Trichotillomania: Advice from a Psychiatrist

Although seemingly rare, trichotillomania may be more common in pediatric dermatology than previously thought. Here are approaches to treatment.

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Trichotillomania is a psychiatric disorder characterized by repetitive or compulsive hair pulling. The reported prevalence is 0.6 to one percent of the population. However, the actual percentage of the population affected is probably much higher, especially in the pediatric population. This is mostly because parents tend not to bring children into the pediatric office until hair loss becomes noticeable. By and large, trichotillomania is an under-recognized condition that is only now starting to receive attention from both physicians and researchers.

Impulse Control
The common age of onset of trichotillomania is six- to 13-years-old. It is different from other psychiatric disorders (such as schizophrenia) insofar that an earlier onset means a better prognosis. When present at a very young age, the condition is termed “baby trich” which suggests its earlier age of onset, its milder form, and its tendency to resolve as the baby grows up.

According to DSM IV criteria, physicians can make the diagnosis of trichotillomania if a patient has an increasing sense of tension that is relieved by pulling out the hair. Recurrent hair pulling must also result in noticeable hair loss. The disorder is classified under “Impulse Control Disorder Not Elsewhere Classified.” This is a “wastebasket” term that includes many other conditions such as pyromania, pathologic gambling, and kleptomania. Brett Johnson, MD, a child psychiatrist at University of California San Diego, believes that under these DSM IV criteria, many cases of trichotillomania will be missed. He suggests that a broader definition should be applied in order to include those who have clinically apparent hair loss and/or those with social disruption or isolation as a result of any type hair pulling, not simply in order to relieve tension. This will allow physicians to diagnose more patients affected by trichotillomania and treat them accordingly.

Dermatologists often are the first-line clinicians to see patients with trichotillomania, although these patients may need psychiatric treatment in the long run. In more severe cases, a referral to a child psychiatrist who specializes in trichotillomania or OCD is appropriate. Unfortunately, there is often a long waitlist, which can worsen your patient’s condition. Therefore, knowing what interventions are appropriate from a psychiatric standpoint is crucial whether you decide to treat these patients yourself or refer to psychiatry for long-term treatment.

According to Dr. Johnson, the most important thing is to maintain as non-judgmental a stance as possible. These patients are often already prone to feel shame and guilt; letting them know that they are not alone may help relieve these feelings.

Reversing the Habit
The first and probably most effective intervention in the treatment of trichotillomania is called Habit Reversal Therapy (HRT). This behavioral therapy emphasizes self-monitoring and teaches patients to use an alternative, non self-injurious action to replace hair pulling. It has been used with good success in skin picking and tic disorders. Below are four steps summarizing HRT:

1. Assessment and functional analysis. Work with your patient to identify “high-risk times” during which the patient is most likely to pull out his/her hair (for example, watching TV, reading, times of high stress, etc). Take a thorough history including what precedes the pulling and what actions result. As many as 50 percent of patients engage in oral rituals after hair pulling, e.g. “trichophagia” (eating hair). Therefore, it is also important to inquire about GI symptoms so as to catch and/or prevent “trichobezoar” (hairball in the GI tract).

2. Self-monitoring. Ensure that the
patient keeps a log of her/his hair pulling activity including what he/she uses to pull out hair (fingers, pincer grasps, tools), how long the hair pulling lasts, and what they do after. Parents should also watch patients during their leisure time for hair pulling that the patients themselves may not notice. Another tip: have patients/parents look for hair on the patient’s pillow every morning.

3. Stimulus control. Use techniques to prevent hair pulling such as wearing gloves or putting a piece of tape or a band-aid on the finger used to pull. These techniques must be socially acceptable and not cause embarrassment for the patient.

4. Competing response intervention. Develop an activity to substitute when the urge to pull hair occurs. Some examples include deep muscle relaxation or taking a walk. If the patient has a strong urge to pull on something, pulling on a “koosh ball” (as shown in the picture) is also an appropriate competing response.

**Oral Therapies**

Habit reversal therapy may not be appropriate in certain populations such as in very young, developmentally delayed, or autistic children. In these cases and other cases refractory to behavioral therapy, oral medications are acceptable. Below are some medications commonly used by psychiatrists in trichotillomania.

**SSRI’s.** These anti-depressants are considered first-line treatments, not because of their higher efficacy than other classes of drugs, but because of the milder side effect profile. Dr. Johnson recommends fluoxetine in pediatric patients. It is also important to let your patient know that SSRIs may take from eight to 12 weeks to take effect. Also, paroxetine should generally be avoided in trichotillomania because it has very little effect on dopamine.

**Atypical anti-psychotics.** These are used as add-ons to SSRI’s when only partial response is achieved and used as a monotherapy only when the condition is completely refractory to SSRIs. Risperidone is an example of an atypical antipsychotic that is recommended for use in trichotillomania.

**Clomipramine.** This is the only tricyclic antidepressant that is commonly used in trichotillomania. It is not a first-line medication because of many severe adverse effects including cardiac rhythm disturbances due to calcium channel blocking properties. Generally, it is used in cases refractory to both SSRIs and atypical anti-psychotics.

**Mood stabilizers.** Examples of appropriate mood stabilizers include lithium and the valproates. Lithium has dermatologic side effects, including cystic acne and alopecia, therefore, it is not recommended for use in trichotillomania.

**Low-potency topical steroids.** Topical steroids such as hydrocortisone 1% are acceptable in helping the irritation and itching that results from new hair growth or chronic inflammation.

**Behavioral Dermatology**

It is important to realize that complete cure in trichotillomania is extremely rare. In most cases, it is a chronic disease that will require a life-long behavioral approach with or without psychiatric medications. Therefore, providers should educate patients and parents about the chronic nature of the disease. Behavioral therapy takes time to implement and most dermatologist visits do not allow for this opportunity. If patients cannot see a psychiatrist for any reason, a psychologist who practices cognitive behavioral therapy can also be useful for patients to receive help and start working on their therapy.

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