

# TRICHOTILLOMANIA — DIAGNOSIS AND TREATMENT: A TRICHOLOGIST'S APPROACH

Tracey Walker

Trichotillomania — a mania or a compulsive, uncontrollable pulling of one's own hair? In a positive sense mania can mean an excessive enthusiasm, a desire or an obsession, but it can also be interpreted negatively as madness, insanity, lunacy, hysteria, raving and violence. It is with this latter interpretation that trichotillomania patients often get labelled. Patients experience guilt, fear, low self-esteem, shame and isolation and need help and support to live with or overcome this distressing hair loss condition. This article describes the trichologist's role and approach in managing and supporting patients with this distressing condition.

Citation: Walker T. Trichotillomania — diagnosis and treatment: a trichologist's approach. *Dermatological Nursing* 2016, 15(3): 28-31

## KEY WORDS

- ▶ Habit tic
- ▶ Traction alopecia
- ▶ Pruritus
- ▶ Psychosocial stress
- ▶ Compulsion

## Introduction

Trichotillomania (TTM) is a manual form of traumatic alopecia and is a habit tic or compulsion where one pulls his or her own hair out. Trichotillomania derives from the Greek: trich (hair), tillo (pull) and mania (excessive excitement) as described by Hallopeau<sup>1</sup>. Hallopeau was the first person to identify TTM as a medical syndrome in 1889 but references to hair pulling go back centuries and have been referred to in literary sources, eg Homer's *The Iliad* and Shakespeare's play *Troilus and Cressida*. Hair pulling has also appeared in art but often in the portrayal of

Tracey Walker, MIT, is CEO of Education for the Institute of Trichologists, London, and Consultant Trichologist at The Hair and Scalp Clinic, Huntingdon, Cambridgeshire

mental illness. The term mania has negative connotations and suggestions have been made to change the name of this condition, however it is most likely that the term TTM will remain for the foreseeable future.

## The role of the trichologist

Trichologists are trained in all matters pertaining to the hair and scalp and, because most practices are privately run, trichologists are encouraged

**In a busy clinic the trichologist will see a plethora of hair and scalp conditions ranging from general hair thinning to patchy alopecias and mild seborrhoeic dermatitis to extensive folliculitis.**

to spend up to one hour on each consultation in order to achieve the correct diagnosis. In a busy clinic the trichologist will see a plethora of hair and scalp conditions ranging from general hair thinning and male/female pattern hair loss to patchy alopecias, either scarring or non-scarring, and mild seborrhoeic

dermatitis to extensive folliculitis or pityriasis amiantacea. Many instances of hair loss and hair breakage are the consequence of careless or inappropriate hairdressing procedures. The trichologist has special training in such matters and may have extensive experience in this area too.

Trichologists tend to adopt a more holistic approach, which works well alongside orthodox medical treatments. Attention is given to lifestyle, diet, hair care and other factors that may contribute to the patient's condition. Often supportive measures such as scalp massage, ultraviolet light and infrared radiation may be employed in addition to the principal therapeutic measures. Counselling of the patient is always taken very seriously.

Often treatments will be carried out by the trichologist or his or her staff, and this is invariably more effective than home-performed treatments.

Trichologists who are members of the Institute of Trichologists are listed on the Institute's website and this is a good referral source for many

members. Members are encouraged to forge professional links with their local GPs, dermatologists and dermatology nurses and, once these relationships have developed, many of our medical colleagues have no hesitation in referring patients to a trichologist, especially one who is adequately trained and who adheres to a strict code of professional practice.

### Epidemiology

TTM can affect approximately 2% of the population, especially in children from the age of four. According to Muller, as cited by Dawber<sup>2</sup>, before the age of six males predominate 3:2, but after the age of six females predominate. TTM is seven times more prevalent in children than it is in adults<sup>3</sup> and can be seen as an extension of thumb sucking or nail biting (onychophagia).

### Clinical signs

TTM presents as areas of traumatic hair loss in which the hairs in the affected areas are often broken. These areas can be diffuse or patchy and are generally asymmetric and non-scarring in nature. They can be localised or quite extensive. One type of extensive loss is termed tonsure trichotillomania. In this case the hairline remains intact and aids as camouflage in order that the hair can be pulled up into a ponytail to hide the loss. Tonsure trichotillomania typically occurs in young females.

The primary site for TTM is the scalp (*Figure 1*) but eyebrows, eyelashes, beard and body hair can be pulled or plucked either deliberately or unconsciously. New hair growth is often visible but only to a length of approximately 1 cm, after which the hair is long enough to grasp and be pulled out again. Telogen hairs are easily removed but anagen hairs need to be plucked or pulled firmly and are often twisted and broken off at various lengths. Trichogram examination shows almost 100% of anagen hairs with telogen hairs missing. The broken hairs have blunted or frayed ends due to the trauma inflicted and hair cast remnants may be revealed by biopsy specimens<sup>4</sup>.



Figure 1

Typical clinical presentation of TTM.

