



ELSEVIER

Contents lists available at [SciVerse ScienceDirect](http://www.sciencedirect.com)

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Prevalence, phenomenology and diagnostic criteria of hair-pulling in an Italian non-clinical sample: A preliminary study

Marta Ghisi ^{a,*}, Gioia Bottesi ^a, Claudio Sica ^b, Allison J. Ouimet ^c, Ezio Sanavio ^a

^a Department of General Psychology, University of Padova, Via Venezia, 8, 35131 Padova, Italy

^b Department of Psychology, University of Firenze, Via di San Salvi 12, Complesso di San Salvi Padiglione 26, 50135 Firenze, Italy

^c Department of Psychology, Concordia University, 7141 Sherbrooke St. West Montreal, QC, Canada H4B 1R6

ARTICLE INFO

Article history:

Received 13 June 2012

Received in revised form

19 September 2012

Accepted 26 September 2012

Available online 26 October 2012

Keywords:

Hair-pulling

Prevalence

Phenomenology

Diagnostic criteria

Non-clinical sample

ABSTRACT

To date, trichotillomania prevalence and phenomenology have not received enough attention in European culture. Although trichotillomania occurs on a severity continuum, few studies evaluated it within non-clinical samples. Studies examining trichotillomania have varied in the criteria used to establish a diagnosis, making it difficult to estimate current prevalence rates. The present study assessed hair-pulling prevalence at varying levels of diagnostic stringency, affective states during the hair-pulling cycle, pulling sites, and environmental cues most frequently endorsed in an Italian non-clinical sample.

Five-hundred and twenty non-clinical subjects completed an ad-hoc self-report measure assessing hair-pulling phenomenology. Hair-pulling prevalence was 16.5% when only non-cosmetic hair avulsion was considered and 2.1% when adding the achievement of both criteria B and C of DSM-IV-TR. A decrease in tension after pulling, but not an increase when attempting to resist the urge to pull emerged; positive affective states were experienced also following hair-pulling, not only during hair-pulling. Scalp and eyebrows, and studying/reading, watching TV and speaking on the phone were the pulling sites and the environmental cues most frequently endorsed, respectively. The present prevalence ratios are comparable with those reported in literature suggesting that criteria B and C might be too restrictive, and supporting their removal from DSM-5.

© 2012 Elsevier Inc. All rights reserved.

1. Introduction

Hair-pulling behaviors lie on a continuum ranging from a subclinical pole, characterized by unnoticeable and non-distressing hair avulsion, to a pathological one, characterized by chronic, noticeable and significantly distressing hair avulsion from different body areas (Stanley, Borden, Bell, & Wagner, 1994; Stanley, Borden, Mouton, & Breckenridge, 1995). The latter pole of such a continuum is usually referred to as trichotillomania¹, a disorder that was first included as a possible diagnosis in the diagnostic and statistical manual of mental disorders, third ed.-revised (DSM-III-R; American Psychiatric Association, 1987). Presently, trichotillomania is included within impulse-control disorders not elsewhere classified. However, several authors have suggested it may belong within the obsessive-compulsive spectrum disorders because of research demonstrating similar phenomenological and psychobiological characteristics (Ferrao, Miguel, & Stein, 2009; Lochner et al., 2005;

* Corresponding author. Tel.: +39 049 827 6037; fax: +39 049 8276 600.

E-mail address: marta.ghisi@unipd.it (M. Ghisi).

¹ In the current paper the terms “trichotillomania” and “hair-pulling disorder” will be used interchangeably as “trichotillomania” is currently adopted in the DSM-IV-TR, whereas “hair-pulling disorder” is the new established name for trichotillomania in the DSM-5.

Stein, 2000). The current diagnostic criteria described in the diagnostic and statistical manual of mental disorders, 4th ed.-text revision (DSM-IV-TR; American Psychiatric Association, 2000) for trichotillomania include: noticeable hair loss (alopecia) due to recurrent hair-pulling (Criterion A); feeling tension immediately before hair-pulling, or when attempting to resist hair-pulling (Criterion B); feeling pleasure or gratification associated with hair-pulling (Criterion C); hair-pulling not due to another medical or mental disorder (Criterion D); significant distress or impairment in social, occupational, or other important areas of functioning due to recurrent hair-pulling (Criterion E).

