

INVESTIGATIVE REPORT

Frequency and Treatment of Trichotillomania in Poland

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Although trichotillomania is a relatively common disorder no large epidemiological studies are available. The aims of this study were to determine the frequency of trichotillomania as identified by Polish dermatologists, and to evaluate the treatment modalities used. A questionnaire was sent to 172 dermatologists; 118 (68.6%) responded. The questions covered demographic data, frequency of trichotillomania and treatments used. During the course of their working lives 68% of respondents had observed at least one patient with trichotillomania and 11% were currently treating such a patient. More than 30% of respondents had observed one or two cases of trichotillomania during the past 5 years, 11% had seen 3–5 cases, 3% had seen 6–10 cases, and 5% had seen more than 10 patients. Of the respondents, 40.7% always and 28.8% often asked for a psychiatric opinion. Dermatologists with more experience more frequently ($p < 0.05$) obtained a psychiatric opinion. Some dermatologists (15.3%) used their own pharmacological treatment (anxiety-relieving drugs and sedatives). Trichotillomania is a relatively common disorder; however, not all dermatologists are sufficiently prepared to treat it. *Key words: trichotillomania; hair loss; frequency; treatment modalities; dermatological practice.*

(Accepted January 8, 2009.)

Acta Derm Venereol 2009; 89: 267–270.

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Trichotillomania (TTM) is an impulse control disorder characterized by chronic hair pulling, which causes noticeable hair loss (1). The disorder produces stress and significant impairment of quality of life. Patients usually experience increasing tension before hair pulling, which is relieved by pulling and this action is gratifying or pleasurable. The exact aetiology of TTM is unknown. Some authors have pointed out the similarities between obsessive compulsive disorder (OCD) and TTM (1). Brain imaging studies suggest some functional and morphological anomalies (2).

TTM is observed more commonly in younger patients, as the average age of onset is 12 years; however it can begin at any age (3, 4). Many authors suggest

that TTM in children, especially at pre-school age, is relatively benign and self-limiting (5, 6). TTM in adolescents and adults is a more serious problem that is often co-morbid with other psychiatric disorders (7, 8). Older patients more often experience tension and relief. TTM is diagnosed more frequently in women; the female to male ratio varied in different epidemiological studies from 2:1 to 7:1 (9–11).

A typical clinical picture of TTM shows irregular, non-scarring, focal patches of alopecia. Patches contain broken hairs of varying length. The scalp is the most commonly involved region, followed by the eyebrows, eyelashes, pubic or any other skin area. The changes are usually present on the contralateral side of the body from the dominant hand (12, 13). There are two subtypes of TTM. One is the focused style, when the patient centres the attention on pulling hairs out. In the automatic style hair pulling occurs during other activities, such as watching television, reading or speaking on the telephone (14). Recently, sleep-isolated TTM has also been reported by some dermatologists (15).

Although hair pulling is usually gratifying, most patients experience significant stress and discomfort due to the condition. They try to resist the urge to pull, often unsuccessfully. Patients feel embarrassed, unattractive, ashamed or depressed. They try to hide their alopecia and usually avoid social meetings. Hair pulling is also time-consuming and on average patients spend 2 h a day performing this action.

Although TTM is a psychiatric condition it is commonly treated by dermatologists. Because of this we decided to evaluate how dermatologists in Poland deal with TTM. Therefore, the aim of this study was to determine the frequency of TTM identified by dermatologists in Poland, and to evaluate the treatment modalities used.

METHODS

A specially designed questionnaire was distributed to 172 dermatologists in two regions of Poland: Lower Silesia and central Poland. The response rate was 68.6% ($n = 118$; 95 women and 23 men). The duration of employment of respondents varied from 1 year to 52 years. Their workplaces were wide-ranging: 33% of respondents worked in hospital dermatology wards, 30% worked in outpatient clinics, 11% had their own practice and 23% had more than one workplace.

The questions covered dermatologists' demographic data and the frequency of TTM observed in their everyday practice. The

frequency of TTM was assessed for the respondents' whole working period, for the past 5 years, and for the current period. Finally, methods of treatment used by the dermatologists in managing patients with TTM were evaluated. Statistical analysis was performed using the χ^2 -test. *p*-values less than 0.05 were considered significant.

RESULTS

During their working lives, 67.8% of the dermatologists participating in the survey had observed at least one patient with TTM in their practice, and 32% had never diagnosed such a disorder. During the past 5 years, 33% of respondents had seen one or two patients with TTM, 11% had seen three to five cases, 3% had seen more than five cases, and 5% had seen more than ten cases. Approximately half of respondents (48%) stated that they had diagnosed no cases of TTM during the past 5 years. Approximately 11% of respondents were currently treating a patient with TTM (Table I).

Dermatologists participating in the survey often ask for a psychiatric opinion about their patients with TTM. The psychiatric consultation consists mainly in establishing the appropriate treatment, and it is not always supported by a psychiatrist examining the patient. Our study showed that 40.7% (48 subjects) of the respondents always ask and 28.8% (34 subjects) often ask for a psychiatric opinion. Only 17.8% (21 subjects) of dermatologists occasionally ask the psychiatrist for a consultation, and 12.7% (15 subjects) never do, but try to treat the patient by themselves. Dermatologists with longer work experience statistically more frequently ($p < 0.05$) obtained a psychiatric opinion about their patients (detailed data not shown).

