

SPECIAL ISSUE ARTICLE

Trichotillomania (hair pulling disorder): Clinical characteristics, psychosocial aspects, treatment approaches, and ethical considerations

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Abstract

Trichotillomania (hair pulling disorder) is a fairly common but underreported disorder characterized by recurrent episodes of pulling hair from different parts of the body. Currently classified in Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-5) under the heading of the "Obsessive-compulsive spectrum and related disorders." The estimated prevalence data suggest that 0.5–2% of the general population suffers from this disorder. Stress and anxiety are directly correlated to the production of trichotillomania symptoms. The psychosocial aspects of trichotillomania are greatly underestimated, but recent literature suggests an increased interest in this neglected area. Although no FDA approved medications are available for the treatment of trichotillomania, a variety of medications including N-acetylcysteine have shown benefit in case reports. Combined liaison clinics, with an interdisciplinary approach, are highly advisable in the treatment of these cases.

KEYWORDS

integrative dermatology, psychodermatology, trichotillomania (hair pulling disorder), dermatoethics

Trichotillomania (TTM) is a psychocutaneous disorder characterized by the repetitive act of hair pulling causing hair loss (Huynh, Gavino, & Magid, 2013; Keuthen, O'Sullivan, & Sprich-Buckminster, 1998; Soriano et al., 1996). The name has its roots in the Greek words "thrix" meaning hair, "tillain" meaning to pull and "mania" meaning madness. In 1889, François Henri Hallopeau, a French dermatologist, first gave its name.

DSM-V diagnostic criteria include (APA, 2013):

- Recurrent pulling out of one's hair, resulting in hair loss.
- Repeated attempts to decrease or stop hair pulling.
- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
- The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder) (APA, (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing).

The disorder was recently changed from DSM IV (impulse control disorder) to be included in DSM V and the name "Hair pulling disorder" was added to it. In the DSM V, TTM has been grouped with obsessive-compulsive disorder (OCD), body dysmorphic disorder

(BDD), nail biting disorder, dermatillomania, tic disorders, and eating disorders. It has been proposed that these conditions may have an overlap of genetic predisposition, clinical features, and even treatment response (Chamberlain, Menzies, Sahakian, & Fineberg, 2007).

1 | EPIDEMIOLOGY

Although extensive epidemiological studies are lacking, it is estimated that subclinical hair pulling may be present in around 11% of the general population (Woods, Miltenberger, & Flach, 1996). Actual diagnosed cases range from 0.6 to 3.4%. A higher prevalence of TTM is reported in women (Christenson & Mackenzie, 1995).

1.1 | Possible causes and associations

Trichotillomania is now being classified under the OCD spectrum rather than under the impulse control spectrum. The exact causation and etiology is complex. Many individuals tend to pull their hair when stressed and most people report that this pulling is painless, if not, pleasurable. It has been proposed that hair pulling creates “counterirritation” to reduce the perception of stress by the brain (Christenson, Pyle, & Mitchell, 1991).

2 | CLINICAL CHARACTERISTICS

TTM has been described in the pediatric population as well as in adults (Sah, Koo, & Price, 2008). The mean age of onset is between 9 and 13 years (Altman, Grahs, & Friman, 1982; Tay, Levy, & Metry, 2004). Usually, it involves only one or two sites, but the involvement of multiple sites has been noted as well (Chamberlain et al., 2007). The scalp is the most commonly described site. The pattern of hair loss is often bizarre with angular or irregular borders (Swedo & Leonard, 1992). The “Friar Truck” appearance or tonsure pattern of alopecia on the scalp is characteristic (Sah et al., 2008). Eyebrows, eyelashes, face, limbs, pubic area, underarms, and chest hair can also be involved.