However, several studies have highlighted the inadequacy and excessive rigidity of these criteria (Christenson, Mackenzie, & Mitchell, 1991; Christenson & Mansueto, 1999; Christenson, Pyle, & Mitchell, 1991; Duke, Bodzin, Tavares, Geffken, & Storch, 2009; Franklin et al., 2008; Lochner, Seedat, & Stein, 2010; Schlosser, Black, Blum, & Goldstein, 1994; Stanley et al., 1995; Woods et al., 2006), as well as their minimal ability to predict symptom severity or functional impairment (Stein et al., 2010). Therefore, some authors have suggested that criteria B and C may be of little clinical or diagnostic use and validity. Rather, they recommend excluding these two criteria from the DSM-5 (Lochner et al., 2010). As such, many clinicians have diagnosed trichotillomania, even in the absence of criteria B and C (Conelea et al., 2012). Furthermore,

Stanley et al. (1995) posited that the emotional changes which take place following hair-pulling are more salient in hair-pulling phenomenology than are the emotional changes experienced during hair-pulling (as stated in the DSM-IV-TR). Finally, other affective correlates (i.e., boredom, anxiety, anger, embarrassment, discomfort, sadness, or frustration) in addition to those described in the DSM-IV-TR criteria (tension, relief and pleasure) emerged to play an important role in the pulling cycle (Christenson, Ristvedt, & Mackenzie, 1993; Diefenbach, Mouton-Odum, & Stanley, 2002; Duke et al., 2009; Duke, Keeley, Geffken, & Storch, 2010; Mansueto, McCombs-Thomas, & Brice, 2007; Stanley et al., 1995). Taken together, the extant research suggests that a revision of the current criteria for trichotillomania may be warranted.

Hair-pulling disorder is considered a relatively rare psychological disorder. However, its prevalence is still largely unclear for several reasons: (1) the use of more or less stringent diagnostic criteria across studies; (2) the poor availability of standardized diagnostic tools; (3) the secretiveness and shame associated with hair-pulling, which likely leads to underreporting; and (4) small sample sizes, which impair the generalization of findings (Duke, Keeley, Geffken, & Storch, 2010). Across studies, prevalence rates of hair-pulling disorder ranged from .6% to 15% (Christenson et al., 1991; Duke et al., 2009; Duke et al., 2010; Graber, & Arndt, 1993; Mansueto et al., 2007; Rothbaum, Shaw, Morris, & Ninan, 1993; Stanley et al., 1994, 1995; Woods and Miltenberger, 1995), depending on the rigidity of the diagnostic criteria adopted.

Results related to the gender distribution of hair-pulling disorder are inconsistent: male to female ratios ranged from about 1:10 (Christenson, 1995; Christenson, Mackenzie, & Mitchell, 1994; Cohen et al., 1995; Lochner et al., 2010; Schlosser et al., 1994; Stanley et al., 1994; Swedo & Leonard, 1992) to about 1:2 (Christenson et al., 1991; Christenson et al., 1991; Duke et al., 2009; Graber & Arndt, 1993; King et al., 1995). It is important to note that women are generally more represented in clinical samples of patients suffering from trichotillomania (Christenson & Crow, 1996; Keuthen, Stein, & Christenson, 2001; Lochner et al., 2010; Odlaug, Won Kim, & Grant, 2010; Miltenberger, Rapp, & Long, 2006; Stanley et al., 1994; Swedo, Leonard, Lenane, & Rettew, 1992). However, research within a college student sample evidenced a 1:4 male to female ratio (Duke et al., 2010). Moreover, Duke et al. (2009) found a male to female ratio of 1:1 in a community sample; however, all participants who reached clinical levels of the disorder were female. As such, although research has generally demonstrated that the gender distribution of hair-pulling disorder varies with disorder severity, males and females have been reported to show comparable phenomenology (Christenson et al., 1994; Duke et al., 2009).

