



## Chronic hair-pulling: Phenomenology-based subtypes

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### ABSTRACT

Distinct subtypes of trichotillomania (TTM)/chronic hair-pulling may exist. The aim of this study was to extend an earlier analysis by our group to a larger sample of patients with chronic hair-pulling, and to assess the validity and clinical utility of several putative subtypes. Eighty patients with various putative hair-pulling subtypes were compared on sociodemographic and clinical variables. Gender and disability due to pulling accounted for a number of important differences; for example, females more commonly had earlier age of onset of pulling, less comorbidity, and more disability than males. Also, those who met DSM-IV criteria B and C of TTM appeared to have a more disabling course of illness than those who did not. These data appear to support a dimensional rather than a categorical approach to subtyping. Future work, incorporating further investigation of the role of gender and psychobiological and treatment outcomes, is needed before definitive conclusions about hair-pulling subtypes can be drawn.

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### 1. Introduction

In the 4th edition of the Diagnostic and Statistical Manual (DSM-IV), trichotillomania (TTM) is characterized by recurrent pulling of one's hair resulting in noticeable hair loss, tension prior to or during pulling, and pleasure, relief, or gratification when pulling, and significant impairment or distress in social, occupational, or academic functioning as a result of pulling (American Psychiatric Association, 1994). The inclusion of TTM in the DSM gave impetus to increased research on this disorder. More recently, a number of authors have suggested that TTM is a heterogeneous disorder and that there may be distinct hair-pulling subtypes or styles (e.g. Christenson & Crow, 1996; Christenson & Mackenzie, 1994; Christenson, Mackenzie, & Mitchell, 1991; Du Toit, van Kradenburg, Niehaus, & Stein, 2001a). For example, given that not all hair-pulling patients meet criteria B and C of DSM-IV, one putative subtype may be patients with or without tension beforehand and relief during/after pulling (e.g. Christenson et al., 1991; Reeve, Bernstein, & Christenson, 1992). Valid subtyping may lead to improvements in our understanding of TTM and to more targeted treatments (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2008).

In a previous study by our group that aimed to detail the sociodemographic and phenomenological features of 47 adult subjects with chronic hair-pulling (Du Toit et al., 2001a), 81% of

whom met criteria for a DSM-IV diagnosis of TTM, possible key subtypes were identified a priori based on existing theory. For example, it has been suggested that TTM may be subtyped according to the age of onset of pulling, with patients with early-onset presenting with phenomenological and course differences compared with those with late-onset of hair-pulling (e.g. Sah, Koo, & Price, 2008). Hair-pulling in males may also differ from that in females, particularly in terms of comorbid characteristics such as tics (Christensen, Mackenzie, & Mitchell, 1994). The literature also suggests other contrasts; TTM is typically conceptualized as a behavioural syndrome whereas chronic hair-pulling is conceptualized more as a behavioural symptom with a number of pathogeneses (O'Sullivan et al., 1997). Previous research has also shown significant differences between "focused" (i.e. with a compulsive quality) and "automatic" (i.e. with decreased awareness) pulling styles (e.g. Flessner, Conelea, et al., 2008). Hair-pulling styles may also have distinct cue profiles – e.g. negative affective states may in some cases trigger hair-pulling (Mackenzie, Ristvedt, Christenson, Lebow, & Mitchell, 1995). Investigation of such contrasts has, to date, provided limited support for the existence of some of these putative subtypes of chronic hair-pulling. More specifically, it has been suggested that distinct clusters of hair-pulling-related behaviours may exist (e.g. hair-pullers with vs. those without automatic/focused hair-pulling, oral habits, and comorbid self-injurious behaviours). At the same time, it has been noted that some of these contrasts may simply reflect greater severity in hair-pulling symptomatology rather than distinct subtypes of chronic hair-pulling. However, given the small sample sizes across these studies, there may have been insufficient power to delineate such categorical subtypes of TTM.

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The aim of the present study was to extend the analysis of Du Toit et al. (2001a), to a larger sample of patients with hair-pulling. We hoped to compare patients who did and did not fall into previously proposed hair-pulling subtypes, on a range of socio-demographic and clinical features (including hair-pulling symptom severity, DSM-IV Axis I comorbidity, and impact on functioning).

## 2. Materials and methods

The Institutional Review Board of the University of Stellenbosch (South Africa) approved the protocol, and all subjects provided written informed consent after being presented with a complete description of the study.

### 2.1. Subjects

Patients, with ages ranging from 18 to 71 years, were referred to our Unit from a wide range of sources including the SA Depression and Anxiety Group, specialist psychiatrists, and community based primary care practitioners, and recruited through media advertisements and with the assistance of the Mental Health Information Centre (MHIC) of South Africa. After obtaining voluntary consent for participation, patients with chronic hair-pulling were included in the study, irrespective of whether they met criteria B (increasing tension) and C (resulting gratification) of the TTM diagnostic criteria in DSM-IV (American Psychiatric Association, 1994). Patients with a history of psychosis, inadequate understanding of the aims and practical implications of participation, or who were unwilling to provide consent, were excluded. All patients were interviewed by a clinical psychologist or other mental health practitioner with expertise in the TTM field.

