Trichotillomania

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Abstract: Trichotillomania (TTM) is a chronic impulse control disorder characterized by pulling out one’s own hair, resulting in noticeable hair loss. In trichotillomania alopecia results from deliberate efforts of the patients who is under tension or is psychologically disturbed. The condition maybe episodic and the chronic type. Efficacious treatments have been developed, in particular cognitive–behavioral interventions involving procedures collectively known as habit reversal training. Recent developments in pharmacotherapies for TTM and in combining cognitive–behavioral therapy approaches with medication hold promise.

Keywords: cognitive–behavioral therapy, combined treatments, habit reversal training, impulse disorders, pharmacotherapy, trichotillomania, TTM

1. Introduction

Trichotillomania (also known as trichotilllosis or hair pulling disorder) is an impulse control disorder, characterized by the compulsive urge to pull out one’s hair, which (depending on where the hair is pulled from) leads to hair loss balding and distress, and often social or functional impairment [1]. Trichotillomania is often not a focused act, but rather hair pulling occurs in a “trance-like” state [2].

The scalp is the most common area, followed by the eyelashes and eyebrows [3]. It belongs to the primary psychiatric disorders (in which the skin manifestations are self-induced), which is one of the 5 categories of psycho dermatologic disorders [4]. Patients with hair pulling represent an extremely heterogeneous group. In broad spectrum of psychopathologies (from a transient mild habit, through impulse control disorder, the OCD spectrum, various personality disorders (e.g. borderline personality, histrionic personality), body dysmorphic disorder, mental retardation to psychosis) hair pulling may be present as symptom in these disorders [5].

Definition

Trichotillomania (TTM) is a chronic impulse control disorder characterized by pulling out one’s own hair, resulting in noticeable hair loss [6].

Epidemiology

It occurs more than twice as frequently in females as in males.[7] The preponderance may be due in part to women's greater willingness to seek medical care; men may hide their hair pulling better by masking if as male pattern baldness and shaving their mustaches and beards.[5] Affected children may be seven times more than adults.[8] The age of onset is usually between 5 and 12 years with equal sex distribution or early childhood to adolescence.[9] When it occurs later in life, during adulthood or in older patients, it is associated with psychopathology and with a poorer prognosis.[5].

2. Diagnostic Criteria (DSM-5)

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), places trichotillomania in the category of obsessive-compulsive and related disorders and notes that it is characterized by recurrent body-focused repetitive behavior (hair pulling) and repeated attempts to decrease or stop the behavior.

The specific DSM-5 criteria for trichotillomania (hair-pulling disorder) are as follows [10]:

- Recurrent pulling out of one’s hair, resulting in hair loss
- Repeated attempts to decrease or stop the hair-pulling behavior
- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The hair pulling or hair loss cannot be attributed to another medical condition (eg, a dermatologic condition)
- The hair pulling cannot be better explained by the symptoms of another mental disorder (eg, attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder)

3. Causes and Pathophysiology

Both environmental and genetic causes have been suspected to be the causative factor for trichotillomania which explanations include the following:

- Coping mechanism for anxiety or stressful events
- Co-occurring with another habitual behavior (ie, thumbsucking) in young children[11]
- Serotonin deficiency - A link may exist between a deficiency of the neurotransmitter serotonin (5-hydroxytryptamine [5-HT]) and trichotillomania.
- Structural brain abnormalities - One study has shown that individuals with trichotillomania have decreased cerebellar volume[12][13]. In several MRI studies that have been conducted, it has been found that people with trichotillomania have more gray matter in their brains than those who do not suffer from the disorder[14]
- Abnormal brain metabolism - Positron emission tomography (PET) scans have revealed that some individuals with trichotillomania have a high metabolic glucose rate in the global, bilateral, cerebellar, and right superior parietal areas
- Genetic susceptibility - DSM-5 notes that there is some evidence that genetic vulnerability plays a role[10]; trichotillomania occurs more frequently in people with...
Hair microscopy may help to show the broken off and fractured hairs with blunt end. Histopathologic changes vary according to the severity and duration of hair plucking.

- The most relevant histologic features is the presence of normally growing hairs among empty hair follicles in a non-inflammatory dermis.
- Follicular plugging with keratin debris can be prominent.
- Strands of basaloid-appearing cells may be present in the base of plucked follicles.
- Separation of the follicular epithelium from the surrounding connective tissue sheath and areas of intraepithelial and perifollicular hemorrhage in a notable absence of inflammatory cells seen if the trauma extraction is severe.

Full blood count and ferritin.
Investigations for trichobezoar.

### Treatment

Various therapeutic modalities which have been considered include:[5],[23] (a) Supportive psychotherapy, (b) Directive and autogenic training. (c) Behavior therapy which involves various techniques-self monitoring; coping strategies; motivation enhancement; awareness training; competing response; relaxation training. (d) Hypnotic therapy, (e) Psychotherapy and (f) Pharmacotherapy.

### Behavior Therapy

The method of choice is cognitive-behavioural therapy (CBT), whose efficacy has been demonstrated in several independent studies [25]. Studies have shown the effectiveness of a habit-reversal training (HRT) as a method limiting the intensity and frequency of behaviours associated with trichotillomania [26]. A key element of the therapy is competing response training – involving patient in a motor activity that prevents the implementation of the motor pattern involved in pulling/eating hair. Other HRT elements used in the treatment of trichotillomania are: self-observation, mindfulness; impulse control techniques and – supportively – relaxation techniques and social support.

### Hypnotherapy

A variety of hypnotic suggestions that have been applied usually as adjuncts to other behavioral or psychotherapeutic treatment elements included pain of touching the scalp or pulling hair,[27] increased awareness of hair pulling behavior through associated hand warming,[28] and rituals other than hair pulling to decrease anxiety.

### Psychopharmacology

Many drugs appear promising but actually the only drug which is found effective in controlled trials appears to be clomipramine [29].

Efficacy for the combination of serotonergic reuptake inhibitors (SSRIS) (flavoxetin, paroxetin, sertraline, citaloprem) and neuroleptics (haloperidol, pimozide, risperidone) is observed in uncontrolled studies. There are reports of successful treatment of trichotillomania with sertraline HCl 50mgs at bed time and fluoxetine 10 mgs daily. Fluocinolone shampoo 0.01 % twice weekly has been found beneficial in some cases.

Because clomipramine (50-200mgs/day) appears to be the...
drug whose effectiveness has been demonstrated in a double blind trial, it deserves primary consideration. Thus the first-line strategy should be a trial of clomipramine.

Venlafaxine and mitrazapine (which strongly enhance both serotonergic and noradrenergic functioning) may become alternative drugs.

References