According to the DSM-IV-TR, chronic hair-pullers may differ with regard to pulling sites. The area most commonly involved is the scalp (generally from peripheral to central zones); however, hair-pulling often occurs from eyelashes, eyebrow, pubic regions, the chest and the limbs, at times resulting in total absence of hair from some of these regions (du Toit, van Kradenburg, Niehaus, & Stein, 2001; Flessner et al., 2008; Flessner et al., 2008; Schlosser et al., 1994; Stanley et al., 1994). In males, other areas include beard and moustaches (Lochner et al., 2010; Mansueto et al., 2007). Seldom do subjects pull hair when other people are present (except for close relatives), because they are embarrassed about their behavior (Casati, Toner, & Yu, 2000; Christenson et al., 1991). Indeed, hair-pullers often avoid social situations (Christenson & Mansueto, 1999; du Toit et al., 2001; Keuthen et al., 2001; Townsley-Stemberger, McCombs-Thomas, Mansueto, & Carter, 2000; Winchel, Jones, Stanley, Molcho, & Stanley, 1992).

In the literature, two main styles of hair-pulling have been identified (Christenson & Crow, 1996; Christenson et al., 1994, 1991, 1993; Diefenbach et al., 2002; du Toit et al., 2001; Flessner et al., 2008; Flessner et al., 2008; Mansueto, Townsley-Stemberger,

McCombs-Thomas, & Goldfinger-Golomb, 1997; Woods et al., 2006): focused-pulling and automatic/habitual-pulling. Focused-pulling is phenomenologically similar to compulsions observed in obsessive-compulsive disorder (OCD). It is associated with an increase in tension before hair-pulling or when attempting to resist the urge to pull hair, and with relief after pulling. The attention of affected subjects is focused on the pull, thus distracting them from other tasks. Therefore, pulling represents a dysfunctional strategy that subjects carry out to cope with unpleasant emotions (Duke et al., 2010; Woods, Wetterneck, & Flessner, 2006). Automatic/habitual-pulling occurs when individuals pull hair without consciousness and in the absence of the urge to pull. It is the predominant style of patients (about 3/4; Christenson & Crow, 1996; Christenson et al., 1994; Minichiello, O'Sullivan, Osgood-Hynes, & Baer, 1994) when they are bored or when they are performing some sedentary or contemplative activities, such as reading, speaking on the telephone, driving, and watching television. Nevertheless, it is important to note that most patients have a mixed clinical condition, characterized by both styles (Christenson & Crow, 1996; Flessner et al., 2008).

The identification of pulling sites, environmental cues, and affective states involved in the pulling cycle and dominant hair-pulling subtype might improve assessment and treatment methodologies. According to the cognitive-behavioral model (Mansueto et al., 1997), such cues may act as inducing and maintaining factors of hair-pulling behavior. Indeed, eliciting (triggers) and discriminative (facilitators) conditioned stimuli consist of both external stimuli, such as particular places (bathroom, car, library), situations (reading, lying in bed, studying, watching television, being alone) or objects (mirrors or tweezers), and internal stimuli, such as emotional state, proprioceptive sensations, urges, cognitions, and postures. Finally, the consequences of hair-pulling may be either positively or negatively rewarding. In the former case, the enhanced probability of subsequent hair-pulling may be due to the achievement of positive affective states symmetry, or orderliness, whereas in the latter case, it may be due to distraction from negative and aversive private experiences.

Despite many studies having identified hair-pulling cues and phenomenological features, additional normative resources drawn from community samples may better clarify the continuum of hair-pulling phenomenology. Therefore, studying hair-pulling behaviors in a non-clinical sample may help to improve both assessment adequacy (by detecting internal and external cues and idiosyncratic characteristics of hair-pulling) and treatment efficacy (by introducing targeted cognitive-behavioral techniques on the basis of specific phenomenological features). Furthermore, most studies focused on hair-pulling were conducted within the United States. Indeed, to the authors' knowledge, no study assessing prevalence and phenomenology of the hair-pulling continuum has been performed in European countries to date. Therefore it would be interesting to investigate the presence of possible cross-cultural commonalities or differences in hair-pulling characteristics.

Therefore, the present preliminary study was designed to assess the prevalence rates in an Italian non-clinical sample when varying the stringency of diagnostic criteria as reported in the literature. The second goal was to investigate the male to female ratio. The third goal was to analyze the emotional changes that characterize the hair-pulling cycle. The final goal was to assess which hair-pulling sites and environmental cues are most frequently endorsed.

2. Methods

2.1. Participants

The sample included 520 participants from the community, living in different towns across Northern and Southern Italy (33.5% male). Participants reported a

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات