

Trichotillomania and trichophagia – diagnosis, treatment, prevention. The attempt to establish guidelines of treatment in Poland

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Summary

Trichotillomania is a disorder characterised by inability to control over pulling own hair from various parts of a body resulting in noticeable hair loss. Due to its long-term, progressive course, untreated trichotillomania can lead to disturbances in the functioning of patients and complications which are dangerous to life and health. Due to the ambiguous nature of the symptoms, they often remain unrecognised by clinicians. Most patients are afraid of revealing symptoms and reluctantly seek for professional help.

In our opinion, it is necessary to increase the awareness of the disorder of physicians of different specialties to improve the detection, treatment efficacy and to prevent dangerous complications of trichotillomania.

This paper summarises the current state of knowledge on the epidemiology, aetiology, clinical presentation, and treatment of trichotillomania. It is also an attempt to create guidelines in all cases of suspected trichotillomania – adapted to Polish conditions. It also highlights the importance of a multidisciplinary treatment as a condition of effectiveness of the therapy and prevention of relapse.

Keywords: trichotillomania, guidelines

Introduction

Trichotillomania is a disorder characterised by inability to control over pulling one's own hair from various parts of a body resulting in noticeable hair loss. One of the diagnosis criteria are attempts to reduce the severity of the behaviour – often with time limited effectiveness. Usually hair pulling is preceded by mounting tension and consequently brings relief or gratification [1].

Often – except of pulling hair – the disorder is associated with the presence of repetitive hair rituals, such as their biting, chewing, swallowing or playing with them. Although the problem affects the hairy parts of the head predominately (75%), some patients pull hair from other parts of the body – such as the eyebrows (42%), eyelashes (53%), chin (10%), pubic region (17%). Typically, patients pull hair from more than one area of the body [2]. Alopecia caused by trichotillomania has different severity – from unobtrusive (pulling single hair from small areas) to significant (massive, visible defects of the head or body hair).

Trichotillomania is rare as the isolated disorder. Often it is a part of broader spectrum of Body-Focused Repetitive Behaviour (BFRB) – involving repetitive autostimulatory activities such as pulling, tearing, biting and/or scratching hair, skin or nails, resulting in body injuries [3]. It estimates that 5 to 20% of trichotillomania cases are accompanied by trichophagia – associated with compulsive or impulsive eating of parts (tips, roots), or the whole (bunches) of hair [2, 4, 5]. In extreme cases – mainly in children and patients with associated psychiatric diagnoses – the ones may also eat hair of other people, animals or hair found in the environment.

The untreated disorder leads to deterioration in social, occupational and other areas of patient functioning. Long-term complications may result in deterioration of general health, and – sometimes – the need for surgical intervention [1]. For proper diagnosis it is necessary to exclude other somatic conditions (e.g. dermatological diseases), or other psychiatric disorders (e.g. dysmorphophobia, delusional disorder), which could explain progressive hair loss.

Despite its relatively high prevalence [6, 7] and potentially serious health and socio-economical complications of the disease, researchers' interest in this issue is low. Approximately 30–40 works on trichotillomania are introduced to PubMed database per year. Of this number, original works dedicated to the diagnosis and/or treatment represent less than a half, the rest of them are mainly review papers and case studies.

Polish publications in this field are limited to a single original papers or case reports (since 2000 there were only three original works on trichotillomania introduced to the PubMed database) [8–10].

The only meta-analysis on the effectiveness of available forms of trichotillomania therapy from 2007 does not include all available treatment methods of the disorder [11]. Few publications on the disorder and insufficient knowledge about trichotillomania among doctors of various specialties, in our opinion, justify taking

of this subject in this paper. An effort of a multidisciplinary team of authors was also to establish the guidelines for the management of trichotillomania – adapted to the Polish health care.

Epidemiology

It is difficult to assess the prevalence of this phenomenon – because of the reluctance to disclose the problem by patients, diagnostic difficulties and imprecise diagnostic criteria. Assuming strict diagnostic criteria for DSM-5 (including sense of growing tension preceding hair pulling) its prevalence is estimated at 0.6%. Considering cases of disorders that do not meet all the necessary criteria, however, still causing a noticeable hair loss, discomfort and patients' dysfunctions in the environment, the frequency of the phenomenon is estimated at 1.5% of men and 3.4% of women. These data probably better reflect the scale of the phenomenon [7]. An anonymous questionnaire survey conducted in the US population estimated the incidence of the trichotillomania-type behaviour at a level of more than 6% [6].

There is a lack of epidemiological studies large enough to assess the disorder prevalence in the paediatric population. It is, however, emphasised, that it occurs in this age group much more frequently than in adults [12]. There are no Polish data on a scale of disorder prevalence. Indirectly, it can be inferred on the basis of a number of patients under dermatological care. Approximately 11% of Polish dermatologists have regular contact with patients from this group and 68% met them throughout their career [10]. There are no statistics describing patients remaining under psychiatric care. A bimodal distribution of disease is suggested – with the “peaks” in periods of early childhood and adolescence. Incidence peaks occur at the age of 4 and 17 years and the medium age of the symptoms disclosure is between 11 and 13 years [12, 13]. It is believed that the earlier onset of symptoms is usually associated with a milder course and a better prognosis, later one – often with more severe symptoms, treatment resistance and morbidity [14].

Most researches confirm that the disorder is more common in women [6, 7, 13]. The imbalance increases with age and it is estimated that in adults the ratio is up even to approximately 10:1 [1]. Some researchers believe, however, that the gender imbalance of disorder prevalence is not so high – only the frequency of disorder disclosure among male patients differs. It is assumed that it is easier for men to conceal the presence of the problem (e.g. by shaving areas affected by disorder) as well as less spontaneously seek for an expert guidance.

The vast majority of patients with trichotillomania meet the criteria for at least one independent axis I diagnosis of DSM [2, 13]. Most often, the comorbidity include depressive disorders (37%–65%), anxiety disorders (55–60%), addiction (over 30%) and eating disorders [2]. Such a high and varied comorbidity is the starting point for an exploration of the trichotillomania aetiology.

Aetiology

In trichotillomania aetiology, the genetic, environmental and temperamental factors are distinguished. High prevalence compatibility among monozygotic twins, estimated at approximately 38%, accounts for genetic background [15]. There are also positive results of molecular studies which confirm the presence of mutations in genes involved in neurodevelopmental processes or synaptic functions [16]. Neuro-imaging studies indicate changes in gray matter density in striatal, hippocampus and amygdala regions [16].

The studies indirectly confirm the complexity of neurotransmission impairment, including malfunction of serotonergic, dopaminergic, glutamatergic systems [14].

Attempts of psychological explanation of the phenomena include emotional regulation mechanisms – with emotional tension among others. That makes understanding of trichotillomania mechanisms similar to those observed in obsessive-compulsive disorders [17, 18]. Another hypothesis takes into account an autostimulation mechanism, which is more common in form of a disease with more automated nature of symptoms [16]. Trichotillomania symptoms may also be understood as a response to stressors. However, the lack of overt pathology in the patient's environment does not exclude the likelihood of developing symptoms. Currently used diagnostic systems (DSM-5 and ICD-10) classify trichotillomania as the impulse control disorder – emphasising its relationship to obsessive-compulsive cluster. However, there are insufficient empirical data to confirm this relationship. There are several alternative hypotheses – each of them partly explains clinical picture, course and response to treatment of trichotillomania.

Trichotillomania as an OCD spectrum disorder

Aetiological relatedness for these two disorders is supported by: overlapping and similar comorbidity, family occurrence of spectrum disorders and response to treatment [18]. Both trichotillomania and OCD are characterised by repetitive, purposeful behaviours, causing discomfort or dysfunction. Similarly to OCD – in trichotillomania behaviour (hair pulling) is often preceded by a sense of growing tension that is released through behaviour. In neuroimaging scans similar changes in patients with trichotillomania, Tourette syndrome and OCD are being described [17]. Linking of these two disorders is reflected in drug trials with serotonin reuptake inhibitors (SSRIs) as the primary therapeutic strategy. Unfortunately, the existing research results on effectiveness of this type of treatment are ambiguous – most research evaluate it as inadequate [19]. Different biological background is also confirmed by clinical observations: no obsessive thoughts prior to behaviour, a frequent gratification (instead of reduction of tension and anxiety) after performing an action, constant time-invariant image of rituals, a significant female predominance among

those affected by the disorder, the beginning of the disorder often in adolescence [20]. Clinical differences between these two patient groups are also confirmed by rarely observed symptoms other from the OCD spectrum (an isolated symptom), anxiety disorders and mood disorders in trichotillomania patients. Comparing to OCD patients – experienced sexual violence and non-adaptive cognitive schemas are less likely to be revealed among trichotillomania patients, more often – a greater need to novelty-seeking is present [20].