**One type of extensive loss is termed tonsure trichotillomania. In this case the hairline remains intact and aids as camouflage in order that the hair can be pulled up into a ponytail to hide the loss.**

### Associated signs

Onychophagia (nail biting) may be associated with TTM. Dermatitis artefacta can also be associated with TTM especially if the patient is trying to remove what they believe is an offending hair, insect or fibre. There is also the risk of gastrointestinal obstruction (trichobezoar) due to a mass of hair being ingested.

### Diagnostic criteria for TTM<sup>5</sup>

- ▶▶ Recurrent pulling out of one's own hair resulting in noticeable hair loss.
- ▶▶ An increasing sense of tension immediately prior to pulling out the

hair or when attempting to resist the impulse.

- ▶▶ Pleasure, gratification or relief when the hair has been pulled out.
- ▶▶ Disorder is not explained by a co-existent mental illness.

### Aetiology

In early childhood (under 5), hospitalisation of the child or mother can trigger TTM, as can sibling rivalry, commencing school or difficulties at school in the case of children and young people (aged 5-18).

In adults (18 and over) TTM is more serious, especially if presenting with tonsure trichotillomania. The issues implicated in the aetiology are often more complicated and need psychological intervention.

Sometimes the causes of trichotillomania are unknown. There are beliefs that it could be a form of addiction, relieving stress or anxiety, self-harm or closely related to obsessive compulsive disorder (OCD).

Other theories include<sup>6</sup>:

- ▶ Abnormalities in the brain — brain scans have revealed brain abnormalities in some people suffering from trichotillomania.
- ▶ Genes — an alteration in a particular gene may lead to trichotillomania in some people.
- ▶ Lack of serotonin — treatment with a selective serotonin reuptake inhibitor (SSRI), which boosts serotonin levels, has been effective in some people with trichotillomania.
- ▶ Changes in hormone levels — trichotillomania is more common around ages when hormone levels frequently change, such as puberty.

### Differential diagnosis

In order to diagnose TTM, other non-scarring patchy hair loss conditions need to be eliminated, such as:

#### Alopecia areata

Characterised by 1 to 3 small round patches of hair loss and most resembles TTM (*Figure 2*). Broken hairs are evident in active alopecia areata, however they are easily extracted due to the hair shaft becoming thinned by the effects of inflammation on the hair matrix. These areata hairs are termed exclamation mark hairs due to their unique appearance. There may also be nail involvement associated with areata, such as fingernail pitting.

#### Tinea capitis

An invasion of scalp hair by a dermatophyte fungus; can present as patches of alopecia. It affects pre-adolescent children and can be transmitted by person-to-person contact, animal-to-human contact (commonly cats), as well as via fomites (combs, clippers, etc) and even soil or sand pits. Inside the annular patches there may be dry, brittle hairs, which break off at the scalp leaving 'black dots'. Scaling, erythema and a dull grey appearance may also be evident. Tinea capitis can be confirmed by using Wood's lamp, which uses ultraviolet radiation filtered through Wood's glass (barium silicate containing 9% nickel oxide). This transmits ultraviolet at 330-390nm and is used to diagnose



**Figure 2**  
Alopecia areata.

**Broken hairs are evident in active alopecia areata. They are easily extracted due to the hair shaft becoming thinned by the effects of inflammation on the hair matrix. These areata hairs are termed exclamation marks.**

fungal infections by causing them to fluoresce when used in complete darkness. Alternatively, culture may be used and this can prove to be more accurate as well as revealing the exact infection involved.

Tinea capitis is a contagious infection and early diagnosis and efficient treatment are paramount in preventing the spread of infection. Griseofulvin has been the preferred treatment for many years, but public health advice should also be advocated to prevent cross-infection, eg avoid sharing combs, brushes, towels, etc until the infection has been eradicated.

#### Traction alopecia

Can be initiated by mechanical force. TTM is a variant of traction caused by the manual pulling and twisting of the hair. Other aetiological factors that need to be recognised are overuse of electrical hair straighteners, particularly in the frontal area, which is also a common site for TTM; tight braids, cornrows and use of harsh chemicals such as sodium hydroxide, which is used in the relaxing of African-Caribbean hair.

### Treatment

In early childhood (5 or under):

- ▶ Encourage new behaviours, eg introduce soft, woolly, whiskery toys or encourage the child to squeeze a ball (children often stroke their face with the hair they have pulled out).
- ▶ Introduce charts to monitor progress with small rewards for continued progress.
- ▶ If eating hair (trichophagia) it may be advisable to screen for iron deficiency since the association with pica — an unusual craving for non-food items — can be associated with iron deficiency.

The younger the patient, the smaller the percentage of cases that will need to be referred to a psychiatrist<sup>7</sup>.

In young people and adults (age 12 upwards):

- ▶ Anti-pruritics (break itch/scratch cycle if applicable).
- ▶ Camouflage products, eg hair fibres/coloured thickening sprays/hair pieces.
- ▶ Referral to psychiatrist for talking therapies, eg Cognitive Behavioural Therapy (CBT), which consists of cognitive interventions and behavioural interventions such as Habit Reversal Training (HRT).
- ▶ Referral to the GP for SSRIs.

