Trichotillomania At A Glance

Trichotillomania, is an impulse control disorder that involves an irresistible urge to pull out hair and results in noticeable hair loss. Successful treatment of trichotillomania is often short-lived, independent of the type of treatment provided. Often times it may be accompanied by other compulsive behaviors, such as picking at sores or abrasions on the skin. The affected individual may alternate between hair-pulling and these other compulsive behaviors. The natural history of trichotillomania may include periods of decreased or no symptoms, so the evaluation of treatment effectiveness may be difficult in some cases.

Treatment

Pharmacological treatment may be used alone but a combination of medication and psychotherapy appears to be more effective. It is generally believed the best chance for any long-term success may involve continued use of a combination of medication and psychotherapy or ongoing psychotherapy even if the medications are discontinued. SSRIs are the best-studied and are the drugs of choice; cognitive behavioral therapy is the psychotherapeutic modality of choice.[1]

Discussion

There have been reports of successful behavioral treatments of trichotillomania (Keuthen et al. 1999; Peterson et al. 1994). These approaches have included habit reversal, punishment, reinforcement, response cost, response prevention, time out, competing responses, overcorrection, self-monitoring, relaxation training, covert sensitization, negative practice, and cognitive-behavioral therapy, as well as hypnosis. Just three randomized, controlled studies supporting the effectiveness of behavioral treatments in trichotillomania have been published. In the first study, Azrin et al. (1980b) randomized 34 subjects with trichotillomania to habit reversal (n = 19) or a negative-practice group (n = 15). Habit-reversal subjects reduced hair pulling by 99% on the first day after training, 97% at the 4-week follow-up, and 87% at the 22-month follow-up. Negative-practice group subjects reduced hair pulling by 58% on the first day after training and 71% at the 4-week follow-up.

In the second study, Ninan et al. (2000b) compared cognitive-behavioral therapy, clomipramine (250 mg/day), and placebo in 16 patients with trichotillomania. After 9 weeks, cognitive-behavioral therapy was more effective than both clomipramine and placebo. In the third study, van Minnen et al. (2003) randomized 43 patients with trichotillomania to six sessions of behavior therapy over 12 weeks (n = 15), 12 weeks of fluoxetine treatment (60 mg/day) (n = 13), or 12 weeks on a wait list (n = 15). Behavior therapy was statistically superior to fluoxetine and the wait-list control in reducing trichotillomanic symptoms, including hair pulling, but not general psychopathological or depressive symptoms.

Of the six randomized controlled trials evaluating the efficacy of pharmacotherapy conducted to date, five involved SSRIs. This may reflect the earlier thinking - the notion that trichotillomania is a variant of OCD and thus should respond to the same

pharmacological agents proven successful in OCD. The results of these controlled studies of SSRIs are equivocal at best. (Christenson et al. 1991b; Ninan et al. 2000; Streichenwein and Thornby 1995; Swedo et al. 1989, 1993; van Minnen et al. 2003). Several case studies indicated that augmentation of SSRIs with atypical neuroleptics may be beneficial (Epperson et al. 1999; Stein and Hollander 1992), and an open trial suggested that olanzapine may be efficacious as a monotherapy for trichotillomania (Stewart and Nejtek 2003). Interestingly, naltrexone, an opioid-antagonist thought to decrease positive reinforcement, has also been found superior to placebo in reducing trichotillomania symptoms (Christenson et al. 1994a).

Although no double-blind discontinuation studies have been conducted in trichotillomania, evidence from open studies suggests that treatment response gained from pharmacotherapy may not be maintained in the long run (Iancu et al. 1996; Pollard et al. 1991).

With respect to behavioral approaches and CBT, a variety of specific techniques have been applied, including awareness training, self-monitoring, aversion, covert sensitization, negative practice, relaxation training, habit reversal, competing response training, stimulus control, and overcorrection. Habit reversal, awareness training, and stimulus control are generally purported as the core efficacious interventions for trichotillomania.

The significant problem of relapse following CBT has been highlighted in several studies (Keuthen et al. 2001; Lerner et al. 1998; Mouton and Stanley 1996). The limited relevent literature suggests that there is neither a universal nor a complete response to any treatment for trichotillomania.[2]

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