behaviors: eyes, fingers, joints, hair, skin, mouth, nails, nose, and ears (Figure 1).

Figure 1: **Body-focused repetitive behaviors**

Repetitive behaviors

Hair on the head, facial hair, eyebrows, eyelashes, body hair
- Pulling out hair from the scalp
- Biting one's hair
- Eating the hair or the hair roots
- Cutting the hair or the ends of the hair with fingernails or scissors
- Rubbing the hair on the head, including to relieve itching
- Pulling out one's body hair (ex. face, arms, legs, pubic region)

Skin
- Picking at areas of the skin affected by acne
- Picking, squeezing, or scratching the skin
- Biting one's skin
- Chewing on the skin around the nails, chewing on skin strips, eating them

Specific areas

Eyes, ears, nose
- Rubbing or cleaning the eyes to remove eye discharge
- Cleaning the ears to remove earwax
- Picking the nose, compulsively digging in the nose, or eating nasal secretions

Mouth
- Grinding or clenching teeth, moving the lower jaw back and forth
- Biting the lips, tongue, cheeks, or oral mucosa
- Cleaning teeth with fingernails or toothpicks
- Licking the lips or teeth with the tongue

Fingers, joints
- Snapping fingers
- Joints cracking
- Rubbing or chewing on knuckles

Nails
- Chewing, biting, or eating nails
- Cutting or tearing nails
- Picking, nibbling, or rubbing nails

... and others

For skin-focused repetitive behavior disorders, the terms "dermatillomania", "skin picking", and "skin picking disorder" (SPD) have become established.

Next to "Hair Pulling Disorder" (HPS), the medical term "trichotillomania" (TTM), derived from Greek, is used.

We group nail-focused repetitive behavior disorders under the term "nail biting". The appendix lists the common medical terms.

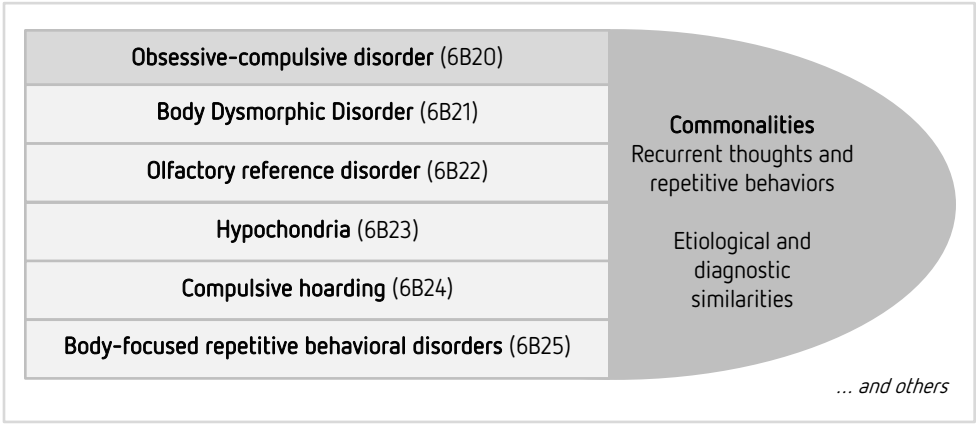
Diagnosis

> *"For a long time, I didn't know that this condition was called trichotillomania. I always knew that I was doing something strange, that I was different from everyone else. People who didn't know me often asked why I had so little hair, or why it was so thin, or even why I had bald spots."*
>
> Marie, affected by BFRBDs

Many people are familiar with behaviors such as occasionally biting their nails when stressed, picking at scabs, plucking out the first gray (beard) hairs, or rubbing mosquito bites. These body-focused behaviors can occur from time to time. However, they are considered a medical condition only when they become repetitive, and those affected are unable to stop them despite considerable effort, leading to significant distress.

In the ICD-11 (International Classification of Diseases, 11th Revision), BFRBDs are classified as a subcategory within the section "Obsessive-Compulsive Disorder and Related Disorders" (Figure 2). The essential commonalities are recurrent thoughts and repetitive behaviors.

Figure 2: **Obsessive-compulsive disorder and related disorders according to ICD-11**



Diagnostic Criteria

All BFRBDs share the following characteristics:

Recurrence: occur frequently or over extended periods (ranging from episodic to chronic).

Loss of control: Those affected feel powerless against the urge.

Physical consequences: Hair loss, skin lesions, scars, infections, etc., often cause additional problems.

Psychological distress and functional limitations: in social, occupational, or psychological domains.

BFRBDs often cannot be identified or diagnosed based on visible characteristics alone. They can be mistaken for physical or other medical conditions of the skin or hair, remain hidden under hair, or affect intimate body areas. For example, excessively cleaned eyes that appear red and inflamed can quickly be mistaken for an allergic reaction. Even in individuals with thick, long hair, areas of hair pulling may remain unnoticeable, as they may target a specific spot under the hair or pull or cut diffusely in various places without it being obvious.

The various forms of hair loss and the consequences of hair pulling are compared below:

Diffuse hair loss *(Alopecia diffusa)* often affects an entire area of hair, such as the scalp, pubic hair, or eyebrows. Its appearance resembles the result of widespread, diffuse hair pulling and differs significantly from repeated pulling at the same spot.

Alopecia areata is characterized by sharply defined, smooth, circular bald patches on the scalp with no visible hair growth or regrowth. However, if short stubble or fine hairs are still visible on a supposedly bald patch, emerging directly from the follicles, it is not alopecia areata. In this case, the condition is more likely to be diffuse or androgenetic hair loss or trichotillomania.

In *Alopecia totalis,* all the hair on the head is lost, and in *Alopecia universalis,* all body hair is lost. Here, too, the effects of trichotillomania can be distinguished because no new hair growth appears on the skin.

Follicular inflammation with scarring, known as *Folliculitis decalvans,* is marked by inflamed hair follicles that eventually scar, leaving permanent bald patches. On the

scalp, this condition can resemble a combination of skin-picking and trichotillomania, and may therefore be misdiagnosed.

Androgenetic, genetically determined, or hormonal hair loss *(Alopecia androgenetica)* manifests in characteristic patterns: enlargement of the frontal hairline (receding hairline), a circular area at the back of the head, and thinning of the hair on top of the head. This can be confused with the effects of trichotillomania, especially if it occurs in the same areas.

Some affected individuals are unable or unwilling to clearly answer whether they are experiencing hair loss or pulling out their hair. Since everyone loses a few hairs daily and more hair always falls out when pulling, the explanation of "hair loss" or "hair loss and trichotillomania" allows those affected to present their symptomatic behavior in a less dramatic light and to avoid feeling completely exposed. Often, others respond to hair loss with pity, compassion, and concern, whereas trichotillomania is usually met with incomprehension, helplessness, or even condemnation.

For an accurate diagnosis, a dermatological evaluation and the patient's self-report of symptoms and perceived distress should be available. Self-assessment questionnaires, diaries, and logs of BFRBDs, photographs, and key details of the patient's personal history are helpful in this regard.

When it comes to the appearance of skin conditions and the visual effects of skin picking, there are some similarities. While the latter result from picking at the skin, they are more socially accepted and widely recognized, for example, in connection with acne, pimples, scratched insect bites, and dandruff on the scalp.

BFRBDs in the oral cavity are visible upon examination of the mouth. The so-called pseudo-knuckle pads (Tylositis pararticularis), which result from chewing and pressing on the knuckles, closely resemble true knuckle pads. Chewed-down nails are clearly recognizable as a result of nail-biting.

Established questionnaires for the assessment and monitoring of BFRBDs

A wide range of validated questionnaires is available for clinical practice and research and can be used for both diagnosis and monitoring the course of BFRBDs. Established assessment tools that enable structured assessment of symptoms are listed in Figure 3.

Figure 3: **Questionnaires for identifying BFRBDs**

Trichotillomania Beliefs in Trichotillomania Scale (BiTS), Hair-Pulling Questionnaire (HPQ), Massachusetts General Hospital Hair-Pulling Scale (MGH-HPS), NIMH Trichotillomania Symptom Severity Scale (NIMH-TSS), Trichotillomania Diagnostic Interview (TDI)

Dermatillomania Diagnostic Interview for Skin Picking Problems (DISP), Milwaukee Inventory for the Dimensions of Adult Skin Picking (MIDAS), Skin Picking Impact Scale (SPIS), Skin Picking Scale-Revised (SPS-R))

Regardless of the specific type of body-focused repetitive behaviors Generic BFRB Scale-8 (GPS)

... and others

Prevalence

Overall, it is difficult to quantify the prevalence of BFRBDs because there remains a lack of robust, population-representative studies. On the one hand, it can be assumed that the majority of the population is familiar with body-focused repetitive behaviors in daily life; on the other hand, according to the ICD-11 criteria (WHO, 2019), only a comparatively small proportion meets the full diagnostic criteria. The most robust data currently available pertain to skin-picking disorder and hair pulling disorder.

It is estimated that between 1.4% and 5.4% of the general population suffers from skin picking disorder. The variation in these figures is primarily due to the use of different assessment tools and survey methods. Significantly higher prevalence rates, up to 22%, are observed among people with chronic physical skin conditions.

Trichotillomania is somewhat less common, with prevalence rates ranging from 0.5% to 2.5%.

It is even more difficult to provide concrete figures for the remaining BFRBDs. A 2022 study found a prevalence of nail-biting of about 15% among children and adolescents. Among college students, the proportion with some form of BFRB was 12%.

Other studies have found prevalence rates of up to 23% in non-clinical samples. However, because these data are based on self-reports rather than medical or psychological examinations, these figures should be interpreted with caution.

Overall, the data suggest that the prevalence of BFRBDs may be higher than previously assumed. There may also be a significant number of unreported cases, as many affected individuals do not seek treatment because of shame or a lack of therapeutic services.

Differential Diagnosis

> *"It is a colorful, dazzling whirlpool that is incredibly alluring, into which I can lose myself completely. The farther away you are from the whirlpool, the easier it is to free yourself, but once you've been swept into it, you have to fight your way back to the surface with all your strength."*
>
> Clara, affected by BFRBDs

It is often difficult to distinguish BFRBDs from other mental disorders, particularly body dysmorphic disorder (BDD), as well as from self-injurious behavior in general, which can occur across numerous mental disorders. However, a differential diagnosis that is as precise as possible is a key prerequisite for initiating appropriate therapeutic interventions.

"Classic" obsessive-compulsive disorders

BFRBDs and obsessive-compulsive disorders have in common that they lead to repetitive behaviors.

- BFRBDs primarily involve one's own body (and very rarely the bodies of others). Compared with classic obsessive-compulsive disorder, individuals with BFRBDs more often experience difficulties with impulse control, and their awareness of the symptomatic behavior is generally lower.
- Classic obsessive-compulsive disorders, on the other hand, typically involve themes such as control, completeness, and the avoidance of illness, danger, and risk. In these cases, the triggering situations, obsessive thoughts, and associated neutralizing behaviors are generally more pronounced.

Body Dysmorphic Disorder (BDD)

Both BFRBDs and Body Dysmorphic Disorder (BDD) are characterized by an initial lack of insight into the condition.

- In BFRBDs, this lack of insight stems from the automatic, self-soothing nature of these behaviors: they typically occur in everyday situations and during times of stress or strain, often without conscious awareness. For example, individuals might touch their lips with their index finger while thinking, unconsciously pick at a scab on a wound, twirl strands of hair around their fingers, or look for split ends.

- In BDD, the lack of insight manifests differently: rather than recognizing their behavior as a symptom of a disorder, individuals engage in skin-picking in response to intrusive negative thoughts about their body and an urgent need to improve their appearance or correct perceived flaws – for example, to make their skin clearer.

Nonsuicidal self-injury (NSSI)

The differences lie in both the underlying, often unconscious intention and the triggers of the behavior.

- Both a need for stimulation (arousal) and a need for self-soothing can lead to BFRBDs. For many affected individuals, these behaviors occur automatically and are barely, if at all, consciously perceived. Self-injurious behavior associated with BFRBDs manifests as frequent pressing, squeezing, picking, nibbling, biting, tearing, cutting or scratching. Unlike NSSI, the underlying intention is not to cause pain or to self-punish, but to regulate arousal or seek comfort.

- A variety of triggers, particularly internal ones, can be present in non-suicidal self-injury (NSSI). Most commonly, NSSI is used for emotional regulation in situations of extreme stress. In some cases, it serves to interrupt dissociation or prevent suicidal behavior. Self-punishment and interpersonal motivations, such as a desire for connection or care can also play a role, though these remain relatively rare. In such cases, the behavior is generally not performed automatically. NSSI often manifests as cutting or burning the skin.

Overall, establishing a differential diagnosis is a crucial step toward successful treatment. It allows BFRBDs to be diagnosed as distinct disorders rather than merely as symptoms of other conditions. This challenge requires close collaboration with specialized physicians or psychotherapists and the patient.

Comorbidities

BFRBDs can occur in isolation, but there are also clinical presentations that occur together, either simultaneously or as a consequence of one another. For example, trichotillomania and dermatillomania are frequently observed in the same individual.

Among individuals with BFRBDs, at least one additional psychiatric diagnosis emerges over the course of their lives in 78.8% of cases (so-called lifetime prevalence). Nearly 40% also had current psychiatric disorders during the study period. The most common lifetime diagnoses include depression, alcohol abuse or dependence, generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD). In addition, social anxiety, depressive symptoms, other anxiety disorders, specific phobias, and compulsive behaviors or thoughts are also common. ADHD, eating disorders, substance use disorders, and skin conditions such as acne can also be observed in connection with BFRBDs.

Many affected individuals report pronounced inner restlessness, which has multiple causes and can present in different clinical forms. Therefore, further evaluation is often advisable. Over the course of treatment, the intensity of comorbid conditions or of the BFRBDs themselves may change. Ideally, both areas improve; however, it is also possible for one aspect to worsen while the other improves. This can lead to what is known as a symptom shift (for example, a deterioration in mood when BFRB behaviors are discontinued). This phenomenon should be carefully addressed in therapy, integrated into the treatment plan, and, if necessary, treated with medication.

An overview of the most commonly reported comorbidities according to ICD-11:

Depressive disorders manifest as depressed mood, reduced drive, rapid fatigue and exhaustion, and a lack of joy and diminished interest in activities. These symptoms are often accompanied by sleep and appetite disturbances, negative rumination, difficulty concentrating, feelings of worthlessness and hopelessness, inappropriate guilt, and suicidal thoughts. Irritability and aggression may also occur. Overall, these symptoms must persist for at least two weeks.

Generalized anxiety disorder is marked by persistent worry about everyday situations or potential dangers that may affect family, work, school, or education. These fears are accompanied by inner restlessness and tension, physical symptoms such as heart palpitations or digestive problems, difficulty concentrating, nervousness, and sleep disturbances. These symptoms must persist on most days for several months.

Eating disorders manifest as severely restricted eating patterns that lead to weight loss and/or underweight (anorexia), recurrent binge eating accompanied by compensatory purging behaviors such as self-induced vomiting, misuse of laxatives or diuretics, or excessive exercise (bulimia), or persistent intake of food that exceeds one's needs, manifesting as binge eating, constant eating, or in particular eating in the evening or at night (binge eating disorder, night eating syndrome). This is accompanied by an excessive preoccupation with food and pronounced concerns regarding body shape or weight.

ADHD include typically attention deficits, easy distractibility, marked impulsivity, inner restlessness, and, in some cases, hyperactivity and a strong urge to move. These symptoms negatively affect academic or occupational performance or significantly impair social functioning. They must have been present for at least six months.

Post-traumatic stress disorder (PTSD) can develop after traumatic experiences, such as extreme threats or disasters. It is characterized by re-experiencing the trauma, avoiding related stimuli, and a persistent sense of threat. In addition, severe physical symptoms such as tension, restlessness, and difficulty relaxing may occur. The symptoms must have been present for several weeks and cause significant impairment in most areas of life and functioning.

A disorder caused by substance use (psychoactive substances and medications) or behavioral addictions is characterized by repeated use or specific behaviors, a strong craving for the substance, difficulty controlling use, the development of tolerance, physical withdrawal symptoms, and the neglect of other activities. Consumption or the behavior often continues despite already-occurring damage or negative consequences.

Studies in childhood and adolescence show that skin-picking behaviors are associated with anxiety, depressive symptoms, and symptoms of attention-deficit/hyperactivity disorder (ADHD) or social behavior disorders.

Case study

Case study Ms. L

Ms. L has regularly pulled out her hair since she was a child, mostly from her head but also from other parts of her body. This typically happens during quiet activities such as reading, studying, watching movies, or participating in video conferences. When she is with other people, she manages to suppress the urge, but often compensates for it in the evening, when she is alone and at rest. When Ms. L tries to stop pulling out her hair, she instead starts scratching her arms or picking at her cuticles.

She often doesn't realize she's pulling her hair out until she's been doing it for some time, but she is unable to interrupt or stop the behavior.

Ms. L suspected that the hair-pulling began around age 12; however, she cannot recall exactly when it started or any specific events, nor is she aware of any contributing factors. During psychotherapy, it emerged that Ms. L has also had ADHD since childhood, which had not been diagnosed and therefore not treated until now. Since childhood, she has experienced severe inner restlessness and a pronounced urge to move. The highly ritualized, body-focused repetitive behaviors (hair pulling, skin picking) have helped reduce her restlessness over the years. When Ms. L tried to stop pulling out her hair and picking at her skin and instead use alternative strategies, the restlessness became so intense that she was unable to perform the exercises discussed at all. Because Ms. L had always moved a lot and enjoyed it, she was unaware of how intense her restlessness was. Ms. L also noticed that she generally found it difficult to perceive, process, and tolerate her emotions – much of this was masked by the hair-pulling. Ms. L finds the trance-like states very pleasant. It is only after a while that she realizes she is pulling out her hair.

Treatment Approaches

Behavioral therapy and its methods are considered the gold standard treatment of choice for BFRBDs. The following section outlines therapeutic approaches and methods that have proven effective for treating BFRBDs.

Regardless of the method chosen, it is important to gain an overview: When and in what situations does the behavior occur?

Monitoring and documentation

Most people with BFRBDs do not exhibit their behaviors constantly, but rather in specific situations – for example, when under stress, while reading, when replying to emails, or at night under the covers. Often, certain times of day also see more frequent behavior.

It is best to carefully record your behavior during the first few days. You can also ask trusted individuals to let you know when you bite your nails, pull out your hair, pick at your skin, or engage in other related behaviors. Create a table for this purpose that looks like the one below (Figure 4).

Record the situations into the table, noting the location and time. Also, note which behavior occurred. Do not intervene in your behavior yet. Observe yourself as neutral as possible.

Figure 4: **Behavioral observation using skin picking as an example**

Day	Location / time	Activity / situation	Feeling	BFRB
Mon	Office / 9 a.m.	Checking emails	Worried	More frequent touching oft the skin
	Office / 5 p.m.	Phone call with L.	Annoyed, internally tense	Increased rubbing of specific skin
	Sofa / evening	Reading a book	Absent-minded	More intense picking
	…	…	…	…

Self-help techniques

Below, we will present four self-help techniques, one after another, that are used by those affected: Habit Reversal Training (HRT) as a self-help method (1), the decoupling method (2), the decoupling method in sensu (3), and the habit replacement method (4).

The following exercises provide practical instructions you can use immediately, which is why we address you directly here. The key steps of these self-help techniques are also summarized in video demonstrations produced by Steffen Moritz's group at the University Medical Center Hamburg-Eppendorf.

(1) Habit Reversal Training

Habit Reversal Training, developed in 1973 by Azrin and Nunn, is a behavioral therapy technique that helps individuals unlearn negative behaviors by learning counter-movements. It is commonly used to treat trichotillomania, skin picking, nail biting, and tic disorders.

The goal of Habit Reversal Training is to replace the old, automatic behavior with a rigid posture. The movement is, in effect, frozen. Below, we present a guide with examples you can easily apply to your own behavior: Through behavioral observation, you should have learned to be more attentive to the behavior you wish to break. If you notice that you are picking, squeezing, scratching, chewing, or tearing at your skin – or feel the urge to do so – stop immediately by adopting a rigid posture. The new behavior could, for example, involve clenching your hands into fists or folding them as if in prayer. For the technique to be effective, you should maintain the new behavior for one to three minutes. In some studies, positive effects were observed even with shorter durations. Of course, a different behavior might be more suitable for you. The important thing is that the rigid movement is as inconspicuous as possible and can be sustained for one to three minutes. The more often you use the alternative behavior instead of the old problematic behavior in the appropriate situations and during the appropriate activities – for example, while watching TV – the greater the chance of re-learning.

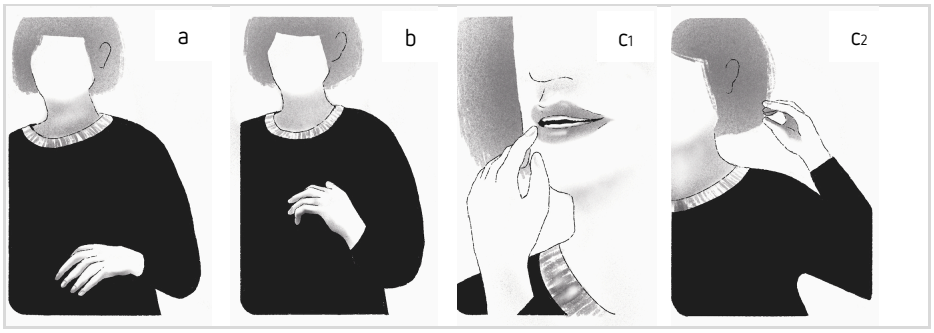
(2) The decoupling method

Decoupling has proven particularly effective in stopping nail-biting and hair-pulling. The decoupling method consists of two steps that gradually replace and unlearn the symptomatic behavior. The old symptomatic behavior is, so to speak, "overridden".

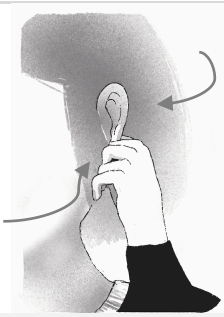
The decoupling approach works by mimicking and redirecting the movements you want to stop. The so-called "behavioral path" is altered so that it leads nowhere. Figure 5 shows some examples: When biting nails, the fingers move toward the face – as they do when biting nails – but they do not reach the mouth; instead, they are diverted toward the ear just before reaching it (see Figure 5, Alternative 1).

Figure 5: **Decoupling method**

Step 1 Imitate the old movement (a → b → c_1 bzw. c_2)



Step 2 Alternative variations/redirection* following the imitation oft he old



*** Option 1:**
Just before the movement reaches the teeth or hair, it is redirected to



*** Option 2:**
Just before reaching the teeth or hair, the hand jerks or is flung forward

This brings the fingernails into contact – not with the teeth, but in this case with the earlobe. This satisfies the urge or behavioral impulse directed toward the fingertips without causing injury. The new target movement should be performed with a certain amount of tension and acceleration. The goal is to make you aware of the old movement pattern – such as nail-biting – so it can be specifically redirected. An important aspect of decoupling is that the new behavior to be established bears a certain resemblance to the old behavior. This facilitates unlearning or redirecting the old behavior.

(3) The decoupling method – in sensu

Decoupling in sensu is a variant of decoupling. In sensu means "in the imagination", since, unlike in the second method, the first part of the exercises is not actually performed but is to take place only in the imagination. As soon as the symptomatic behavior – such as nail-biting or hair-pulling – is about to occur in the imagination, the second step involves switching to active execution: for example, the hand initially imagined should be clenched into a fist and quickly brought forward. At the end of the movement, the fingers should be spread apart (Figure 6).

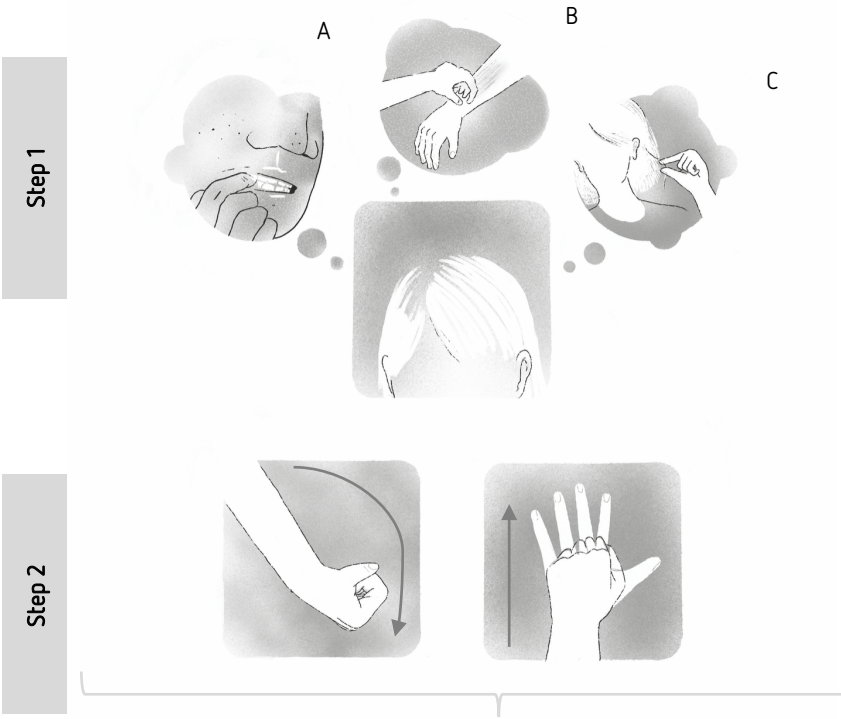
Because the procedure is similar to the decoupling technique described earlier, we will demonstrate it only for nail-biting. The technique can be adapted to other disorders.

If possible, go to the place where you frequently engage in this behavior, or put yourself in a situation that often triggers it, such as while watching TV. Rest your hands loosely on your thighs. In your mind, first move your fingers toward your face in the manner characteristic of your nail-biting behavior. Just before reaching the target, forcefully and, above all, physically snap your previously imagined hand forward with a clenched fist, then spread your fingers at the end of the movement. This accelerated movement is intended to disrupt the old pattern and ultimately override it. After completing the jerky target movement, return your hands to the starting position. Try different variations. Always perform the jerky movement as consistently as possible, since the old behavioral pattern is most likely to be broken when strong alternative patterns take its place.

Figure 6: **Decoupling method – in sensu**

Execution

At the exact moment when contact is **about to** occur in your imagination **(Step 1),** the arm that performed this action in your imagination should be thrust forward in reality with a clenched fist, and the fingers should be spread wide at the end of the movement **(Step 2**)



Regardless of the type of behavior (see, for example A, B, C)

- Step 1 is performed exclusively **in the mind**
- Step 2 is **actively** carried out (behavior)

(4) Habit replacement method

The habit replacement method involves substituting one habit for another. Unlike the Habit Reversal Technique, it does not require adopting a rigid, opposite posture but instead uses alternative movements. Circular movements, for example, can be performed very easily. Trace a circle with the tip of your thumb around the tip of your index finger, or use the tips of several fingers to trace a circle on your other forearm. Try out which movement suits you best. If you tend to scan for "blemished areas of skin" while picking and later pick at them, it may be helpful to perform the circular movements on your clothing or on parts of the body where you typically do not pick, such as the crook of your arm. To keep the movement inconspicuous, trace only a small arc each time. Alternatively, you can lightly tap your skin with your fingers. The movement itself, especially when performed quickly, helps release tension – an important, possibly even unavoidable, and useful physical response to strong emotions. Unlike with most FBRBDs, the new movement should be performed in a way that resembles a gentle caress.

As soon as you become aware of your behavior – for example, when picking – notice a triggering emotion or strong tension, you apply the habit replacement procedure.

- Make small, circular movements, for example, by moving your fingers along your trousers or sleeve, or by placing the fingertip of one hand on the opposite forearm. You can also choose other, preferably simple, movement patterns, such as tracing a figure eight. Alternatively, you can gently tap with your fingers. If you wear one or more rings, you can incorporate them as well.

- The movement should be gentle and light so as not to cause damage or strain to the skin or nail. Perform the movement as quickly as needed, but without touching the area with your nail or applying pressure to the corresponding body part. Try to associate the new movement with a positive feeling and to enjoy this gentle movement slightly.

- Also, in everyday life, try to avoid abrupt, painful, or high-pressure touches to your body – whether with your hands, feet, or tongue. You will not always succeed. Be gentle with yourself. View these exercises as a process that not only reduces BFRBDs but also fosters greater self-care and mindfulness.

General guidance on applying the self-help techniques

It is best to start with the technique that most naturally appeals to you. In one study, the greatest success came when people began with the decoupling method. You can use the techniques individually or in combination. See what works best for you. Because BFRBDs often involve behavior patterns ingrained for many years, it is necessary to practice the new behavior very deliberately, several times a day, and in typical situations. The new behavioral sequence should be performed five times in a row, for at least three minutes each time. It is best to set a timer on your smartphone for this.

Do not let yourself get discouraged if you experience relapses or if the exercises do not work right away. View these situations as learning opportunities, because we are often unaware of exactly what our fingers, tongue, etc., are doing when we are nervous or bored.

In illustrating the techniques, we have mainly focused on hair pulling and nail biting. However, with a bit of imagination, these techniques can easily be applied to other unwanted behaviors.

In addition to the movements described here as part of habit replacement, do something good for your body more often. Treat yourself to a massage, take a bath, then apply lotion to your body deliberately and with care. You should not touch scars or raised areas of skin. If the urge is too strong, circle the area without applying pressure.

Please keep the following in mind as a final note:

With these techniques, one behavior is replaced by another. However, the crucial difference is that the new behavior does not cause secondary damage, such as injured skin, pulled-out hair, or bitten nails and cuticles. Nail biting is not an option, even if a nail happens to be torn; instead, use a nail file. Pimples, for example, should not simply be picked off, nor should uneven areas of skin be removed. Likewise, gray or split hairs must not be pulled out. We recommend always carrying a small amount of hand cream and/or a nail file – especially if you tend to pick at your skin or bite your nails.

Occasional slip-ups can happen. The initial goal is to reduce the behavior. A great deal is already gained if the behavior occurs less frequently. However, you should by no means allow yourself "slip-ups" from the outset, such as keeping pieces of nail, hair, or bits of skin. Keep practicing, even if you have already significantly reduced the behavior. Ideally, practice at fixed times and/or whenever the urge arises. The new behavior should, so to speak, become second nature to you. New

behavior takes time to become established. The effect is most likely to occur if you apply the method consistently on a daily basis.

Mindfulness-based and compassion-based strategies

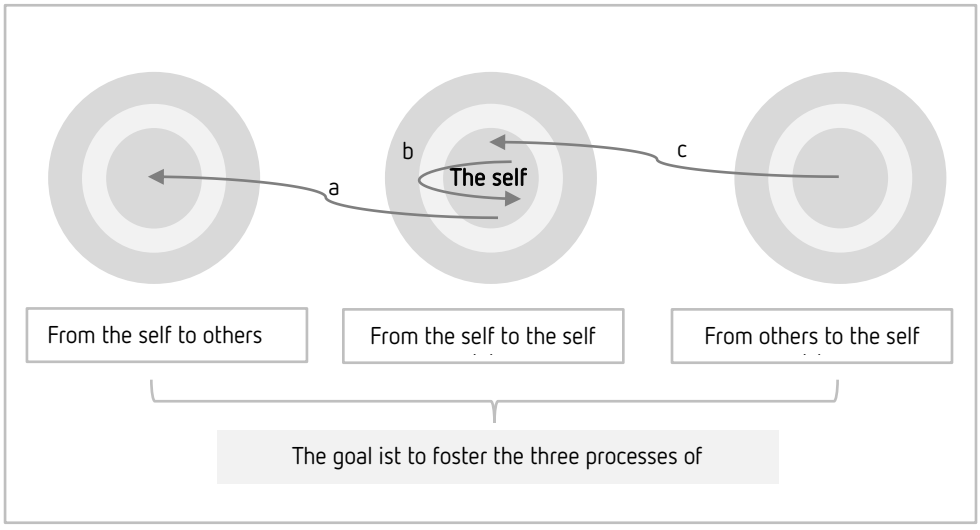
BFRBDs are often accompanied by intense shame and devaluating self-criticism. In such cases, it is advisable to incorporate additional treatment components to complement cognitive behavioral therapy.

In treating shame and self-criticism, compassion-focused approaches are considered particularly promising. Compassion-Focused Therapy (CFT) is especially important here; it is a comprehensive therapeutic model and a third-wave behavioral therapy. The goal is to reduce devaluing, harmful self-criticism, and to promote compassion for oneself and others (Figure 7).

Compassion is sensitivity to one's own suffering and that of others, as well as the motivation to alleviate and prevent it. It is expressed through three processes: from the self to others, from others to the self, and from the self to the self.

"Self-compassion" is defined as the ability to treat oneself with kindness and understanding during moments of suffering or perceived inadequacy, to feel connected to others through a sense of "common humanity", and to be mindful of oneself and one's thoughts.

Figure 7: **Processes of compassion**



This therapeutic approach is grounded in an evolutionary psychological, biopsychosocial understanding of mental disorders. Central to this approach is fostering compassion through psychoeducation about the genetic, biological, psychological, and social influences on the human psyche, as well as the role of psychological stress in mental disorders. This is an important prerequisite for developing the motivation and intention to treat oneself and others with compassion. Often, this is initially unfamiliar to those affected and feels strange. Within the framework of psychoeducation, patients' emotional experiences are classified using the so-called "3-Circle Model" (Figure 8a). This affect-regulation model posits that humans possess three primary affective systems:

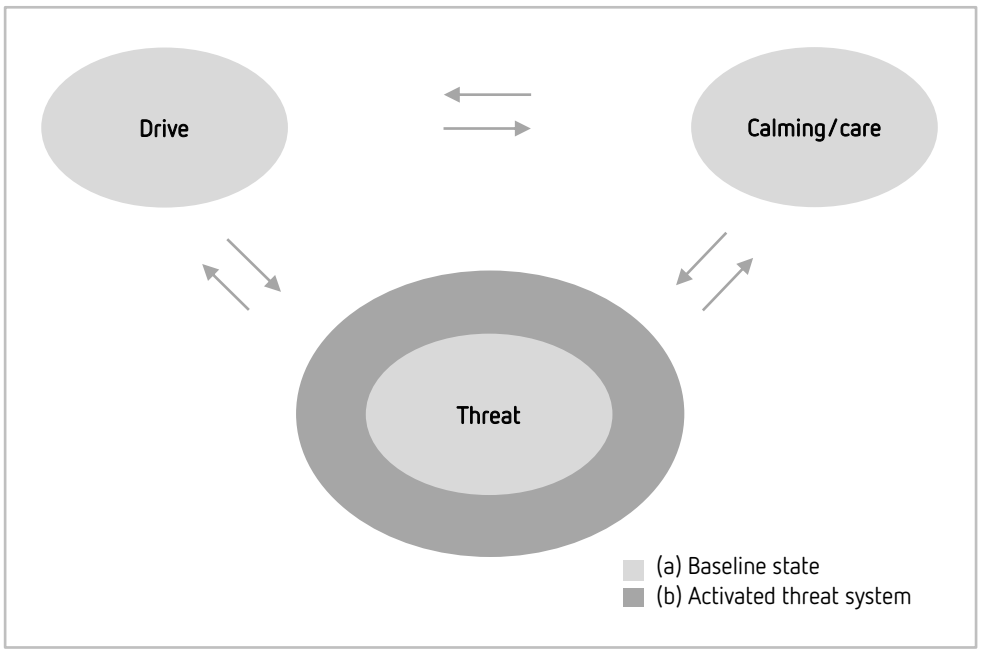
Threat system: Activated by fear, stress, and danger (e.g., triggers for BFRBDs),

Drive system: Driven by reward and goal achievement,

Calming system: Responsible for safety, attachment, and overall well-being.

These three systems are often out of balance in mental illnesses and are frequently characterized by an overactive threat system in obsessive-compulsive disorder (Figure 8b).

Figure 8: **The 3-circle model**



The goal of CFT is to strengthen the calming system to counterbalance the overactive threat system. This is achieved by cultivating compassion for oneself and others.

Key interventions in CFT include targeted breathing techniques to calm the nervous system (Soothing Rhythm Breathing), imagery exercises (such as "Compassionate Companion"), writing compassionate letters, and working with different aspects of the self (for example, debating the inner critic within the framework of chair constellations). In addition, interventions from the field of "metta meditations" (such as Loving-Kindness Meditation) and other mindfulness-based approaches can be integrated. Other compassion-based interventions can be found in various therapeutic approaches, such as Mindful Self-Compassion and Mindfulness-Based Compassionate Living, as well as in recent developments in dialectical behavior therapy (DBT).

Medication

Currently, no medications are specifically approved for BFRBDs. Some older studies report responses to established medications, including SSRIs (selective serotonin reuptake inhibitors), other antidepressants (e.g., clomipramine, mirtazapine), N-acetylcysteine (NAC), and neuroleptics (e.g., olanzapine, aripiprazole, risperidone). However, these findings do not yet support treatment recommendations. In clinical practice, the decision to prescribe medication is also influenced by comorbid disorders such as obsessive-compulsive disorder, depression, or anxiety disorders. Although SSRIs and clomipramine are often first-line treatments, they show only mild to moderate effects in controlled studies – particularly when administered alone without accompanying psychotherapeutic interventions. Overall, there are too few studies to demonstrate a clear advantage of individual substances.

Although NAC has shown success in treating BFRBDs in adults, with a slight advantage for trichotillomania, there are still too few studies and case reports to make systematic recommendations. Its efficacy in children and adolescents has not yet been demonstrated.

Other substances already used in neurology, such as antagonists at glutamatergic NMDA receptors (e.g., memantine), antiepileptic drugs (e.g., topiramate), and naloxone (an opioid receptor antagonist), have also been investigated, as have substances such as tetrahydrocannabinol; however, no treatment recommendations have yet been derived from the study results due to low evidence or lack of response. Sedative substances such as benzodiazepines should not be used to treat BFRBDs. Whether medication is indicated should be discussed on an

individual basis with the treating physician, particularly if comorbidities are present (see above). Before starting medication, the potential side effects and contraindications should be carefully weighed against the expected benefits. It is recommended to integrate medication into psychotherapy, even if this still involves waiting times. There are few studies demonstrating that medication alone is sufficiently effective, and further research is needed on the duration and dosage of medication-only treatment. Currently, medication alone is inferior to psychotherapy, particularly behavioral therapy with HRT elements.

Treatment of Children, Adolescents, and Their Educational Environment

Hair pulling is sometimes observed in early childhood. Although it is not classified as a behavioral disorder, it should be addressed here for completeness.

Early childhood hair pulling

In most cases, hair pulling in toddlers lasts only a few months before subsiding. However, if parents notice hair loss in their toddler, it is advisable to consult a pediatrician or dermatologist to rule out other conditions, such as alopecia areata, fungal infections, or thyroid disorders.

Hair pulling in toddlers may be part of normal body exploration and self-discovery: touching, stroking, twirling, and pulling their own hair as well as their caregivers' hair. It is believed that toddlers who pull out their hair may need additional physical stimulation. They use hair pulling as a self-soothing behavior. Some infants or toddlers pull out their own hair while sleeping.

Children and adolescents

Children and adolescents suffer greatly from the symptoms of their condition and experience an overwhelming sense of shame. In our clinical consultations, we often hear statements such as "I don't dare talk to others about it, not even my parents." The following case study illustrates which aspects of treatment require special attention for children and adolescents.

Case study

Case study Emil

Emil lives in an apartment with his mother, father, and 4-year-old sister. His parents report that they have observed Emil twisting individual strands of hair, always pulling them out using the same technique, and sometimes putting them in his mouth. Emil himself says that he "likes to lick the hair and shape it into a point", but that he does not eat it. The parents further state that the hair-pulling is particularly pronounced during periods of high stress. Emil confirms that he pulls out his hair, especially when he is tense, but he also likes to twist and pull it when he is relaxed. He is not teased for it. He enjoys pulling his hair, except for the occasional mild, and sometimes more severe, headaches that accompany it.

The parents also report that Emil has outbursts of anger, some of which are severe. These occur when Emil does not get his way and/or feels he is being treated unfairly, for example, by his sister. The tantrums manifest as screaming and "kicking out." The parents report that they have tried to provide Emil with clear structures to help him better adapt to demands such as brushing his teeth. They also try to explain these demands to him clearly, for example, why he has to go to school even if he would rather stay at home.

The parents also state that Emil has always exhibited a certain rigidity regarding specific routines. For example, at one point, he would tie his shoelaces in a specific way. This rigidity manifested intermittently in relation to certain routines.

Twisting and pulling his hair reportedly began during a visit to the babysitter at age 2. Emil had massive problems staying with the childminder; he would already start crying heavily on the way there and not want to be separated from his parents. The babysitter was a kind but stern woman. This stood in stark contrast to his parents' upbringing. Previously, he had rarely been separated from his parents. The grandparents had sometimes looked after Emil, but he was also very comfortable with them. At the daycare provider's, he had trouble falling asleep and began pulling out his hair intensely. The separation issues gradually subsided in Emil. After initial separation difficulties, Emil enjoys going to kindergarten, and school attendance is also going well.

Emil has also been exhibiting these outbursts of anger for a very long time. As with the hair pulling, these outbursts vary in intensity over time. The parents assume that the outbursts of anger also occur primarily during periods of high stress. During the conversation, Emil appeared to be developing appropriately for his age and was quite capable. At the beginning of the therapeutic session, he was reserved, but after a short time, he became more engaged. Emil made an effort to answer questions and work on therapy tasks. If he did not like a task, he would wander around the room and immerse himself in a book or a toy. His mood was mostly cheerful, but at times it was clearly tense. When Emil moved around the room, distinct bald patches in his hair were visible. There was no indication of danger to himself or others. Nor were there any other psychopathological abnormalities.

Interventions for children

Child-centered interventions

Child-centered interventions involve establishing an age-appropriate, positive relationship between the child or adolescent and the therapist. This fosters a transparent, safe therapeutic environment, including through the joint development of therapeutic goals. Another component is psychoeducation on trichotillomania and self-regulation disorders.

Children and adolescents are guided to observe their own behavior in an age-appropriate manner:

- When do I pull out my hair?
- What happened before?
- What happens afterward?
- In which situations does pulling my hair help me?

As part of Habit Reversal Training, self-awareness is improved through self-observation, and alternative behaviors are practiced to counteract the problem behavior, for example, by using tactile stimuli such as cold or heat. In addition, children and adolescents receive guidance on conscious relaxation, which they can practice and apply independently in daily life with their parents' support.

To reduce tantrums, the initial focus is on the perception and expression of feelings, followed by addressing the regulation of emotions such as anger and frustration. For this purpose, thematically appropriate children's books are used. The children learn to recognize emotions using pictures, to name them correctly, and to match them to the needs of the book's characters. In addition, an anger thermometer is created, and methods such as the "Anger and Cool Glasses" – a technique in which the child learns to view frustrating situations through two different lenses, one representing the immediate angry perspective and one representing a calmer, more rational viewpoint – are used. Building on this, so-called "anger-killer thoughts" are developed together, and role-plays are conducted, with a particular focus on situations in which the child cannot get their way or feels treated unfairly. The goal is to strengthen tolerance for others' wishes.

Finally, a joint reflection on the therapy occurs. The key insights are summarized, and an emergency plan or an emergency kit for potential relapses is created.

Parent-centered interventions

Parents can provide their child with positive stimulation through various behaviors, which they can use individually or in combination, including

- Stroking the child, especially on the head
- Brushing the child's hair several times a day with a soft baby brush or gently running the brush over other parts of the body
- Massaging the child's back
- At times when the child is pulling out their hair, the child should be distracted, e. g.
  - giving them a bath and playing with soap bubbles or rubber animals while touching the child with them. This redirects their attention to other parts of the body.
  - give the child toys or objects with textures similar to hair, such as feathers, tassels, or a satin cloth, when they need to calm down, for example, before falling asleep.

In daily interactions, it can be helpful to implement the following recommendations, among others:

- Children learn through various mechanisms. Modeling is a central learning mechanism. It involves children learning through observation and imitation. They observe the behavior of models and role models and uncritically adopt what is demonstrated to them. For parents, this means observing their own behavior and questioning how they handle tension and stressful situations. For example, how do they regulate themselves as parents when they feel angry, anxious, or depressed? As parents, you can serve as role models for your child and show them how to behave appropriately in stressful situations. This also includes talking to your child about feelings.
- Learning from success means that children repeat behaviors when they receive positive feedback. If a child experiences a pleasant consequence, such as praise, affection, or joy, they view it as a reward. The learning effect for the child: "If I behave this way, something nice will happen again." In this way, the behavior is reinforced and, over time, solidified.
- Parents can consider how they, as parents or caregivers, solve problems and convey this to the child. Together, parents and children can discuss what should be changed and how.

- Guide and support children in structuring their daily lives and reducing stress, for example, by incorporating relaxation exercises and guided imagery.
- Blame or punishment should be avoided. It is not uncommon for parents to feel that the child is exhibiting behavior to "annoy" them. Parents should be aware that the younger the child is, the less likely this is to be the case, because children are not yet capable of such nuanced thinking.
- Good sleep routines, avoiding sensory overload (e.g., from media), healthy nutrition, and exercise also help.

A good relationship with the child is an important prerequisite for successfully changing inappropriate behavior. In doing so, the following points should also be considered:

- It is important that you consciously set aside time for your child. This should provide space for social and emotional connection – such as through cuddling, listening, and loving care – and create opportunities for the child to be active in a stimulating learning environment.
- Encouragement and positive attention strengthen children's motivation. It is particularly effective to offer specific praise, listen attentively to the child, and converse with them in a child-appropriate manner. In doing so, it is important to respond empathetically to the child's individual needs and signals.
- Challenging behavior in children should be met with clear, consistent responses. This requires firm rules for interacting with one another (including how to address problem behavior), as well as self-discipline and reliability on the part of parents.
- Many parenting challenges stem from unrealistic expectations. Parents want their child to be well-adjusted, successful, and "low-maintenance." But children develop at their own pace, with unique strengths and weaknesses. It helps to accept the child as they are and set realistic goals together.
- Parents can better respond to their child's needs if they do not lose sight of their own needs. The desire for rest and for time together as a couple or alone is completely natural and important, in order to muster the strength, patience, and emotional presence for the child in the long term. Those who take good care of themselves lay the foundation for a stable and loving relationship with their child.

Parent-centered interventions: The case of Emil

- Building a relationship between the therapist and the parents by providing a safe space for conversation
- Psychoeducation on TTM and the challenges of self-regulation
- Addressing the potential influence of the parents on Emil's internal tension by reflecting on their parenting practices to date, including: What can Emil already decide for himself? In which situations does he still need guidance and boundaries from his parents? Support for more effective emotion regulation, for example, by providing a calm space that is as free of stimuli as possible and by guiding and reminding him to use breathing and relaxation exercises.
- Practicing clear yet loving communication about boundaries and expectations through "role-playing", establishing consistent behavior that Emil can understand, while simultaneously and appropriately demanding flexibility to soften Emil's rigidity
- Guiding parents on how to handle Emil's anger outbursts

School-based interventions

The goal of school-based interventions is to change the conditions at school that contribute to the development and persistence of a child's or adolescent's difficulties (e.g., appropriate ways of dealing with stressful situations, such as high academic demands, exam periods, and conflicts with classmates). Teachers may be involved only with the consent of the child or adolescent and the parents.

- Providing access to a safe space for conversation.
- Psychoeducation on trichotillomania, with a particular focus on internal tension and the lack of more effective self-regulation strategies.
- If necessary, providing guidance to classroom teachers on how to address the child's lack of self-regulation (supporting the child in applying self-regulation strategies (squeezing a stress ball; practicing mindfulness exercises, such as the 5-4-3-2-1 exercise (sequentially identifying five things, then four, then three, then two, and finally one thing that can be seen, heard, felt, smelled, or tasted)), and possibly, especially with children, the use of reinforcement schedules).
- If a child or adolescent is humiliated, verbally abused, insulted, or excluded by classmates because of bald spots, appropriate measures to address the issue should be implemented in collaboration with the child or adolescent, the parents, the teaching staff, and the school social worker.

School-centered interventions: The case of Emil

Emil seemed very well-adjusted in the school setting. In a conversation with his homeroom teacher, she noted that she had not observed any inner tension or hair pulling in Emil at school. However, she occasionally noticed bald spots in Emil's hair. The teacher asked Emil to let her know when he "feels very tense" so she could support him in using appropriate regulation strategies. However, it was important to Emil to remain as inconspicuous as possible at school. Therefore, potential regulatory strategies were developed with him that he could implement "discreetly". For instance, when experiencing intense internal tension, he wanted to squeeze a stress ball in his pants pocket with his hand. This was also discussed with the teacher. Emil didn't initially want to inform the homeroom teacher every time he used it, but agreed that if the internal tension became too much, he would let her know. Then, as agreed with the teacher, he could briefly retreat to the classroom play corner. Emil stated that he only wants to do this if there's absolutely no other option.

- Offering a safe space for conversation
- Psychoeducation on internal tension and the lack of more effective self-regulation
- If necessary, providing guidance to the homeroom teacher on how to handle Emil's lack of self-regulation

Pathways to Therapy

Recognized and approved therapies

Currently, the following therapeutic approaches are recognized: psychoanalysis (PA), depth psychology-based psychotherapy (TP), systemic therapy (ST), and behavioral therapy (BT). All of these may be covered by health insurance.

The therapeutic relationship

It is important to build a trusting relationship with the therapist. The therapeutic relationship accounts for at least 50% of the treatment's success. Both parties need to determine whether they get along and can envision working together.

If the rapport isn't right, it's important to address it openly and, if necessary, seek another therapist.

The following questions and suggestions can help you before starting therapy:

Questions about motivation

Why do I want to start therapy now?

Is this my own decision? Or are family members, friends, or my partner pushing me to seek therapy?

What do I personally think needs to change in my life?

How do I believe therapy can help me?

Am I willing to try different therapeutic approaches to change my behavior?

Outpatient, day treatment, or inpatient?

Outpatient treatment is generally recommended. If improvement is not possible with outpatient treatment due to personal or social circumstances, day treatment or inpatient treatment may be considered. This may be the case, for example, when

the disorder is accompanied by other conditions such as severe depression, anxiety, obsessive-compulsive disorder, or other psychological symptoms.

How do I get an appointment with a therapist?

International information and support are also provided by non-profit organizations such as International OCD Foundation (www.iocdf.org), and BFRB UK & Ireland (www.bfrbukireland.com).

In some federal states, health insurance companies may still approve treatment at private practices through a so-called cost-reimbursement procedure. If you have questions about the cost-reimbursement procedure, please contact your health insurance company.

Questions for therapists

When making initial contact – by phone or by email – you can ask the following questions:

- Are you familiar with the treatment of BFRBDs, such as skin picking, trichotillomania, or nail biting?
- Would you be willing to work with me to learn more about this topic?
- Do you offer online counseling or therapy?
- Will my family members, partner, or parents be involved in the treatment?
- How long is the waiting period in your practice?
- What happens next? Should I check in with you periodically, or will you contact me when a spot becomes available?

When is it advisable to consult other specialists?

In general, it is recommended to undergo a medical evaluation at the start of psychotherapy, in cooperation with the therapist. However, given the nature of BFRBDs, further examination may be necessary, especially if body-directed behaviors damage the skin, hair, nails, lips, or cheeks. In addition to behavioral symptoms, pain or physical damage may occur:

- in the stomach from swallowing hair
- on the teeth from enamel wear caused by nail-biting
- loose teeth from nail-biting
- on fingers and hands due to prolonged, repetitive hand positions
- on the lips and cheeks due to inflammation in the mouth and throat from biting
- on inflamed skin areas due to scratching

All these symptoms should be taken very seriously, as they can lead to serious complications such as infections. Those affected should be referred to appropriate specialists, such as internists, dermatologists, dentists, or orthopedists. Even though it is often associated with shame and embarrassment for those affected, it is important to speak openly about these issues. Only then can doctors initiate the necessary treatment and prevent more serious damage.

A personal experience report by Antonia Peters, formerly affected by BFRBD

Since 1970, I have been pulling out my hair, running it over my lips, chewing on it, and finally swallowing it. To hide the first bald spots, I wore headscarves and, for four years, a wig.

In the 1980s, I underwent my first course of behavioral therapy and later spent eight weeks in a psychosomatic clinic.

Although I was able to take away some insights for myself, the hair pulling persisted.

In 1997, I learned about the first German study of trichotillomania at the University Medical Center Hamburg-Eppendorf, directed by Professor Iver Hand.

At first, I took a selective serotonin reuptake inhibitor (SSRI) for two years. Within a week, I no longer felt the urge to pull my hair. However, side effects such as sleep disturbances, itchy skin, weight gain, and an unsteady gait occurred – the latter was particularly difficult, as I have had a walking disability since birth.

After two years, I believed I had overcome the hair pulling and began to taper off the medication. But after the last pill, the urge returned. Therefore, I subsequently requested outpatient behavioral therapy.

From 2000 to 2001, I completed 50 hours of behavioral therapy at the University Medical Center Hamburg-Eppendorf (UKE) Outpatient Clinic for Behavioral Therapy.

My goals were:

- to reduce trichotillomania by at least 50%
- to learn to perceive my feelings again
- to let go of my high expectations
- to develop a new daily routine

I chose Habit Reversal Training as my method. Often, I didn't even notice when or why I was pulling my hair. With the help of a self-observation sheet, I learned to recognize my triggers and situations

(see appendix). It turned out that I felt physical tension before pulling, but I couldn't identify the emotions behind it. That's why I worked with my therapist on various emotions: Which ones were familiar to me, and which ones couldn't I recognize or allow myself to feel? These included, among others, anger, sadness, and fear. I made an effort to notice these different feelings in my daily life and give them space.

We then examined how emotions – especially my own – were handled during my childhood and adolescence. They were often dismissed, ignored, or not taken seriously. When I was angry or sad, I was often told, "Don't be such a drama queen." Afterward, I developed strategies with my therapist to combat my hair pulling urges:

- putting on a hat
- putting on gloves
- wrapping Band-Aids around my fingers or getting my hair wet
- clenching my hands into fists and enduring the tension

At first, I used these strategies only for one or two triggers or situations, such as when I was sitting at the computer or watching TV in the evening. I relied on two methods: clenching my fists and putting on gloves. I used them daily until I felt confident. Only then did I add additional strategies, which I eventually applied to all triggering situations.

I also incorporated relaxation exercises. In the morning, after breakfast, I began with ten qigong exercises to start the day off right and become more self-aware. During the day, I also practiced mindful breathing.

As in behavioral therapy for classic compulsions, the concept of exposure also played an important role for me. However, finding a suitable exposure exercise was not easy. For example, I could have taken off my wigs or hairpiece in front of my therapist, or even come to the office from home without them. Thanks to prior medication therapy, however, all my hair had grown back. I noticed, however, that I was particularly tempted to pull my hair when I transitioned from activity to rest. From then on, I practiced sitting or lying still for five minutes every day without pulling my hair. At first, I found this very difficult and could barely stand it. The more often I did this exercise, the better I got at it. Eventually, I even found it so soothing that I extended the time by one minute each day. Today, I can relax for more than an hour.

After the successful exposition, I was allowed – and wanted – to reward myself. My rewards included listening to music, reading, cooking, baking, going for walks, and meeting up with friends to share my successes with them.

For time management, we developed the following plan: During breakfast, I planned my day using my therapy journal:

- Do Qi Gong exercises
- Complete only two tasks in the morning, such as doing the dishes, grocery shopping, answering emails, or taking care of club tasks
- Lunch
- Do an Expo relaxation exercise
- Treat myself to a small reward

Every time I completed a task, I checked it off in my therapy book with a thick red pen.

At the end of each day, I asked myself how satisfied I was with myself and the day and entered my rating on a scale from 0 to 8.

Most of the time, my satisfaction level was between 5 and 8.

Another helpful method was to stick small stickers with green frogs on my bathroom tiles. If I had a slip-up, I turned the frog upside down – that way I could immediately see where a relapse had occurred. Afterward, I asked myself what was behind the slip-up and tried to address or satisfy my need accordingly.

The longer the "frog line" got, the prouder I was of myself, and it motivated me even more to continue to become or remain relapse-free.

I also learned to pay more attention to my needs and to say no once in a while. I practiced forgiving myself when small slip-ups did occur and focusing on the here and now. Almost every morning, I told myself in front of the mirror: "I don't need to pull my hair today!"

"What happened yesterday and what will happen tomorrow doesn't matter. Only today counts." Since I've taken the pressure off and forgiven myself, I've been feeling much better.

At the end of therapy, Professor Iver Hand gave me an important piece of advice: "You must continue practicing for at least an hour every day, even when you're feeling well, to protect yourself from a relapse."

I was happy to follow this advice. I've established daily routines and strategies so firmly that I still follow them today. After more than 24 years, I'm still 95% free of urges – I'm very proud of that and grateful.

Practical Tips for Hair, Skin, and Nail Care

"My hairdresser recommended that I brush my hair regularly. I used to think that would just make more hair fall out, but she explained to me that's not the case. Now I brush my hair several times a day and enjoy the massaging, smoothing effect. Afterward, my head feels pleasantly light, and the urge to pull my hair disappears."

Birgit, affected by BFRBDs

The field of hair, skin, and nail care provides a point of reference for BFRBDs, some of which are referred to as pathological – meaning excessive – body care behaviors. Implementing appropriate care behaviors can also be a therapeutic goal. Below are practical, easy-to-apply examples and recommendations:

External hair care

Brushing: To care for your hair and scalp, brush your hair every day with gentle, loving strokes. This stimulates blood circulation and, if you use a natural-bristled brush, distributes your hair's natural oils all the way to the tips. Brushing can be relaxing or stimulating.

Scalp massage: For some people, self-massage can trigger hair pulling, while for others it serves as an alternative to hair pulling. A professional scalp massage or one performed by a loved one can be pleasant and soothing. However, being touched by another person can also be unpleasant or difficult to tolerate.

Washing the scalp: In hair care, there is a difference between washing the scalp and washing the hair. The wording invites a shift in treatment. When the scalp is shampooed, the hair is washed along with it as the shampoo is rinsed out. In general, it is not necessary to rub the hair. This can cause the hair to tangle unnecessarily and roughen the outer cuticle layer.

Water quality: Very hard water leaves a film on the hair, which can trigger hair pulling when searching for and scanning specific strands. There are several options: boil the water, filter it, or use still mineral water.

Shampoo and hair soaps: Less is more! To prevent your hair from drying out, use only a small amount of shampoo, or dilute it and apply it directly to your scalp with

an applicator bottle. When choosing a shampoo, read the label: The fewer ingredients, the more natural it is. Fewer chemical, drying ingredients mean you're less likely to need additional hair care products.

How often you wash your hair depends on your lifestyle. A general recommendation is two to three times a week, and you can also just rinse your hair with water sometimes. It is nearly impossible to scan for specific hairs when they are wet!

Additional hair care products: conditioners, oil treatments, and hair pieces

In principle, it is helpful to treat your hair with love and care. It is important to figure out for yourself whether certain products act more as a balancing agent, a barrier, or a trigger. For example, if oily hair is a trigger, an oil treatment might not be appropriate.

Beware of false promises and of chemical and aggressive hair-growth products. It is advisable to do thorough research and read customer reviews. When used, these products can also cause itching and burning of the scalp, as well as changes in hair texture, such as a film or dryness, which can be an additional trigger for hair pulling for some.

Hairpieces

Wigs offer protection against reactions in the social environment and serve as a barrier. However, there are disadvantages. The scalp is covered, and the wig traps heat, which can cause sweating, altered sebum production, and consequently dryness, dandruff, and oily hair. Wearing a wig can also lead those affected to pull at their hair more frequently and without inhibition when they are alone, since they know they can hide the consequences under the wig. This inappropriate coping behavior can lead to extreme episodes. A wig can itself become a burden – for example, during sports or in certain weather conditions when it does not provide reliable protection. Wearing a wig can also cause stress in interpersonal relationships and lead to avoidance of physical closeness – from hugs to sexual intimacy.

External skin care

One of the first steps – and an important one – could be a consultation at a beauty salon to determine your skin type and receive recommendations for skin care

products suited to your needs. Based on this, you can develop a skin care routine that you can follow regardless of your skin-picking habits.

External nail care

People have individual preferences when it comes to caring for their fingernails and toenails. The best approach is to find what works for you: filing with a nail file, clipping with nail clippers, or cutting with scissors. To keep the skin around your nails supple, use a hand cream or a specialized nail care product. It can be helpful to treat yourself to a professional manicure or pedicure at a nail salon every now and then.

Professional hair, skin, and nail care

Getting a haircut at a Salon

Before your first appointment, we strongly recommend speaking with the stylist and letting them know you have trichotillomania. If privacy is important to you, ask whether there is a private room or a less-busy time of the week.

During your visit to the hairdresser, it is important that you feel understood and not judged, but simply treated with respect as you would be without the BFRBD.

If your hair is thinner and frayed due to trichotillomania, ask for a haircut that precisely evens out the length using a blunt-cut technique. Avoid hair treatments that use thinning shears, thinning techniques, feathering, point cutting, and slicing. Discuss layers in advance. Layers can only create more visual volume in wavy hair, if at all. Layers always reduce hair volume.

Facial and neck/chest treatments at the beauty salon

In addition to the personalized care and product advice mentioned above, we recommend visiting a beautician to treat yourself, relax, and let someone else take care of your concerns. Treat yourself to an appointment like this as often as it does you good.

Nail care at the nail salon

Nail polish, manicures, and pedicures are well-known ways to help you stop biting your nails. Here, too, treating yourself to a nail salon session can be a soothing, relaxing experience.

Hair, skin, and nail care from the inside

There is a wide range of dietary supplements specifically developed to support the health of hair, skin, and nails. These supplements, along with nutritional advice, should always be evaluated on an individual basis and, if necessary, discussed with a family doctor or dermatologist. A comprehensive blood test can determine whether there is a deficiency in vitamins and minerals. Generally speaking, a balanced, healthy diet and lifestyle contribute to the overall well-being of those affected.

Self-perception and how others perceive visible BFRBDs

People whose BFRBDs are visible often worry intensely about their appearance and how others perceive them. They often fear that their condition will be immediately recognized. This concern can severely impair social interactions and, in extreme cases, lead to social isolation.

A behavioral experiment, conducted with therapeutic or family support, could involve appearing in public without a head covering or concealing makeup to observe how others react to one's appearance. This exercise should only be attempted alongside people the client trusts and feels safe with. Questions to reflect on beforehand might include: "How do others perceive me? What happens when I show myself with the visible consequences of trichotillomania, skin picking, or bitten fingernails?"

When those affected practice this behavior, it can lead to increased self-confidence and acceptance of the condition.

What Can Affected Individuals Do?

Adults affected by this condition can often help themselves effectively. Self-help is an important step – it gives you the feeling that you are no longer at the mercy of your urges and can actively make a change.

Self-help is available at no cost, can be done at any time, and is independent of therapy availability or waiting lists. It can complement professional therapy or serve as a step toward it.

Key components of self-help are:

- Self-observation: When and why does the behavior occur?
- Self-awareness: What do I really need in these moments?
- Self-discovery: What helps me personally?

Many people affected often know more about their disorder than those around them – including professionals who have no experience with BFRBDs. They are experts on their own behavior. That is why it can be easier and more helpful to start with oneself rather than constantly explaining to others what is actually going on.

Self-help includes:

- Measures to generally improve living conditions and quality of life
- testing and applying specific BFRBD strategies to avoid triggers and to establish constructive behavioral alternatives
- as well as actively using information sources, networks, and self-help groups that address BFRBDs

In the following, we will discuss these three areas in more detail.

Practical ways to improve quality of life

Below are areas of life with examples that may be related to BFRBDs. For those affected, self-help initially means reflecting on one's own areas of life with regard to potential stress, being over- or under-challenged, boredom, and imbalances. Self-observation in the lifestyle area also involves considering the potential

influence of factors such as hormone levels and medication use, general health status, diet, menstrual cycle, physical activity, and sleep patterns on symptomatic behavior. Adjustments and improvements in these areas can influence the urge and intensity of BFRBDs.

It can be helpful to establish a stable daily routine that balances activity and relaxation. This includes sufficient sleep, a healthy, regular diet, and an individually optimal level of social contact, online activities, hobbies, and exercise. Those affected often tend toward impulsivity and perfectionism and frequently put themselves under significant pressure. In this context, it may be helpful to create a weekly schedule that outlines activities and relaxation periods. Making daily entries in a journal or diary each morning serves the same purpose.

First steps may involve closely observing and evaluating one's daily routine. It can be helpful to make targeted changes to behavioral patterns and routines to establish a tailored, beneficial daily structure.

A conscious, reflective approach to social media is advisable – supported, if necessary, by specific regulatory measures such as setting screen time limits.

Regularly practicing relaxation techniques supports inner balance. Consciously doing something good for yourself every day promotes well-being. Think about what brings you joy and keep track of these ideas in a mental or written list.

Special attention should be given to building and strengthening self-esteem. One's self-image should not depend exclusively on outward appearance or behavior but should encompass the person as a whole, with all their individual strengths. The goal is to approach one's own weaknesses and learning processes with kindness and acceptance.

In interpersonal relationships, it is advisable to improve communication, clearly express your needs, and inquire about others' needs. Relationships benefit from attention and appreciation. It is equally important to endure conflicts, face challenges, set boundaries, and say "no" – just as it is to open up, say "yes," and ask for support.

Strategies for dealing with BFRBDs

The first strategy for dealing with BFRBDs is self-monitoring of the symptomatic behavior. Many people affected are unaware of when and in what situations they pick at their skin, pull their hair, bite their nails, or engage in other body-focused behaviors. Therefore, it is helpful to observe yourself over a few days or weeks to identify triggers and the situations in which they occur. A self-observation chart (Figure 9) can be used for this purpose.

Figure 9: **Self-assessment form**

Date	Situation / event	Feelings before	Thoughts before	BFRD behavior	How long? How often?	Feelings afterwards	Waht could I have done instead?

Other proven BFRBD strategies include protection, distraction, and endurance:

Protection can be provided, for example, by hats, gloves, hair ties, petroleum jelly for the eyebrows, artificial nails, nail polish, dimmed bathroom lighting, or covered mirrors.

Distraction can involve using fidget toys (Figure 10), such as stress balls, stuffed animals, bracelets, rings, or vibrating wristbands. Crafts such as sewing, knitting, or crocheting keep the hands occupied, preventing them from reaching for the face or hair. Chewing gum, effervescent tablets, or smelling and tasting a spicy spice can also help bring those affected out of a trance-like state and back to the here and now. Leaving the situation – such as the room, sofa, computer, or bed – and getting up to get something to drink or eat can also be helpful. Often, simply moving around is enough to break the cycle.

Figure 10: **Various fidget toys**

Fidget toys etc.

Classic

- **Fidget spinner** – spinning toys that are spun between the fingers
- **Fidget cube** – a cube with various buttons, switches, wheels, and surfaces
- **Pop it / push pop bubble** – silicone sheets with bubbles to pop (like bubble wrap)
- **Tangle toy** – twistable link toy that can be reshaped endlessly
- **Stress ball / Anti-stress ball** – soft balls for kneading and squeezing
- **Infinity cube** – foldable cube that can be folded endlessly
- **Magnetic balls / building blocks** – small magnetic pieces for combining and shaping
- **Modeling clay / thinking putty** – stretchy, moldable substance, similar to playdough
- **Fidget pad** – like a game controller with various buttons and switches
- **Marble and mesh** – a ball that can be pushed through a mesh

Sensory / tactile focus

- **Texture plates / sensory pads** – with rough, soft, spiky, or smooth surfaces
- **Fluffy stuffed animals or fabric ribbons** – for stroking, especially for sensory needs
- **Click-clack bracelets** – snap-on or twistable bracelets
- **Squeeze or push toys** – with sounds or resistance

Special variations

- **Fidget jewelry (e.g., spinning rings)**
- **Fidget figures / fidget animals** – flexible figures with movable joints
- **Hand trainers with springs or resistance** – combine playfulness with strength training
- **Fidget pens** – pens with rotating, clickable, or magnetic parts
- **Bendable sticks** – flexible sticks made of rubber or wire
- **Worry stones** – smooth stones that may have a calming effect when rubbed

... and others

These behaviors often occur when a person is alone. Reaching out to people you trust can be helpful. BFRBDs often manifest during quiet or passive activities, such as watching TV, video calls, or reading. In such moments, mindfulness – such as conscious breathing – and the targeted use of fidget toys can be helpful.

Endurance involves consciously noticing and tolerating inner tension, restlessness, or strong emotions. Those affected may, for example, sit on their hands, clench a fist, or press their hands together. It is important to experience that the inner tension, restlessness, or anxiety subsides over time. For some, this takes only a few minutes; others experience relief only after one to two hours. In behavioral therapy,

these are known as structured behavioral exercises. They can be challenging and stressful at times, which is why they should first be practiced with a psychotherapist before those affected continue them on their own.

Therefore, it is advisable to learn how to relax and tolerate periods of inactivity. The more often these strategies are used – ideally daily – the more firmly the new behavior becomes established. After each successful exercise, the effect can be reinforced with a positive experience: listening to favorite music, cooking, reading, meeting friends, or treating yourself to a small pleasure.

It is important to (re)activate resources, as positive behavioral alternatives should be consciously reintegrated to help distance oneself from the behavior one wishes to change. For example, if you want to shorten your care routine, it helps to have an exciting mystery novel nearby. A guiding principle can be helpful here:

"Do more of what makes you happy." Consciously integrating joyful activities into your life helps balance out stress and strain.

Those affected should not let slip-ups or relapses discourage them. Instead, they should forgive themselves and keep practicing the next day. "That's okay! Tomorrow is a new day when I will resist the urge!" It can be helpful to listen to your inner self and ask: "What am I missing? What do I need right now?"

The methods already mentioned – Habit Reversal Training, the habit replacement method, and decoupling methods – can be used independently. Apps like Cogito help users become aware of and interrupt behaviors.

Resources, networks, and support groups

> *"I'm so glad this group exists and that I'm no longer alone. It's comforting to hear how others in the same situation are coping."*
>
> Michael, affected by BFRBDs

Organized support groups can be a great way to connect, find emotional support, and build a network.

Many people who struggle with these behaviors feel deeply ashamed and believe they are the only ones who pull their hair, pick at their skin, or bite their nails. In their personal lives – with family and friends, as well as at school and work – they

often encounter misunderstanding and are repeatedly told the hurtful phrase: "Just stop doing that…!" This leads to greater social withdrawal and lower self-confidence. Self-help groups offer a valuable opportunity to connect with others who also suffer from BFRBDs. Here, those affected feel understood and accepted and learn about others' experiences with therapy or self-help manuals. Self-help groups are not a substitute for therapy. However, they offer the opportunity to stay engaged with the issue before and after therapy and to receive empathy and understanding during potential crises. Self-help groups are led by those affected, are free of charge, and are independent of cultural and religious backgrounds. In addition to the approximately online groups for those affected, their families, and children and adolescents have also been available for a few years.

Today, self-help groups for BFRBDs are offered in person and online in numerous countries and in a wide range of languages, making peer support more accessible than ever for those affected. The websites and organizations listed in the Appendix provide a useful starting point for finding a suitable group, and many are also willing to offer further recommendations upon request.

Social media groups

For several years, those affected and their families have had the opportunity to exchange information in various groups on Facebook and Instagram. These online platforms enable people from all regions to access information and connect with one another.

In the realm of self-help, the following applies: Anything that helps those affected cope with and overcome the condition is valid – whether it's keeping a journal, creating logs, learning dream analysis, participating in self-discovery workshops, practicing yoga or meditation, playing sports, attending a support group, researching the condition, or much more.

Practical tips from Antonia Peters, formerly affected by BFRBD

Since 1970, I have been pulling out my hair, running it over my lips, chewing it, and finally swallowing it. To hide the first bald spots, I wore headscarves and, later, a wig for four years.

Self-observation

Many people with this condition are unaware of when or how often they bite their nails, scratch their skin, or pull their hair. These behaviors often occur unconsciously and automatically. A first step toward change can be conscious self-observation. There are various methods to determine when and how often you pull, scratch, or bite.

Tally-sheet

One option is to keep a tick tally or a note in a large calendar to track when and how often you didn't pull. It might be more visually appealing to draw little hearts in the daily calendar for encouragement, or to stick colorful stickers on for every day without pulling. If a relapse occurs, you can tell yourself: "Okay, today there was apparently nothing better to do than chew, scratch, or pick. But tomorrow I'll have another chance to stop."

Visual observation and documentation

Many people affected by this condition now reach for their cell phone or smartphone to take a photo to check their appearance or to celebrate small successes, such as when they've managed to refrain from picking or scratching.

However, consciously focusing on one's appearance can reinforce the behavior in some people, especially when the thought arises: "It doesn't matter anyway." Feelings of guilt and anxiety then increase, so the behavior is used to calm oneself down. Therefore, caution is advised! It is best to conduct this observation phase as part of psychotherapy.

Self-motivation

To motivate myself, I wrote inspiring quotes on cards and hung them in the bathroom and in the places where I frequently pulled my hair. My favorite quote was: "I love my hair, and today I don't need to pull or tear at it. I can do this!" I also hung an old photo of myself with a perm and full hair on my bathroom mirror – that's how I wanted to look again.

What Can Family Members Do?

"No amount of reassurance helped – on the contrary, it often made the situation worse."

Wolf, family member

Parents, family members, partners, friends, and colleagues can support those affected in reducing and overcoming BFRBDs. The following tips are specifically for close caregivers. Recommendations for teachers and educators appear later in these treatment guidelines.

Each family member should decide for themselves which recommendations seem appropriate for their interactions with those affected. There is no one-size-fits-all solution; rather, it is important to adapt the guidance to the specific family situation, relationship dynamics, and personal reality, and to integrate it into daily life.

Before you start the conversation, it is advisable to read these treatment recommendations in full and to learn more about BFRBDs.

Recommendations for initiating conversation

For family members who have not yet spoken with those affected about their behavior, the first question is: How do I broach the subject of these behaviors with my child or partner? We recommend setting aside enough time for this conversation and choosing a moment when you can talk undisturbed. This is especially important because it is a highly stigmatized topic for those affected.

Here are some suggested phrases:

- I have something on my mind and would like to talk to you about it.
- Can we set a time to talk without being interrupted?

When you sit down with the person concerned:

- I want to let you know that I've done some research into what's going on with your behavior. I've learned that it's not just a bad habit you can easily break. TTM, SPD, and others are part of the BFRBD spectrum.
- How are you coping with this?
- I want to let you know that I'm here for you. What do you need from me?
- How can I support you? Shall we brainstorm different options together?
- One option is for me to address your behavior, or – if we're not alone – to use a code word or gesture.
- I'll talk to other people only with your consent.

Recommendations for parents of children with BFRBDs

Learn about the condition

It's crucial for parents to educate themselves about the condition. There are helpful recommendations and strategies for how parents can support their children in coping with the condition.

Shift the focus – symptoms shouldn't dictate daily life

It can be helpful, among other things, to focus not only on the symptoms themselves but also on enjoyable time spent together. Depending on the child's age and level of involvement, it may be advisable to encourage shared activities.

Self-care

Parents should also make time for themselves. Striking a balance between self-care and "being a parent" appears crucial.

When and why do family members need professional help?

Some family members of people with BFRBDs feel emotionally burdened by the condition. They want to help but feel overwhelmed, frustrated, or helpless at the same time. These feelings can intensify over time, especially if it seems nothing is improving despite their efforts. In such cases, it can be very helpful for them to seek professional help.

The desire to help can also lead family members to put their own needs aside or slip into controlling roles. Some take responsibility for the affected person's behavior, which can negatively affect both the relationship and the symptoms. If family tensions rise, misunderstandings persist, or if daily life is significantly affected by the affected person's behavior, this may indicate that family members also need support.

Professional help offers family members the opportunity to learn more about the illness. Through psychoeducation, they can better understand the affected person's behavior and recognize that it is not merely a bad habit but a serious mental disorder. At the same time, they learn to be supportive while maintaining boundaries, avoiding overprotectiveness or pressure.

Therapeutic support can also help protect one's mental health. Over time, many family members develop symptoms of exhaustion, anxiety, or even depression as they wear themselves out in their supportive role. Talking with professionals or sharing experiences in support groups can provide relief, offer new perspectives, and show ways to take good care of oneself while being there for a loved one.

Last but not least, the individuals affected also benefit when their social environment is informed, stable, and supportive. An understanding, yet non-pressuring social environment can enhance the effectiveness of therapeutic interventions and reduce the risk of relapse. Professional support for family members is therefore not a "minor matter" but an important component of treatment and care for BFRBDs.

Should family members seek help for themselves?

Family members can seek help and support through self-help groups specifically for family members. If their own stress becomes too great, or if their own fears and insecurities come into play, they can also seek psychotherapy for themselves. Here are questions family members can ask themselves:

- How am I coping with my family member's illness? How does this affect our relationship?
- Am I being too controlling of my child or partner, etc.?
- Am I placing too high expectations on my child or partner, etc.?
- Am I asking too much? Do I set too many rules for how we interact?
- In what ways can I support my child/partner, etc., even more if necessary?
- As a family member, how can I further encourage the healthy aspects of my child/partner, etc.?
- Do I also suffer from BFRBD? Do I feel guilty because of this and therefore react in a controlling manner?

The key point is: It's not about finding someone to blame! However, it can still be helpful to determine whether family members are contributing to the persistence of the body-focused urges.

Appendix

Selected Resources on Body-Focused Repetitive Behavior Disorders

The following selection includes informational resources, videos, podcasts, self-help materials, community resources, professional societies, and books related to BFRBDs. Some German-language resources have been included because they also provide English-language content, are run by leading German-speaking BFRB experts, or may be useful to bilingual readers.

General Information, Advocacy, and Support

Anxiety and Depression Association of America – Body-Focused Repetitive Behaviors

Information about common BFRBs, their characteristics, and treatment.

https://adaa.org/understanding-anxiety/co-occurring-disorders/body-focused-repetitive-behaviors

BFRB Changemakers

BFRB education, advocacy, lived-experience resources, and online peer support.

https://bfrbchangemakers.org/

BFRB UK & Ireland / BFRB Con

Information, advocacy, research, and events related to BFRBs in the United Kingdom and Ireland.

https://www.bfrbcon.org/

German Society for Obsessive-Compulsive Disorders (DGZ)

German-language association for obsessive-compulsive and related disorders; offers a BFRB working group and online peer-support groups for body-focused compulsive behaviors, and provides referrals to self-help and treatment resources.

https://www.zwaenge.de/

Free from BFRB

Information about BFRBs and scientifically based self-help techniques, including resources on hair pulling, skin picking, nail biting, and lip and cheek biting.

https://www.free-from-bfrb.org

TLC Foundation for BFRBs (in partnership with the International OCD Foundation, IOCDF)

After 35 years of advancing BFRB research, education, and community support, TLC announced the end of its independent operations and partnered with the IOCDF to help carry this work forward.

https://www.bfrb.org/

International OCD Foundation – Body-Focused Repetitive Behaviors

General information about BFRBs, including trichotillomania and skin-picking disorder.

https://iocdf.org/about-ocd/related-disorders/body-focused-repetitive-behaviors/

Picking Me Foundation

Information, advocacy, resources, and online peer-support groups for people affected by skin-picking disorder and other BFRBs.

https://pickingme.org/

Skin Picking & Trichotillomania – Dr. Christina Gallinat

German-language information website on skin picking, trichotillomania, and other BFRBs; sister project of the BFRB.care podcast.

https://www.skinpicking-trichotillomanie.de/

Podcasts

BFRB.care – Dr. Christina Gallinat

A German-language podcast about skin picking, trichotillomania, and other BFRBs.

https://bfrbcare.podigee.io/

The BFRB Podcast – Jose Alvear and Ashley Robles

Conversations about BFRBs featuring lived experience, advocacy, and mental-health professionals.

https://podcasts.apple.com/us/podcast/the-bfrb-podcast/id1324408003

The Dermatillo-Diaries

A podcast focusing on skin-picking disorder and everyday experiences with the condition.

https://open.spotify.com/show/5EsOpDdkKKS6TEOHCI19W5

TrichStop: Honest Conversations About Hair Pulling

A podcast focusing specifically on trichotillomania and experiences with hair pulling.

https://podcasts.apple.com/us/podcast/trichstop-honest-conversations-about-hair-pulling/id1839912104

American Psychological Association – Understanding Trichotillomania and Other Body-Focused Repetitive Behaviors

https://www.apa.org/news/podcasts/speaking-of-psychology/body-repetitive-behaviors

Selected Videos

Antonia Peters in conversation with Linda Hollatz about BFRBs

https://www.youtube.com/watch?v=r6LuRETceOs

Anxiety and Depression Association of America – What Are Body-Focused Repetitive Behaviors?

https://www.youtube.com/watch?v=1z-MSvIzJ0Q

Light On Anxiety – Understanding BFRBs

https://www.youtube.com/watch?v=TMNHfTKbn3k

The Trich Prof

https://www.youtube.com/watch?v=lYXne3PNN2w

Personal Experiences and Documentaries

Bad Hair Life – Documentary about Trichotillomania

https://www.youtube.com/watch?v=Ko7x4kwTwnQ

Barbara's Story: Living with Trichotillomania

https://www.youtube.com/watch?v=FHLVO8vCTPk

Children with Trichotillomania

https://www.youtube.com/watch?v=WiEbi7E18qY

Living with BFRBs

https://www.youtube.com/watch?v=9m4XPnS9tKE

Self-Help Techniques

Habit Replacement

https://www.clinical-neuropsychology.de/habit-replacement/

Tricks Against Tics

Self-help approaches for BFRBs developed by the Clinical Neuropsychology Working Group at the University Medical Center Hamburg-Eppendorf.

https://www.tricks-gegen-ticks.de/

Free from BFRB – Video Library (HRT, Decoupling, Decoupling in sensu, Habit Replacement)

https://www.free-from-bfrb.org/videos/

Video HRT: https://www.free-from-bfrb.org/videos/2/

Video Decoupling: https://www.free-from-bfrb.org/videos/3/

Video Decoupling in sensu: https://www.free-from-bfrb.org/videos/4/

Video Habit Replacement: https://www.free-from-bfrb.org/videos/5/

Skin-Picking Disorder

Julia Röseler – Out of Meaninglessness, Into Self-Efficacy

Personal experience with skin-picking disorder.

https://www.podcast.de/episode/664413480/19

Professional Societies in English-Speaking Countries

United States – American Psychological Association (APA) – https://www.apa.org/

United States – American Psychiatric Association – https://www.psychiatry.org/

Canada – Canadian Psychological Association (CPA) – https://cpa.ca/

United Kingdom – British Psychological Society (BPS) – https://www.bps.org.uk/

United Kingdom – Royal College of Psychiatrists – https://www.rcpsych.ac.uk/

Ireland – Psychological Society of Ireland (PSI) – https://www.psychologicalsociety.ie/

Malta – Malta Chamber of Psychologists (MCP) – https://www.mcp.org.mt/

Australia – Australian Psychological Society (APS) – https://psychology.org.au/

Australia / New Zealand – Royal Australian and New Zealand College of Psychiatrists (RANZCP) – https://www.ranzcp.org/

New Zealand – New Zealand Psychological Society (NZPsS) – https://www.psychology.org.nz/

Fiji – Fiji Psychological Society – https://psychology.org.fj/

Jamaica – Jamaican Psychological Society (JamPsych) – https://jampsych.com/

The Bahamas – Bahamas Psychological Association (BPA) – https://www.bahamaspsych.org/

Trinidad and Tobago – Trinidad and Tobago Association of Psychologists (TTAP) – https://psychologytt.org/

Caribbean / Guyana – Caribbean Alliance of National Psychological Associations (CANPA) – https://www.wearecanpa.com/

Glossary of BFRBDs

Head and beard hair, eyebrows, eyelashes, body hair, pubic hair

Trichocryptomania – snapping off hair above the scalp
Trichodaknomania – biting the hair
Trichophagia – eating hair
Trichorrexomania – cutting hair with fingernails
Trichorrhizophagia – eating the hair root
Trichoteiromania – rubbing the hair on the head, also to relieve itching, resulting in very short, bristly hair
Trichotemnomania – cutting the hair, the ends of the hair
Trichotillomania, Hair Pulling Disorder – pulling out one's hair

Skin

Acne excoriée – picking at acne-affected areas of the skin
Dermatillomania, Excoriation Disorder, Skin Picking Disorder – picking, pinching, squeezing, or scratching the skin
Dermatophagia – biting, nibbling, and eating one's own skin
Perionychophagia – nibbling the skin around the nails
Perionychotillomania – tearing off the skin around the nails
Pruritus – intense scratching

Nails

Onychodaknomania – painful nail biting
Onychophagia – chewing, biting, or eating nails
Onychotillomania – pulling out nails
Onychoteiromania – rubbing nails
Onychotemnomania – cutting nails

Eyes

Mucus Fishing Syndrome – repeatedly cleaning the eyes with the fingers to remove eye secretions such as mucus or discharge

Ears

Compulsive ear cleaning – repeatedly cleaning the ears with fingers or instruments to remove ear secretions

Nose

Rhinotillexomania – picking the nose, compulsive nose-picking
Mucophagia – eating nasal secretions

Mouth

Bruxism – grinding or clenching the teeth, moving the lower jaw back and forth
Cavitadaxia – collective term for biting the cheeks, lips, and tongue Cheilitis factitia – licking the lips
Morsicatio buccarum – biting the cheeks
Morsicatio labiorum – biting the lips
Morsicatio linguarum – biting the tongue
Morsicatio mucosae oris – biting the oral mucosa
Cleaning teeth with fingernails and toothpicks, licking teeth with the tongue

Fingers and Joints

Sucking habit, sucking reflex – Sucking on fingers or thumbs
Tylositis pararticularis – Pseudoknuckle pads, changes caused by rubbing, chewing, or picking
Crepitation – Cracking joints

Fidget toys at a glance – colorful photo gallery



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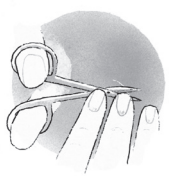
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Understanding and Treating Body-Focused Repetitive Behaviors

Body-focused repetitive behavior disorders (BFRBDs), such as hair pulling, skin picking, nail biting, or lip biting, can profoundly impact a person's life — they often cause shame and frequently go unnoticed by loved ones. This book provides in-depth knowledge of the symptoms, course, and causes of BFRBDs and offers nuanced insights into diagnosis and treatment. Practical treatment recommendations and evidence-based methods, such as Habit Reversal Training and decoupling, support both professionals and those affected in treatment and self-management. Whether in therapy or self-help, change takes time — and understanding.




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