

Trichotillomania: Targeting the root of the disorder

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An estimated 1% of Americans have trichotillomania (TTM), an impulse-control disorder in which patients experience pleasure or gratification from recurrently pulling out their own hair, resulting in noticeable hair loss.^{1,2} This disorder is more commonly diagnosed in women, likely reflecting treatment-seeking bias; women may be more likely to seek care for TTM because of social stigma associated with hair loss.² Avulsion of hair usually occurs at the scalp, but also can be seen in multiple sites, including eyebrows, eyelashes, beards, and pubic regions; the number of sites typically increases with the patient's age.³

The lifetime prevalence of comorbid axis I disorders in patients with TTM is 82%.³ Because of this, TTM often is first encountered in a psychiatric setting. Psychiatrists should have knowledge of TTM diagnosis and treatment because they may be the only point of care for TTM patients. When considering a TTM diagnosis, be aware that in some cultures ridding hair is a mourning ritual or a rite of passage.³

Evidence for cognitive therapies

Behavioral models suggest TTM behaviors are learned and maintained by both classical and operant conditioning. Therapies that target the cognitive processes that trigger urges to pull, the avulsion of hair, and recognizing the consequences have the best empirical support.³

Habit reversal training (HRT) is considered the most effective treatment for TTM.³ One trial found a single 2-hour HRT inter-

vention resulted in greater reductions in hair pulling episodes and higher remission rates compared with placebo.³ HRT trains patients to create a competing response, such as fist clenching, that is incompatible and blocks the undesired response.

Other therapeutic approaches to TTM include acceptance and commitment therapy, cognitive-behavioral therapy (CBT), and dialectical behavioral therapy-enhanced HRT. Evidence is most robust for CBT-HRT; randomized controlled trials found a statistically significant reduction in TTM in patients receiving CBT-HRT.³ One review suggests CBT-HRT should be considered first-line therapy for TTM.³

Pharmacologic options

Although no medications are FDA-approved for treating TTM, options include clomipramine, olanzapine, fluoxetine, pimozide, inositol, naltrexone, and *N*-acetylcysteine.^{2,3} The most robust trials of pharmacotherapy monotherapy were for *N*-acetylcysteine and naltrexone; both medications had significantly greater reduction in hair-pulling symptoms compared with placebo.³ Some evidence suggests combined pharmacotherapy and psychotherapy might be an effective approach.^{2,3}

References

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