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Trichotillomania: a mini review

Abstract

Trichotillomania is a chronic psychiatric illness that is cognitively debilitating with the potential to be life threatening. Classified as an obsessive-compulsive related disorder, it is more prevalent among younger and female patients. Clinicians must complete a thorough psychiatric evaluation to screen for co-occurring psychiatric disorders. Gastrointestinal blockages must also be screened for in patients who present with abdominal symptoms. Trichotillomania is best treated via behavioural therapy with a focus on habit reversal therapy, with limited agreement on pharmacotherapy options.

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Akber Sheikh,[1] Asim Godil[2]

[1]Western University of Health Sciences, Pomona, USA
[2]University of California San Diego, La Jolla, USA

Correspondence: Akber Sheikh, Western University of Health Sciences, Pomona, CA, USA, Email akber.sheikh@westernu.edu

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Background

Trichotillomania is a psychiatric condition that is characterized by the repeated pulling of one's own hair from the scalp, eyebrows, and pubic regions, legs, and eyelashes.[1] Trichotillomania was not considered a mental health disorder until 1987, when it was officially included as a mental health disorder in the DSM-III-R. Within the up-to-date DSM-5 trichotillomania is classified as an obsessive-compulsive (OCD) related disorder, however this is still a point of contention among many researchers. Various studies have found the prevalence to range from 0.5%-2.0% with the disorder being more common among females than males.[1–3] This could partially be explained by men being able to mask this condition easier than women by claiming male pattern baldness.[4] Studies have found an average illness duration of 21.9 years.[5,6] The average age of onset was found to be in the age range of 10-13 years old.[1,7,8] One study found that slightly more than half of a sample of 45 women reported stronger, more frequent urges to pull hair in the week before menstruation with a decreased ability to resist.[4] The purpose of this review is to provide a thorough review of the literature to improve clinical acumen, along with diagnosis, management, and treatment.

Clinical description

The current DSM-IV diagnostic criteria for trichotillomania are as follows:

A. Recurrent pulling out of one's hair resulting in noticeable hair loss

B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour

C. Pleasure, gratification, or relief when pulling out the hair

D. The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition

E. The disturbance provokes a clinically marked distress and/or impairment in occupational, social, or other areas of functioning

72.8% of patients pull from their scalp, 54.4% of patients pull from their eyebrows, and 50.7% of patients pull from their pubic regions.[9] Over 20% of patients eat their hair after pulling it out, which can result in gastrointestinal obstructions such as trichobezoars (hair balls) which can require surgical intervention in extreme instances.[5] Trichotillomania triggers are typically sensory, emotional, or cognitive with many patients pulling at random strands of hair, while others exhibit more 'focused' pulling where they pull hair that they feel is out of place or irregular.[1,10] Hair plucking is typically carried out in a linear manner across the scalp or centrifugally from a single point. Visually, trichotillomania can be distinguished from alopecia through linear or circular hair patches with irregular borders containing hairs of varying length.[4]

This disorder has associations with low self-esteem, social anxiety, and psychosocial dysfunction.[11] Common among patients is the tendency to deny their condition and to conceal any alopecia with things like wigs, hair pieces, hats, bandanas, and hair styling.[4] While the DSM-5 groups trichotillomania under the umbrella of Obsessive-Compulsive Disorder (OCD), this is a point of contention today. OCD-compulsions tend to be ego-dystonic (a behaviour that the patient recognizes is bad and desires to change), never pleasurable, and performed fully in an attempt to decrease/avoid feelings of anxiety.[10] While trichotillomania as a whole is ego-dystonic, meaning patients are aware it is a negative hindrance on their lives, many patients derive pleasure from the physical act of hair pulling itself, marking a critical distinction from OCD.[12]

Treatment/Interventions

Seeking professional help from a clinician is uncommon among patients with trichotillomania with one study finding that among 1048 individuals only 39.5% sought treatment from a therapist and only 27.3% sought treatment from a psychiatrist.[9] Another study found that 87% of individuals feel as though their providers know very little about the disorder. Many patients also feel shame or embarrassment and resist seeking help out of fear of stigmatization from providers.[8] Trichotillomania concurrently occurs with a variety of other disorders such as depression, anxiety, and substance use disorders.[4] To effectively identify this disorder providers must also screen for these secondary manifestations of the behaviour. In addition trichobezoars (intestinal hair balls resulting from ingestion) should also be screened for. A thorough physical examination is recommended for those who present with abdominal pain, chest discomfort, change in stool colour, vomiting, unexplained weight loss, diarrhea or constipation.[10]

In terms of treatments for trichotillomania, behavioural therapy has shown the most efficacy, focusing primarily on habit reversal therapy (HRT) but also incorporating aspects of acceptance, commitment, and dialectical behavioral therapy.[13] Habit reversal therapy involves the following 13 components:

1. Competing response training
2. Habit awareness training
3. Identifying response precursors
4. Identifying situations in which the habit is likely to occur
5. Relaxation training

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6. Response prevention training
7. Habit interruption
8. Positive attention/overcorrection
9. Practicing motor responses that compete with the habit in front of a mirror
10. Self-monitoring
11. Solicitation of social support
12. Habit inconvenience review
13. Display of improvement

Improvements in acute response have generally been seen for 3-6 months following treatment.[10] Looking at medication options there is no universally agreed upon medication however glutamatergic agents, antipsychotic medications, cannabinoid agonists, and N-acetylcysteine (NAC) have all seen benefits in individual studies.[5,14] The tricyclic antidepressant clomipramine has shown utility in trichotillomania treatment, specifically in pediatric populations.[15]

Clinical recommendations

We recommend that clinicians be aware of this diagnosis and recognize signs of trichotillomania behavior early on via a thorough psychiatric assessment along with a thorough general inspection of the patient. Patients in early adolescence who present with patchy or full alopecia of the scalp, tonsural pattern of baldness (sparse distributions of varying lengths of hair throughout the scalp with an intact and normal distribution of hair in the periphery - on the sides and back of the head), random small areas of baldness, or imperceptible thinning across the hair should also be screened for trichotillomania. Similarly, patients who exhibit other body focused repetitive behaviors like skin picking, compulsive nail biting, or acne picking are also more susceptible to trichotillomania. Additionally, studies have shown a familial component with patients who have a first-degree relative with trichotillomania having a higher chance of developing the disorder. Thus, clinicians must look out for the following among female adolescent youth in particular:

1) Family history
2) Co-occurring body focused repetitive disorders (skin picking, nail biting, etc.)
3) Co-occurring psychological disorders (anxiety, depression)
4) Clinical features (alopecia, tonsural pattern, etc.)

Conclusion

Trichotillomania is a chronic psychiatric illness that is cognitively debilitating with the potential to be life threatening. It is more prevalent among younger (aged 10-13) and female patients. Treatment providers must ensure they complete a thorough psychiatric evaluation to screen for co-occurring psychiatric disorders. In addition gastrointestinal blockages must also be screened for in patients who present with abdominal symptoms. Behavioural therapy with a focus on habit reversal therapy has proven to be most effective with limited agreement on pharmacotherapy options.

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None.

Conflicts of interest

The authors declared that there are no conflicts of interest.

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