### 2.2. Interview material

Demographic data, including current age, age at onset of the illness, gender and ethnicity, were obtained. The Structured Clinical Interview for Axis I Disorders – Patient version (SCID-I/P) and the SCID-II/P were used to assess other lifetime comorbid Axis I- and II-disorders (First, Gibbon, Spitzer, Williams, & Benjamin, 1994; First, Spitzer, Gibbon, & Williams, 1998). The Structured Clinical Interview for putative obsessive-compulsive spectrum disorders (SCID-OCDSD) (Du Toit, van Kradenburg, Niehaus, & Stein, 2001b) was implemented to assess the (lifetime) presence of TTM or chronic hair-pulling as well as comorbid OCD-related conditions not covered by the SCID-I/P. The Trichotillomania Behaviour Profile (TBP, available from the first author upon request) which focuses on a broad range of areas of importance to individuals with hair-pulling symptoms was also administered. The TBP include questions assessing the phenomenology of participants' hair-pulling, stressors associated with pulling, and comorbidity (e.g. anxiety and other behaviours, such as skin-picking and nail-biting). The psychometric properties of this scale have not yet been investigated. The Massachusetts General Hospital Hair-pulling scale (MGHHPs) (Keuthen et al., 1995), a seven-item patient-rated scale, was the primary measure of TTM symptom severity. MGHHPs items focuses on respondents' ratings of the frequency and intensity of their urges to pull, their ability to control these urges, the frequency of actual hair-pulling, the frequency of attempts to resist pulling and ability to control their pulling and their level of associated distress. The MGHHPs demonstrates good internal consistency (Keuthen et al., 1995), excellent test-retest reliability, strong convergent and divergent validity and sensitivity to change in hair-pulling symptoms (O'Sullivan et al., 1995). The Yale-Brown Obsessive-Compulsive Symptom Severity Scale (YBOCS-SS), a clinician-rated 10-item scale with each item rated from 0 (no symptoms) to 4 (extreme

symptoms), with separate subtotals for severity of obsessions and compulsions, was used as an additional measure of illness severity (Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). The YBOCS-SS possesses good reliability and validity, and is sensitive to treatment effects (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989).

The Disability Profile (Schneier et al., 1994) was used to assess functional impairment and disability due to hair-pulling. This questionnaire assesses current and lifetime impairment in eight (8) life domains and each item is rated separately for current (i.e. the past 2 weeks) and lifetime disability on a 5-point descriptively anchored Likert-type scale ranging from 0 (no impairment) to 4 (severe impairment). The eight domains assessed are school, work, family life, marriage/dating, friendships, "other interests" (i.e. sport, hobbies, etc.), activities of daily living (e.g. hygiene, shopping, etc.) and suicidal behaviour. The scale possesses a Cronbach's alpha for lifetime and current disability subscales ranging from 0.87 to 0.92 and good concurrent validity with standard scales of social phobia symptoms and disability (Schneier et al., 1994).

### 2.3. Data analyses

Regarding age of onset criteria, there is presently no agreement in the literature regarding the age that defines early-onset of TTM. Chi-square, *t*-tests and analyses of variance (ANOVAs) were performed to investigate hair-pulling related phenomenology of the different putative subtypes. Non-parametric analyses (Spearman's ranked correlations) were performed to investigate the relationships between variables related to hair-pulling. As this was an exploratory study, corrections for multiple testing were not applied.

## 3. Results

Eighty ( $n = 80$ ) patients with self-reported chronic hair-pulling (7 male, 73 female), with ages ranging from 18 to 71 years (mean: 34.08 years, SD: 10.58) were included in the analyses, irrespective of whether they met DSM-IV criteria for TTM. In terms of education level and ethnicity, data from 78 participants were available. Five ( $n = 5$ , 6.4%) reported completion of grades 8–10, whereas 36 (45.2%) finished grades 9–10 (the equivalent of 11–12 years of schooling). Thirty seven ( $n = 37$ , 47.4%) participants had successfully completed their tertiary education (including college or university training). Most participants were of Caucasian origin ( $n = 68$ , 87.2%); non-Caucasians comprised mixed race or Black ( $n = 6$ ), Indians ( $n = 2$ ) and "other" ( $n = 4$ ) (e.g. Portuguese, Italians, etc.). All participants that were screened were eligible for inclusion in the study.

### 3.1. Sociodemographic characteristics

#### 3.1.1. Age of onset: Early vs. late age of onset

For the entire sample, the mean reported age of onset of hair-pulling was 14.45 years (SD = 8.20), ranging from 2 to 50 years. We, therefore, chose 14 years as the threshold between early-onset and late-onset hair-pulling, with an age of onset of 14 years or younger representing early-onset hair-pulling, and older than 14 years representing late-onset hair-pulling. In our sample, almost two thirds ( $n = 55$ , or 68.8%) presented with early-onset hair-pulling. Patients with early-onset hair-pulling reported more functional impairment in terms of "other interests" such as hobbies and sport ( $1.13 \pm 1.04$ ) than those with late-onset ( $0.5 \pm 0.97$ ;  $t = 0.21$ ,  $p = 0.04$ ). The two groups did not differ significantly in terms of hair-pulling severity or comorbidity.

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