Various treatment strategies were used by the dermatologists. Most often (38.1%), dermatologists tried to obtain a psychiatric opinion and then treated the TTM patient according to the psychiatric advice. Approximately 27% of respondents always referred such a patient to a psychiatrist. Many dermatologists (19.5%) tried to talk to the patient and explain the reasons for the condition, as the only method of treatment. Finally, some dermatologists (15.3%) used their own pharmacological treatment, initially using anxiety-relieving drugs, sedatives and placebo. Other pharmacological methods used by dermatologists were antidepressants and antipsychotic agents; however, they were used only in single cases (Table I).

DISCUSSION

In order to meet the diagnostic criteria of TTM according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) hair pulling must be preceded by a sense of increasing tension, and the action of hair pulling has to be pleasurable or gratifying. On the other hand, many patients, especially very young children, do not report such phenomena. Moreover, some patients admit that they pull their hair out for other than cosmetic reasons, but they have no clinical evidence of hair loss. Such clinically negative hair pullers are quite common in the general population (11). Thus the exact prevalence of TTM is difficult to establish and may be underestimated. Many patients are unwilling to admit that they pull their hair out. That is why some cases of TTM are treated as alopecia areata, traction alopecia or even fungal infection. The lifetime prevalence of TTM has been reported to be 0.6–3.4% (7). If the exact criteria of TTM referring to tension and gratification are ignored, the incidence ratio is even higher, up to 11% (16). The prevalence of hair pulling in children has been reported to be approximately 1%; however, there have been no large epidemiological studies including children and adolescents (17–19). The present study suggests that TTM is a relatively frequently diagnosed disorder. More than half of practicing dermatologists had diagnosed TTM at least once and 11% had such a patient currently under treatment. This proportion is quite high and there is thus a real possibility of seeing such a patient in a regular dermatological practice. On the other hand, more than one-third of respondents stated that they had never seen a patient with TTM. This is a significant number, and there is a possibility that some dermatologists do not consider a diagnosis of TTM when dealing with patients with hair loss. It is therefore essential to be familiar with the principal guidelines for the management of TTM. To the best of our knowledge there have been no similar studies assessing dermatologists' knowledge of TTM. A postal survey on this topic has been conducted

Table I. *Trichotillomania (TTM) reported by Polish dermatologists*

Variables	Distribution of affirmative dermatologists (%)
I have seen TTM patients (<i>n</i> = 118)	
Sometimes during my career	67.8
During the past 5 years	51.7
At present	11.0
Number of TTM patients treated last 5 years (<i>n</i> = 118)	
0	48
1–2	33
3–5	11
6–10	3
> 10	5
Procedures used in patients with TTM (<i>n</i> = 118)	
Referral to psychiatrist	38.1
Treating according to psychiatric advice	27.1
Explaining and talking to the patient	19.5
Own pharmacological treatment	15.3
Pharmacological treatments used (<i>n</i> = 19)	
Antidepressants	5.6
Antipsychotics	11.1
Placebo	22.2
Sedatives	27.8
Anxiety-relieving drugs	33.3

in the USA among psychologists and physicians, but not among dermatologists (20). Due to the high level of coincidence of psychiatric disorders it is strongly recommended that patients with TTM be referred for psychiatric evaluation.

The most beneficial therapy for children with TTM is behavioural therapy under the supervision of a psychiatrist. There are special techniques, such as positive reinforcement, punishment procedures, habit reversal training or self-monitoring, which help to control the condition (21–25). For older patients, adolescents and adults, pharmacotherapy is needed. The best-studied and most effective drug for TTM is clomipramine, a tricyclic antidepressant, and serotonin reuptake inhibitor (SRI) (25–27). There are also reports of good effects of treatment with selective serotonin reuptake inhibitors, such as fluoxetine, fluvoxamine or paroxetine (25, 28–30). Other agents, such as naltrexone or lithium, may also be considered in treatment of TTM (31). Some studies report that augmentation of SRIs with antipsychotic agents, such as pimozide, risperidone or haloperidol, may be considered in patients who show a partial response to these agents (32–34).

The dermatologists participating in this survey referred patients with TTM to psychiatric care relatively often, or at least obtained a psychiatric opinion about the patients. However, some respondents used their own pharmacotherapy, which in most cases was inappropriate. Anxiety-relieving drugs and sedatives were the most-often used drugs for the treatment of TTM. Antidepressants and antipsychotic agents were used very rarely by dermatologists. Our previous studies have shown that other psychodermatoses, such as delusional parasitosis and body dysmorphic disorder, are also treated inadequately by dermatologists. Skin doctors usually take a similar approach to all conditions with a psychiatric background, reluctantly using antipsychotics and antidepressants (35, 36).

Bearing all this in mind, our data show that dermatologists in Poland do not treat patients with TTM adequately. If they decide to introduce pharmacological treatment they usually choose medications with poor effectiveness. According to our findings, dermatologists in Poland are not sufficiently prepared to treat patients with TTM successfully. There is an urgent need for improved co-operation with psychiatric units.

ACKNOWLEDGEMENT

The authors are grateful to all the dermatologists who participated in the survey.

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