Pulling often occurs while engaged in sedentary activities and in a “trance-like” state. Hair pulling during sleep is another extreme form (Diefenbach, Mouton-Odum, & Stanley, 2002; Tay et al., 2004). Commonly, a single hair is pulled at a time and each episode of pulling can last for hours. Patients with TTM have hair shafts of varying length and shape. Usually, hairs are broken and have blunt ends. There may be minimal perifollicular erythema and hemorrhage (Mansueto, Stemmerger, Thomas, & Golomb, 1997). Overall, hair density is normal, and hair pull test is negative (Sah et al., 2008). Dermoscopy findings show localized decreased hair density, short vellus hair, broken hairs with different shaft lengths, coiled hairs, short vellus hair, trichoptilosis, sparse yellow dots which may or may not contain black dots, and no exclamation mark hairs (Abraham, Torres, & Azulay-Abulafia, 2010).

When the clinical diagnosis is challenging, biopsy and histologic examination can be considered.

A study performed by Bergfeld et al showed that specific histological findings includes trichomalacia and pigmented casts; while

nonspecific histological findings includes follicular plugging, decreased number of follicles, reversed anagen : telogen ratio, decreased number of sebaceous glands, melanoderma, increased number of fibrous tracts and vellus hairs, superficial dermal inflammation, evidence of hemorrhage, and presence of hair granulomas (Muller, 1990).

When patients admit to hair pull, the diagnosis is straightforward. The differential diagnosis includes alopecia areata, tinea capitis, traction alopecia, loose anagen syndrome, and secondary syphilis (Hautmann, Hercogova, & Lotti, 2002; Huynh et al., 2013; Sah et al., 2008; Shelleh, Khan, & Al-Hatiti, 2006).

3 | COMPLICATIONS

Some complications that can occur with TTM *include* repeated stress injury, infections, trichophagia, and trichobezoar (Chamberlain et al., 2007). Trichophagia is the medical term used to describe individuals who ingest hairs. In some cases, the ingestion can become chronic and lead to a ball of hair in the stomach called a trichobezoar. A rare presentation of this Trichobezoar is the “Rapunzel syndrome” in which the tail of the hairball extends into the intestines and can cause intestinal obstruction. Rapunzel syndrome and trichobezoar are more common in neglected children (Chamberlain et al., 2007; Mateju, Duchanova, Kovac, Moravansky, & Spitz, 2009; Pul & Pul, 1996; Sah et al., 2008; Ventura, Herbella, Schettini, & Delmonte, 2005).

4 | RELATIONSHIP WITH STRESS

While TTM may be triggered by stress, the habit itself can cause significant stress, low self-esteem, guilt, and shamefulness (Huynh et al., 2013). Some individuals perceive it as a minor problem, while in a few others, it can cause extreme isolation and depression (Chamberlain et al., 2007). Some authors have classified TTM as automatic/unconscious act, or a focused/conscious act. Most children and over 75% of adults fall into the former category. Focused hair pullers tend to pull hair that feels different from the rest (kinky, white, or odd texture) and they may also have other associated rituals such as chewing, hair licking or trichophagia (Christenson, Mackenzie, & Mitchell, 1991; Du Toit, van Kradenburg, Niehaus, & Stein, 2001; Walsh & McDougale, 2001).

5 | PSYCHOSOCIAL ASPECTS OF TRICHOTILLOMANIA

Trichotillomania (hair pulling disorder) is a very impairing and distressful condition for a patient. It causes an evident impact on quality of life, social, and psychological functioning (Diefenbach, Reitman, & Williamson, 2000; Diefenbach, Tolin, Hannan, Crocetto, & Worhunsky, 2005; Duke, Keeley, Geffken, & Storch, 2010; Franklin et al., 2008; Woods et al., 2006). Several studies have reported the tremendous psychological impact of TTM (Casati, Toner, & Yu, 2000; Diefenbach et al., 2002; Diefenbach et al., 2005; Swedo & Rapoport, 1991; Townsley Stemmerger & McCombs Thomas, 2000; Winchel, Jones,

Stanley, Molcho, & Stanley, 1992). Patients frequently experience self-isolation and avoidance due to feeling of unattractiveness caused by hair loss. TTM most commonly involves visible areas of the body such as the scalp, eyebrows, and eyelashes causing embarrassment and shame. Other negative feelings commonly identified in these patients are humiliation, fear, and guilt, which contributes to social isolation and functional impairment; becoming a vicious cycle that worsens the disease. These negative feelings impair the ability to seek help from a competent physician.

The impact of trichotillomania on social and day-to-day functioning is well documented. Franklin et al. gathers in its review "Trichotillomania and its treatment: review and recommendations" the most relevant studies evaluating this problem (Franklin, Zangbar, & Benavides, 2011). These studies have shown hair pulling as a disabling disorder, with great impact in school, work, and family functioning (Diefenbach, Tolin, Crocetto, Maltby, & Hannan, 2005; Franklin et al., 2011; Moore et al., 2009; Seedat & Stein, 1998). TTM is most commonly diagnosed during early adolescence, however; it is not rare during childhood (Walther et al., 2014; Wright & Holmes, 2003). Two large studies in pediatric population, ages 0–17, showed that TTM had a moderate impact in social and academic areas that was comparable to the adult population (Franklin et al., 2008; Walther et al., 2014). The authors conclude that although the young children are not always aware of the disorder and its consequences, the impact is significant. Thereby, physicians must be aware of this disabling disorder in the pediatric population and start an early intervention.

According to different studies, Trichotillomania (hair pulling disorder) is a highly comorbid disorder, with a lifetime prevalence of comorbid psychiatric disorder as high as 80% (Christenson, Mackenzie, & Mitchell, 1991; Houghton et al., 2016; Schlosser, Black, Blum, & Goldstein, 1994). The most common associated disorders are anxiety, major depression, substance abuse, eating disorders, post-traumatic stress disorder (PTSD), personality disorders, OCD and BDD (Christenson, Mackenzie, & Mitchell, 1994; Duke, Bodzin, Tavares, Geffken, & Storch, 2009; Ferrão, Miguel, & Stein, 2009; Houghton et al., 2016; Soriano et al., 1996). It has been reported to overlap with other OCD, such as skin picking and nail-biting (Stein et al., 2008).

The etiology of trichotillomania is not well understood yet. However, it is likely to be the results of the interaction of several factors on a single patient (genetic, psychological, social, and neurobiological) (Duke et al., 2010). As mentioned by Duke et al., it is likely that multiple independent or interrelated factors contribute to TTM. An example would be genetic predisposition to psychological stress or trauma. There is strong evidence supporting the role of genetic inheritance in the development of this condition (Cohen et al., 1995; Novak, Keuthen, Stewart, & Pauls, 2009; Ozten et al., 2015). Psychoanalysts have proposed that hair pulling is the expression of unconscious conflicts, poor object relation, and childhood traumas (Enos & Plante, 2001). In regards to childhood trauma, Ozten et al. reported a significant association of traumatic childhood events such as emotional neglect, abuse, extreme violence, sexual harassment, and intercourse with TTM (Ozten et al., 2015). Boughn and Holdom reported that 86% of individuals from a sample of 44 women with TTM had a history of violence at the onset of the disorder and 91% of them had a

previous history of trauma or violence overall (Boughn & Holdom, 2003). Another study found a higher prevalence of childhood trauma, including sexual trauma, and PTSD among 42 patients with TTM (Gershuny et al., 2006). These studies may point that childhood trauma and violence play an important role in the development of TTM. However, a more recent study by Houghton et al. evaluating the association between trauma, negative affect, and hair pulling in 85 individuals with TTM contradict previous results (Houghton et al., 2016). The study reported that history of trauma is not directly related to hair pulling severity. Even more, this study suggested that the relation between trauma and TTM is mediated by depressive symptoms. The authors concluded that rather than a direct link between this condition and trauma, TTM serves as an emotional regulatory or coping mechanism to the depressive affect brought in by trauma. A similar finding was reported in an earlier study by Diefenbach et al. who found that after controlling for depression the impairment in functioning and life satisfaction caused by TTM disappeared compared with control group (no psychiatric diagnosis) (Diefenbach, Tolin, Crocetto, et al., 2005). The results suggested that hair pulling might not be associated with significant functional impairment unless a depressive affect is present. Hopefully, more studies in patients with hair pulling disorder and other OCD will help to better understand the role of depression in this condition; nonetheless, these results point out that a comprehensive evaluation and treatment of depressive symptoms will improve the management of patients with trichotillomania.