Trichotillomania as a behaviourally conditioned disorder (habit)

An alternative explanation for trichotillomania symptoms is recognising them as a habit, which has been developed during a learning process. They may also be understood as a trained stress coping strategy – using behaviours regulating an emotional tension [14]. The main evidences in favour of this theory are the results of studies demonstrating the efficacy of behavioural therapy in the treatment of trichotillomania. Habit reversal training, comprising three basic modules (mindfulness training, competing response training, environment support), is one of the most effective therapeutic strategies [20].

Trichotillomania as an addiction spectrum disorder – the theory of positive reinforcement

The backgrounds for this hypothesis are clinical similarities of these two groups of disorders, including: repetitive or compulsive patient's involvement in the activity – despite of awareness of its negative consequences, reduced control over problematic behaviour, increasing urge for an action prior to pulling out the hair and gratification during or after the activity. Feeling of pleasure associated with hair pulling is a basic differentiator between the trichotillomania and obsessive-compulsive spectrum disorder and the main argument for its affinity with the addiction spectrum disorder [21]. This hypothesis is strengthened by encouraging results on the effectiveness of a treatment with agents modifying dopaminergic transmission. Among others, studies using bupropion [22] and naltrexone [23] have provided positive results.

Dopamine theory

Poor efficacy of serotonergic drugs in trichotillomania treatment suggests possible involvement of other neurotransmitting pathways in development and maintenance of the symptoms. Preliminary studies on the effectiveness of antipsychotics (quetiapine, olanzapine, aripiprazole) – both in monotherapy as well as in combined therapy with SSRIs – support involvement of dopaminergic pathways [24–26].

Other hypotheses and indirect evidence

Indirect evidence for a different or more complex biological background of trichotillomania than OC spectrum disorders comes from research on the effectiveness of agents affecting a different action mode than inhibition of monoamine uptake. The positive effects were recorded after the treatment with, *inter alia*, topiramate [27], lamotrigine [28], oxcarbazepine [29], N-acetylcysteine [30].

Regardless of proposed explanations of aetiology of the disorder – there are three main subtypes – with different clinical presentation and prognosis [14]:

1. Early onset – in which the disorder develops before the age of 8. It is considered to be the mildest form of the disorder. The majority of patients are not covered by the medical care because of the often self-limiting nature of the disorder.
2. Automatic – in which the symptoms are usually nonconscious and occur mostly when patients are engaged in various activities, such as reading, watching TV, listening to the radio, driving a car. Comprises about 75% of all cases.
3. Concentrated – where patients concentrate on activities related to pulling out/playing with hair. This subtype is most pronounced by pre-existing tension prior to the action and the subsequent relief/gratification as well as intense thoughts about (pulling) hair. Clinical picture is more similar to OCD – there is also greater efficacy of SSRIs [20].

Clinical presentation and course

The diagnosis of the disorder is not easy. Patients rarely seek for psychological or psychiatric help spontaneously and even if they do, they often deny the problem during a routine medical interview. In this situation, an unquestionable diagnosis can be made only on the basis of the result of gastroscopy or – in severe cases – during laparotomy. However, despite the difficulties, there is a series of symptoms that may suggest the diagnosis of trichotillomania and should be considered in the differential diagnosis.

Psychological characteristic of the patient includes: feeling of unattractiveness, dissatisfaction with the appearance of their own body, accompanied by a feeling of shame, embarrassment, and low self-esteem. Many patients have difficulties in functioning in social roles, actively avoid or withdraw from everyday activities, especially related to being exposed to public view. Some patients cope in social roles to a limited extent, still reporting the sense of isolation, loneliness, alienation. Very often patients suffer from co-morbid psychiatric disorders (82%) and problems associated with abuse of alcohol and other psychoactive substances [2, 13].

“Warning signs”, which should draw a clinician’s attention – regardless of his/her specialisation – are listed below:

- a. Loss of scalp hair or reported problems with hair loss – usually accompanied by attempts to camouflage symptom with hairstyle, wigs, scarves, makeup, etc.;

- b. Loss of hair in other regions of the body: eyebrows, eyelashes, pubic hair, beard, armpits, chest, legs – often masked with a makeup, costumes, or other appropriate means;
- c. Sometimes – accompanying changes in glabrous skin (scrapes, wounds, inflamed areas of the skin) – as a result of regular irritation of these areas;
- d. Observed behaviour of hair pulling and/or plucking during daily activities or sleep (reported by caregivers);
- e. Abnormal behaviour or appearance of the patient – including, unwarranted by other circumstances, wearing hats, scarves, wigs, heavy eye makeup, extravagant spectacles;
- f. Avoiding adverse weather conditions or activities associated with exposure to wind/water (swimming pool, sports activities);
- g. Deterioration in school or vocational functioning, or a change in the patient’s model of social behaviour – for which it is difficult to find a clear reason.

Unspecific general symptoms reported by some patients include: weakness, increased fatigue, discomfort in a chest, dizziness, fainting. Symptoms of a gastrointestinal tract – usually in cases where a trichobezoar is present – include abdominal pain, nausea, vomiting, recurrent diarrhoea or constipation, weight loss (with or without loss of appetite) or lack of expected weight gain during growth period.

Trichobezoar occurs in approximately 30% of trichophagia cases [5], more frequently in children and adolescents. In these cases, physical examination of a stomach usually reveals a tumour in the abdomen. Patients can seek help due to associated gastrointestinal disorders: gastritis, stomach or duodenal ulcers, pancreatitis, protein-losing enteropathy.

Some abnormalities may be present in the additional tests – including: sideropenic anaemia (associated with impaired iron absorption), megaloblastosis (vitamin B₁₂ deficiency), or – not always present – leukocytosis. All of which cannot be explained by other causes [9, 31, 32].

Sometimes the first reasons for searching for medical help are only disease complications requiring immediate surgery. Most frequently, patients present with symptoms of peritonitis, mechanical obstruction, gastrointestinal tract perforation or bowel wall intussusception [31, 33, 34]. Less often patients report congestive jaundice – resulting from blockage of the bile ducts by fragments or the trichobezoar (Rapunzel syndrome) or – developing secondary to gallstones – acute necrotising pancreatitis [33]. Typically, diagnostic difficulties are being resolved using diagnostic imaging of the abdomen or – in severe cases – scout abdominal laparotomy [31–33]. Available imaging methods have limitations arising from research technique itself or its complications. Radiography allows only confirming the presence of obstacles in the gastrointestinal tract. However, insufficient sensitivity makes usefulness of this technique in the diagnosis of the trichobezoar limited. The use of a contrast radiography increases diagnostic capa-

bilities – but this is not a standard procedure in Poland [9, 32, 34, 35]. In a suspected obstruction in the gastrointestinal tract a computed tomography with contrast is used much more often [9, 32, 35]. An available and cheap abdominal ultrasound imaging is of limited importance in the diagnostics of trichobezoars [9, 35].

The ultrasound images, CT or MRI – repeatedly fails to clearly determine the nature of the foreign object found in the digestive tract. The use of MRI in Poland is limited due to the test cost. The definitive diagnosis of a trichobezoar is often determined intraoperatively.

In acute conditions, relatively simple and accessible abdominal CT allows for accurate diagnosis in approximately 97% of the trichobezoar cases [32]. Next to contrast radiography, CT is the most commonly used diagnostic method in cases of a suspected trichobezoar [9, 35]. However, limitation of this method for routine application to monitor patients who underwent surgery due to trichobezoar, for recurrence of the trichophagia symptom, is the size of irradiation during the test. This makes it difficult to apply this method as a standard, particularly among paediatric patients (e.g. due to a significant increase in the risk of developing cancer) [36].

The only specific enough diagnostic technique, which allows for an accurate estimation of the size and composition of the embolic material, is gastroscopy [9, 31, 33, 35].

Treatment and relapse prevention of trichotillomania

Psychotherapy

In any case of trichotillomania, the primary and the initial stage of the treatment should be psychoeducation – adapted to the age and intellectual capacity of the patient. In children and adolescents psychoeducation should be addressed to family members, and in some cases, members of the immediate environment, who should be involved in the treatment process [3]. Part of the treatment may also be involvement of the patient or the family member to participate in a support group. Unfortunately, the availability of this method in Poland is very limited. For youth patients, some help may be accessible via international forums for trichotillomania patients.

