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WHEN HAIR-PULLING BECOMES A PROBLEM

WHAT IS HPD?

Hair-pulling disorder (HPD), also known as trichotillomania, is a psychiatric condition classified as an obsessive-compulsive related disorder in the latest versions of DSM and ICD. The condition is characterised by recurrent pulling of hair, resulting in hair loss or thinning. Patients with HPD typically present with repeated attempts to decrease or stop the pulling. The pulling behaviour and its sequelae can cause significant distress and may even impair multiple important areas of the individual's functioning. HPD is also grouped as a body-focused repetitive behaviour, which includes other behaviours such as skin-picking and lip-biting.

WHO IS AFFECTED?

Females seem to be 10 times more affected than males. Age of onset of pulling is typically at menarche or early adolescence but early childhood onset also occurs. HPD is more often than not a lifelong challenge which needs careful management.

WHAT ARE THE CAUSES?

The causes of HPD are not well understood. However, several explanatory theories and models exist. Some of these argue that hair-pulling is related to excessive grooming. Others assume the behaviour is linked to stress, and that pulling is a self-soothing strategy when anxious. Genetic factors may play a role as these behaviours are often seen in families. However, modelling of behaviour of parents or sibling by younger children might also play a role, as hair-pulling can be a learned behaviour. Changing hormones have also been noted as a possible culprit, as the behaviour usually starts during adolescence when many physiological changes occur. Various theories also highlighted affect dysregulation, behavioural addiction and cognitive control difficulties in HPD. People may also pull when they are either over- stimulated (i.e angry , irritable, sad) or understimulated (i.e bored). It is likely that no one model could ever fully explain HPD; treatment should speak to all the various inputs, internally and externally, that may play a role in maintaining this repetitive behaviour.

WHAT IS THE IMPACT OF HPD?

Individuals with HPD report many difficulties. The behaviour often causes family conflict, distress,

isolation, shame, guilt, humiliation and body image issues, to name a few. Some patients eat their hair after pulling, which might result in trichobezoars (hairballs trapped in the gastrointestinal system). Furthermore, the symptoms of HPD (which includes pulling, attempts at hiding or covering bald/thinning spots, etc) are time-consuming. HPD is also associated with poor self- esteem, and avoidance of social interaction, some sports (like swimming) and group activities (such as church or movies where they have to sit in front of others). Individuals with HPD can also experience comorbid mood, anxiety, substance and other obsessive-compulsive related disorders like skin-picking disorder which complicate their lives further.

Hair-pulling is often not disclosed for various reasons, such as shame or embarrassment or ignorance about the existence of a disorder like HPD. This can lead to delays in treatment seeking, incorrect diagnosis and reduced quality of life. Also, it's important to note that delays in help-seeking increase the possibility that comorbid psychiatric difficulties may arise. Early intervention is thus important to reduce the negative effects of HPD.

Hair Pulling Disorder Myths	
Myth #1: HPD is a rare disorder	**Fact:** 200 000 reported cases in the US each year
Myth #2: People with CPD can just stop pulling out their hair with will-power	**Fact:** Pulling is a compulsion, not just a bad habit
Myth #3: Hair pulling is physically harmless	**Fact:** Physical effects of HPD can include: • Infections in skin or hair root • Permanent hair loss • Repetitive stress injury • Carpal tunnel syndrome • Gastrointestinal obstruction if hair is ingested
Myth #4: HPD can be cured easily	**Fact:** HPD is often a chronic disorder if left untreated; there are psychological and pharmacological agents that may be of value in HPD
Myth #5: HPD Makes you ugly	**Fact:** Always keep in mind that beauty is deeper that skin and hair

Taken from - https://www.trichstop.com/program

WHAT ARE THE TREATMENT OPTIONS FOR HPD?

Various intervention avenues have been developed. In general, treatments address symptoms of HPD but also aim to improve associated distress and impairment in work, family and social relationships, self-esteem and health. Both psychological and pharmacological agents may be of value in HPD.