Another etiological mechanism proposed for TTM is the neurobiological theory. In this regard, studies have been conducted with serotonergic and dopaminergic drugs (Duke et al., 2010), and is also thought to be similar to Tourette's syndrome or OCD (Enos & Plante, 2001). A hormonal link was also proposed, but research is still lacking (Stein, O'Sullivan, & Hollander, 1999).

Finally, a comprehensive evaluation of individuals with trichotillomania must be conducted by a physician trained in the field of trichopsychodermatology. This is an emerging field of psychodermatology focused on the study of the psychosocial impact of hair disorders. A detailed past medical history, including personal and familial history, and history of trauma will help in the management of this disabling and highly comorbid disorder.

6 | TREATMENT APPROACHES

Most children outgrow the habit when managed conservatively or with minimal intervention. Adults, however, are more likely to require therapy. As of now, there are no FDA approved drugs for TTM. Cognitive behavioral therapy (CBT) seems to be the most effective treatment module. Psychotherapy in the form of habit reversal techniques has emerged as an important treatment *modality*. Referral to a psychologist, psychiatrist, or psychodermatologist may be necessary in some cases.

The main components in most habit-reversal programs include self-awareness of pulling behaviors, coping strategies (addressing situations where hair pulling occurs and using alternative behaviors to avoid pulling), social support networks, relaxation therapy, and competing responses. This technique has been successful in both adult

and pediatric populations (Bloch et al., 2007). Ninan et al. conducted a randomized control trial in which one arm of patients received clomipramine or placebo, and the other arm received CBT. Patients receiving CBT showed a better response than the clomipramine or placebo arm. Also, patients on clomipramine had a better response than those on placebo. The response was assessed after a 9-weeks period, however, no follow up was done (Ninan, Rothbaum, Marsteller, Knight, & Eccard, 2000). A similar study with 43 patients compared fluoxetine and CBT. Those enrolled in CBT showed a better response than patients taking fluoxetine (Van Minnen, Hoogduin, Keijsers, Hellenbrand, & Hendriks, 2003).

6.1 | Tricyclic antidepressants

Tricyclic antidepressants block the reuptake of norepinephrine and serotonin in the brain. Swedo et al. compared clomipramine and desipramine in a double-blind, crossover study in 13 women. The study reported a significantly better response to clomipramine than to desipramine (Swedo et al., 1989). In the study conducted by Ninan et al., clomipramine showed a better response when compared with placebo. However, CBT proved to be superior to drug therapy in their study (Ninan et al., 2000). Although initially tried, these have not been first line drugs due to reduced efficacy and side-effects.

6.2 | Selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs)

SSRIs inhibit the uptake of only serotonin from the brain, while SNRIs prevent the uptake of both serotonin and norepinephrine in the brain. Christensen et al. tried fluoxetine at a dose of 80 mg/day for about 6 weeks in 21 patients with TTM. This double-blinded study concluded that fluoxetine did not prove to be efficacious in the treatment of TTM (Christenson, Mackenzie, Mitchell, & Callies, 1991). A long-term double-blind placebo controlled trial on 23 patients, fluoxetine 80 mg/day was compared with placebo. The patients were treated for 12 weeks followed by a 5-week washout period and again crossed over to the other arm of treatment. In this study, Fluoxetine did not appear to be superior to placebo (Streichenwein & Thornby, 1995). Dougherty et al. compared SSRI, CBT, and their combination. They found that combination therapy was more effective than either SSRI or CBT alone (Dougherty, Loh, Jenike, & Keuthen, 2006). Venlafaxine is an SNRI with a modest effect on dopamine receptors as well. Ninan et al. reported that the efficacy of this drug on TTM was lesser than clomipramine but better than SSRIs (Ninan et al., 1998). A meta-analysis also showed the poor efficacy of SSRIs in the treatment of TTM (McGuire et al., 2014). Thus, multiple studies have shown the poor efficacy of SSRIs in the treatment of TTM.