### Prognosis

In young children (under 5) the prognosis is good often without any intervention. In young people and adults, especially those suffering from tonsure trichotillomania, the prognosis can be quite poor. It is always beneficial to obtain the correct diagnosis as soon as possible as the longer the duration of the condition the more challenging it is to reverse behaviour.

### Conclusion

TTM can be a short-term condition (in children aged 5 or under) or a long-term condition (most often in young people and adults), which is distressing for both the patient and their families. Prompt diagnosis is essential — firstly, to eliminate infectious conditions such as tinea capitis and secondly in order that intervention can be introduced as soon as possible, as this may aid the

## CASE HISTORY

Patient A, aged 13, attended my clinic with her mother in June 2015 concerned about her hair loss and a wider parting developing. The hair loss was on the top of her head only (Figure 3).

Prior to the appointment the mother contacted me quite distraught about her daughter's hair loss. She told me they had been to see their GP who recommended terbinafine hydrochloride 1% cream, which they used on her scalp, and after a while the hair in that particular patch started to grow, although she explained it was very fine, like 'baby hair'. Full blood tests had been checked including thyroid function and all came back as normal.

They went back to their GP and saw a doctor who specialised in dermatology and he said to take vitamins and referred them to the hospital. Because of the wait to see the consultant at the hospital the mother made contact with me at my clinic.

She explained that the bald patches started on her daughter's parting, so they had had to change her parting several times. However, it was getting to a point where they were struggling to disguise the patchy hair loss. The daughter was complaining that her scalp was getting itchy. Some of the areas had developed red spots in them. They hadn't changed hair products just in case it made things worse on the recommendation of their hairdresser.



Figure 3

Atypical presentation of TTM.

The mother told me it was very upsetting to see this happen to her daughter and that she was now very anxious about the hair loss being noticed by her daughter's peers in school, which could make matters far worse and destroy the little confidence her daughter had left.

On examination there were variable lengths of hair in the parting area and at first sight it did look as if the hair was re-growing. However, on closer inspection (under the magnifying lamp) broken hairs were visible at various lengths. The hairs did not extract easily, which they would if they had been exclamation hairs from a patch of alopecia areata. Also, in the patch were pustules, which is not a typical sign of alopecia areata. Other causes of traumatic alopecia were

eliminated, such as use of straightening irons and chemical processes. There were no signs of a fungal infection. I asked the patient if she fiddled with her hair, especially when studying, but she said no. It is an extremely sensitive subject to bring up and most patients will deny pulling out their own hair. Later I spoke with the mother to voice my suspicions that her daughter was suffering from trichotillomania. This can also be difficult as many mothers can get quite upset and find it hard to believe that their child could pull out their own hair.

A few days later I received an email from the mother: "Just thought I would let you know that I caught my daughter pulling her hair out yesterday — after a long chat she admitted it and was embarrassed about it. There seem to be lots of small reasons why she does it so we couldn't pinpoint it to anything directly — which is a shame but at least she has admitted it to me and we can start the long, slow journey of trying to stop her from doing it."

Having spoken to the mother recently she tells me that her daughter began counselling a few months ago, although it is a difficult process for both of them. If ever they have heated discussions at home (quite common during the teenage years) the daughter goes upstairs and starts pulling again. The mother then discovers the hair under the bed.

prognosis. Examination of the hair and scalp must be thorough to identify the clinical signs, however, in doubtful cases the histology is quite useful. In the early stages haemorrhages and intrafollicular and perifollicular fissures are evident.<sup>8</sup> **DN**

### Useful websites

[www.ocduk.org/trichotillomania](http://www.ocduk.org/trichotillomania)  
[www.trichotillomania.co.uk](http://www.trichotillomania.co.uk)  
[www.nhs.uk/conditions/trichotillomania](http://www.nhs.uk/conditions/trichotillomania)  
[www.trichologists.org.uk](http://www.trichologists.org.uk)

### References

- Blume-Peytavi U, Tosti A, Whiting DA, Trueb R. *Hair Growth and Disorders*. 2008. Springer. Ch 14, p294 paragraph 14.2.1.3.2
- Dawber R. *Diseases of the Hair and Scalp*. 1997. Blackwell Science. Ch 9, p328
- Mehregan AM. Trichotillomania: a clinicopathological study. *Arch Dermatol* 1970, **102**: 129-33
- Blume-Peytavi U, Tosti A, Whiting DA, Trueb R. *Hair Growth and Disorders*. 2008. Springer. Ch 14, p294 paragraph 14.2.1.3.6
- Sinclair RD, Banfield C, Dawber R. *Handbook of Disease of the Hair and Scalp*. 1999. Blackwell Science, Ch 7, p86
- NHS Choices. Trichotillomania. Available at: [www.nhs.uk/conditions/trichotillomania](http://www.nhs.uk/conditions/trichotillomania) [accessed 27.5.16]
- Blume-Peytavi U, Tosti A, Whiting DA, Trueb R. *Hair Growth and Disorders*. 2008. Springer. Ch 20, p416
- Ferrando J, Gimalt R. *Atlas of Diagnosis in Paediatric Trichology*. 2000. IMC, Ed Madrid. Ch 111, p92