PSYCHOTHERAPY

Several psychotherapies have been developed and investigated as possible psychological treatments for HPD. These interventions include habit reversal therapy, (HRT), CBT enhanced with dialectical behavioural therapy (DBT) and acceptance and commitment therapy (ACT). HRT is a first line intervention for HPD and include techniques such as awareness training, self-monitoring, competing response training, HRT and stimulus control are the cornerstone of many psychotherapy treatments for HPD symptoms and in general focus on the motor aspect of pulling. Specifically, in HRT the patient's specific hair-pulling behaviour is examined and these techniques are then used to address symptoms including reversal of the positive reinforcement of pulling

behaviours, using competing reactions, identification of response precursors, self-monitoring, stimulus control procedures, competing responses, relaxation training, keeping a journal of hair- pulling, prevention training and habit interruption. Given the evidence for the partial efficacy of HRT, several studies have investigated ways of augmenting this modality. Although traditionally individual therapy is the most used treatment modality for adults and children with HPD, group therapy may also show benefit as group members who go through similar challenges can identify with each other.

PHARMACOTHERAPY

In terms of pharmacotherapy, options are relatively limited. No medication has been approved for HPD treatment. Nevertheless,

N-acetylcysteine, clomipramine and olanzapine have shown promise in randomised control trials, but further replication is needed. SSRIs i.e. fluoxetine and sertraline showed no significant effect in the treatment of HPD or only showed efficacy in an HPD patient subgroup.

When patients present with poor response to psychotherapy, medication is often added as augmentation. In studies comparing cognitive behaviour therapy (CBT) - which include HRT techniques - with fluoxetine and clomipramine, CBT was found to be significantly more effective than medication. In a study of sertraline alone versus sertraline with add-on HRT, combined pharmacotherapy and psychotherapy treatment showed significantly better gains than medication only.

Although some of the interventions described above seem promising, a large proportion of patients don't have access to, or cannot afford these treatments. An easily accessible and reasonably affordable treatment intervention in the context of South Africa's scant mental health resources would be particularly welcome.

WHAT IS NEW ON THE HORIZON?

Under the supervision of Profs Christine Lochner and Dan J. Stein, who head up the MRC Unit on Risk and Resilience in Mental Disorders in South Africa, Dr Derine Louw, a clinical psychologist, responded to the above need by conducting a single-blind, randomised, 5-week, 25-session cognitive working memory training (CWMT) programme versus a placebo intervention in 30 participants with HPD. CWMT significantly decreased hair-pulling severity compared to the placebo at five weeks and three months. Although participants didn't demonstrate notable impairments in working memory (WM) at baseline compared with norms, WM improved immediately post- training. Although gains in symptoms and WM were maintained at three months, there was no longer a significant difference between the cognitive training and the group that received the placebo intervention. The study also looked at impulse control (IC) and emotional regulation (ER) at baseline, which was not impaired. Also, the CWMT did not have greater impact on IC and ER than the placebo intervention. Qualitatively, participants indicated that CWMT was feasible and acceptable; furthermore, participation in the study was associated with greater openness about symptoms at home, feeling less isolated, and feeling more supported.

Please refer to the table for more interesting information regarding participants to the study.

Cognitive working memory training in Hair-pulling Disorder	
Gender	28 participants identified themselves as female and 2 males.
Age	The youngest person included in the study was 18 and the eldest 73
Home language	Afrikaans and/or English were the home language of most of the participants.
Level of education	The level of education was matric 20%, college/technical college 17% and University 63%
Occupation	Occupation in general was professional 33.3%, business owner 13.3%, homemaker 10%, sales 6.7%, student 20%, pensioner 6.7% and other 10%
General Intellectual Ability Estimates	All had above average intellectual abilities
Age of Onset of Pulling	On average 14 years of age
Duration of Pulling	On average the participants have been pulling for 24 years

Louw, Stein & Lochner (2019)

Some other interesting studies are being done in the field of body-focused repetitive behaviours, and more specifically on HPD. These include the testing of techniques like wearing an awareness bracelet, namely the Keen bracelet, (Dr Doug Woods, a researcher at Marquette University Psychology Department, and Scientific Advisory Board member of the TLC Foundation for Body- Focused Repetitive Behaviors). Investigating the effectiveness of transcranial electric stimulation, cannabis, sceletium or light therapy as treatments are also future directions that may be of interest to HPD researchers. Profs Lochner and Stein are continuing with their work on HPD, which includes clinical, genetics and brain imaging components. MHM

References available upon request