6.3 | Antipsychotics

These drugs act primarily on Dopamine receptors. Olanzapine was trialed in a randomized placebo controlled trial and yielded better response than placebo (Van Ameringen, Mancini, Patterson, Bennett, &

Oakman, 2010). Similar reports of successful treatment with aripiprazole are documented in the literature (White & Koran, 2011; Yasui-Furukori & Kaneko, 2011). Some authors tried risperidone after the failure of SSRIs and reported a positive response (Gabriel, 2001; Senturk & Tanriverdi, 2002). Current evidence shows that there is scope for using antipsychotics in TTM.

6.4 | Opioid antagonists

Naltrexone is an opioid antagonist that was evaluated in pediatric patients showing good results as reported by De Sousa et al.; however, subsequent studies did not yield similar results (De Sousa, 2008; Grant, Odlaug, Schreiber, & Kim, 2014). It is postulated that opioid blockers might decrease the positive reinforcement derived from hair pulling, hence decreasing the urge to pull.

6.5 | N-acetyl cysteine

N-acetyl cysteine (NAC) is a derivative of the amino acid cysteine. It is popularly used as an antidote to paracetamol poisoning, as a mucolytic, and as a reno-protective agent before contrast administration (Samuni, Goldstein, Dean, & Berk, 2013). It is a glutamate inhibitor and a well-known anti-oxidant that can synthesize glutathione in the body (Racz, Sweet, & Sohoni, 2015). NAC is also known to have anti-inflammatory effects and immunomodulatory properties (Racz et al., 2015; Samuni et al., 2013). NAC has been shown to reduce inflammation in the microglia, reducing oxidative damage (Samuni et al., 2013). Interestingly, it also reduces the release of certain cytokines such as TNF- α , IL-1 β , and NF- κ B (Dean, Giorlando, & Berk, 2011; Khan et al., 2004). Many psychiatric disorders have been associated with oxidative damage to the brain; hence NAC is being explored as a newer therapy in certain psychiatric disorders. NAC activates cysteine/glutamate antiporter increasing extra-synaptic glutamate. It also acts on the N-methyl-D-aspartate (NMDA) and 2-amino-3-hydroxy-5-methyl-4-isoxazolepropionate (AMPA) receptors. These actions, perhaps, explain its mechanism of action in OCD such as TTM (Moran, McFarland, Melendez, Kalivas, & Seamans, 2005; Samuni et al., 2013).

There are case reports describing the therapeutic benefit of using NAC in TTM (Odlaug & Grant, 2007; Rodrigues-Barata, Tosti, Rodriguez-Pichardo, & Camacho-Martinez, 2012; Silva-Netto, Jesus, Nogueira, & Tavares, 2014; Taylor & Bhagwandas, 2014). One large double-blind placebo-controlled study enrolled 50 adults who received either 1,200 mg/day of NAC over a 6-weeks period and 2,400 mg/day for another 6 weeks. The group receiving NAC had significant improvement of symptoms when compared with the control group (Grant, Odlaug, & Kim, 2009). However, when Bloch et al. used NAC for pediatric patients, they did not obtain a favorable response (Bloch, Panza, Grant, Pittenger, & Leckman, 2013). Further studies with NAC need to be done to confirm its efficacy against TTM (K Franca & Lotti, 2017b). Nevertheless, NAC appears to be a promising therapy (K Franca & Mohammad, 2017).

6.6 | Silymarin

Silymarin is a flavonoid derivative of milk thistle, an herb with medicinal properties. Grant and Odlaug have reported three cases they successfully treated TTM with silymarin (Grant & Odlaug, 2015). It is postulated that Silymarin exerts antioxidant effects and increases dopamine level by inhibiting the monoaminoxidase enzyme (MAO), thus improving symptoms of OCD (K Franca & Lotti, 2017c; Surai, 2015). A randomized control trial compared fluoxetine and milk thistle in OCD (Sayyah, Boostani, Pakseresht, & Malayeri, 2010). However, it did not find a difference in efficacy between the two.

6.7 | Other drugs

Other drugs that have been used for the treatment of TTM include fenfluramine, oxcarbazepine, topiramate, valproate, dronabinol, escitalopram, citalopram, bupropion, haloperidol, and lithium (Adewuya, Zinser, & Thomas, 2008; Chamberlain et al., 2007; Gadde, Ryan Wagner, Connor, & Foust, 2007; Grant, Odlaug, Chamberlain, & Kim, 2011; Klipstein & Berman, 2012; Leombruni & Gastaldi, 2010; Lochner, Seedat, Niehaus, & Stein, 2006; Mahr, 1993; Sharma & Corpse, 2008; DJ Stein, Bouwer, & Maud, 1997; Van Ameringen, Mancini, Oakman, & Farvolden, 1999). St. John's wort was compared with placebo in a trial of 60 patients with OCD. However, the results failed to support the efficacy of St. John's wort as monotherapy in OCD (Kobak et al., 2005). In a double-blind study conducted by Palatnik et al., Myo-inositol, when used as monotherapy, was reported to improve symptoms in patients with OCD (Palatnik, Frolov, Fux, & Benjamin, 2001).

Lately, the concept of brain-gut axis is gaining popularity. It is postulated that the microbiota in the gut communicate with the brain through the Vagus nerve. These gut bacteria are also known to produce neurotransmitters. Probiotics are being used in various fields of medicine and researchers are pondering over the thought of using probiotics in OCD and TTM (Franca & Lotti, 2017a; Wang, Lee, Braun, & Enck, 2016).

7 | ETHICAL CONSIDERATIONS

Ethical issues in the treatment of dermatologic diseases are an under-explored topic in the medical literature. In this session, the authors highlight some important ethical aspects involving the treatment of patients with trichotillomania (hair pulling disorder).

8 | OFF LABEL TREATMENTS

Since there are no FDA approved medications for the treatment of Trichotillomania, the off-label treatments are widely used. Off-label treatment refers to the use of a pharmaceutical drug for an unapproved indication, using an unapproved dosage, route of administration, or for an age group not previously approved by regulatory agencies. The majority of studies addressing off-label treatments focus on prescription drugs; it is important to remember that over-the-counter drugs can also be used in off-label ways (Gupta & Nayak, 2014). These prescriptions are legal and common worldwide, but

during the past two decades, there have been numerous conflicting ideas and controversies about off-label use of medications.

The disadvantages and controversies involving off-label medications are related to the efficacy and safety of these drugs since they are used without the approval of regulatory authorities. Another disadvantage is that they can also significantly increase health care costs and discourage evidence-based practice. Stafford points out that the off-label drugs "undermines the incentives for manufacturers to perform rigorous studies—and instead subtly encourages them to game the system by seeking approval for secondary indications for which clinical trials are less complicated and less expensive" (Stafford, 2008).

On the other hand, the prescription of off-label treatments allows physicians to offer to their patients new therapeutic options based on the latest scientific evidence. Physicians can adopt these new treatments based on new and emerging evidence and credible studies; innovating their clinical practices and giving patients different options (Mithani, 2012).

Whether to inform or not inform a patient that he or she will receive an off-label medication has been the subject of debate for a long time. Often patients are not correctly informed that the treatment they are receiving was not approved for that condition. Not informing the patient could be considered an ethical issue that affects the patient's informed consent right (Mithani, 2012; Veatch, 1997). Disclosing the information about that treatment protects patient's autonomy and educates them about risks, safety, and alternatives (Wilkes & Johns, 2008). Other researchers argue that informing patients about the off-label treatment could divert their attention to irrelevant information and confound their decision-making. Off-label prescribing is common in dermatology practice (Sugarman, Fleischer, & Feldman, 2002). From these data, we conclude that it is currently within the standard of care to use off-label prescriptions in the treatment of trichotillomania; however, there is no consensus about the need of informing patients about this practice.

9 | DISTANCE THERAPY

Trichotillomania (hair pulling disorder) is not considered treatable by general psychotherapy or psychoanalytic psychotherapy. The most effective method available is cognitive behavioral therapy such as habit reversal therapy and stimulus control therapy (Snorrason, Berlin, & Lee, 2015). Unfortunately, there are few trained and specialized therapists that know how to appropriately treat this condition. Many patients experience difficulties to find qualified professionals and access to treatment. With the advances in technology, online and telephone therapies have become a popular way for treating these patients. Online and telephone therapy have been found to be effective and cost-effective in many studies. A study performed by Seol et al. investigated the effectiveness of the Internet-Bases Cognitive Behavioral Therapy (ICBT) for Obsessive Compulsive disorders in Korea. The patients showed significant improvements in OCD, depressive symptoms, and in work/social functioning after ICBT completion. This method was found to have similar effectiveness for patients with moderate OC symptoms and little treatment experience (Seol, Kwon, Kim, Kim, & Shin, 2016). Andersson et al. conducted an

open trial where patients received a 15-week ICBT program with therapist support consisting of psychoeducation, cognitive restructuring, and exposure with response prevention. The authors reported a reduction in the OCD symptoms, depressive symptoms, and improvement in the general functioning of these patients (Andersson et al., 2011).

These emerging modalities of treatment have been widely discussed from the ethical perspective. The American Psychological Association states that the ethics codes for distance therapy should follow the same standards of face-to-face treatment. This includes: "standards on informed consent, competence to practice, confidentiality, not harm, and how terminations, interruption of service, and payment arrangements are handled." As a practical matter, it is extremely difficult to monitor if these ethic codes are being followed. These treatments modalities are considered legal in multiple countries and states, and are becoming more and more popular during the last decade. Psychological associations are offering continuing education workshops on these topics. This is certainly a complex issue, and further discussion is necessary (Nakagawa et al., 1994).

10 | MANAGING DIFFICULT PATIENTS

Patients facing psychological challenges are often perceived as "difficult" by their treating physicians. Between 15% and 60% are considered challenging; psychiatric pathology is the usual explanation for these challenging encounters (Fiester, 2012). Patients experiencing hair pulling disorder often feel ashamed, stigmatized, embarrassed, and isolated. Hence, it is not uncommon for patients to deny pulling their hair. This can make the diagnosis more difficult and can bring tension to the doctor-patient relationship. General dermatologists often do not feel comfortable managing these cases and patients are better assisted by psychodermatologists when available (França et al., 2017).

Despite the challenging relationships that a patient and a doctor may develop, it is important to remember that refusing to assist a patient, not making efforts, and not taking time to understand the patient are not consistent with the ethical principle of beneficence. This concept is of the primacy of patient welfare or the obligation of the profession to care for the sick (Hood, 2008). Patient-centered relationships are a primary emphasis of bioethics. Altruism should be the essence of professionalism. The best interest of patients is the rule, not the physician's self-interest (DeVoti et al., 2008).

11 | FUTURE DIRECTIONS

It is expected that in the next decade more attention will be given to Trichotillomania (hair pulling disorder). Some possible future directions are listed below:

- New studies and development of protocols for existing drugs
- Development new treatment options
- Development of epidemiologic, genetic, neuroimaging, and diet studies

- Changes in the classification and nomenclature. The term "trichotillomania" may be replaced for "Hair Pulling Disorder" or "Neuro-mechanical Alopecia" (Walling & Swick, 2007)
- Further discussion about Ethical aspects of Trichotillomania with a multidisciplinary team
- Training of more therapists and psychodermatologists specialized in Trichopsychodermatology

12 | CONCLUSION

Trichotillomania (hair pulling disorder) requires a comprehensive treatment plan and interdisciplinary approach. Although basic questions concerning etiology, epidemiology, subtypes, and pharmacotherapy are still to be answered, there is a dire need of systematic and controlled epidemiological studies. During the treatment process, the physician should have a non-judgmental, empathic, and inviting attitude toward the patient. Recent interest in different pharmacological agents for the treatment of trichotillomania shows hope toward better treatment options. The role of psychiatry-dermatology liaison clinics is extremely important with concomitant patient and parent (In case of pediatric patients) support services in place.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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