Psychotherapy is currently a standard treatment for trichotillomania. The method of choice is cognitive-behavioural therapy (CBT), whose efficacy has been demonstrated in several independent studies [37–39] and which forms the basis for the guidelines established by a group of experts from the Trichotillomania Learning Centre [3]. Studies have shown the effectiveness of a habit-reversal training (HRT) as a method limiting the intensity and frequency of behaviours associated with trichotillomania [3, 40]. A key element of the therapy is competing response training – involving patient in a motor activity that prevents the implementation of the motor pattern involved in pulling/eating hair. Other HRT elements used in the treatment of trichotillomania are: self-observation, mindfulness, impulse control techniques and – supportively – relaxa-

tion techniques and social support. Results of randomised control studies confirm the effectiveness of behavioural interventions, exceeding the available pharmacotherapy. It has been shown that behavioural techniques surpass the use of clomipramine [39]. Similar results were obtained in a study of fluoxetine, indicators of improvement in the group treated with CBT and receiving SSRIs were 64% and 9% respectively [37]. Behavioural techniques have proved efficacy in reducing symptoms of both trichotillomania and accompanying anxiety and depression – what may partially explain the long-term response to the treatment. In Woods et al. the treatment efficacy was maintained in three-month period of the follow-up [38]. Some studies confirm the efficacy of the CBT in paediatric population [41, 42]. In Tolin et al. response to the treatment was 77% (assessed by CGI-I), and most of participants maintained remission 6 months after completion of the therapy [42].

In the study on the effectiveness of various forms of therapeutic interventions it is increasingly emphasised that the effectiveness of therapeutic techniques can be affected by the dominant style of pulling out hair. In automatic style, where motor activity takes place largely outside the patient's consciousness, hair-pulling is often preceded by a tactile stimuli (touching, playing with hair). In these cases, the effectiveness of behavioural techniques (including awareness training, stimulus control, competitive response training) appears to be higher than in the concentrated style. In the latter case, usually there is a higher share of the preceding emotional and/or cognitive stimuli and CBT cognitive techniques (offered by, among others, dialectical behaviour therapy and acceptance and commitment therapy) may occur more effective [38, 43].

So far, there are no studies evaluating the effectiveness of other psychotherapy modalities in trichotillomania treatment. In the treatment of children and adolescents the legitimacy of family involvement in a therapy is indicated [3]. However, there are no clear guidelines suggesting systemic therapy as a treatment strategy.

Individual descriptions confirm the effectiveness of, among others, self-monitoring tools [44] or the use of hypnosis [45].

Pharmacotherapy

Most reports concern the use of SSRIs as a method of choice or as a method complementary to psychotherapy. The potential benefits of pharmacological treatment with antidepressants and anxiolytics may result from alleviating symptoms of associated mental disorders. Hence the decision on implementation of pharmacotherapy may be beneficial in most cases [2]. However, there is insufficient empirical data to support the efficacy of this class of drugs in reducing the intensity of pulling/swallowing hair [46–50]. The efficacy of the combination therapy (CBT + sertraline) was shown to be superior to both methods used separately [51]. This result was most likely conditioned by the favourable impact of serotonergic drugs for comorbid symptoms of anxiety and/or depression.

There are many reports on the potential efficacy of other pharmacological agents. At this stage, however, they are predominantly experimental therapy and verification of preliminary results is needed. The study comparing the effectiveness of different agents has shown promising results obtained, among others, by the use of clomipramine, N-acetylcysteine and olanzapine [19]. In Ninan et al., clomipramine efficacy was slightly higher compared to placebo and less effective than CBT [39]. However, all results need to be confirmed in randomised controlled studies on larger groups of patients.

The encouraging initial results of the bupropion – including its effectiveness in cases resistant to SSRI – make it another potential drug reducing the severity of trichotillomania symptoms [22, 52]. Inhibitory effect of naltrexone, confirmed in studies in different age groups [23, 53], have not been reflected in the controlled study of Grant et al. [54].

Promising preliminary results were provided with modulator of glutamatergic system – N-acetylcysteine. The significant efficacy in reducing symptoms of pulling hair – along with a preferred profile of treatment tolerance and safety has been shown [30, 55]. The use of atypical neuroleptics – despite encouraging data regarding their efficacy in the treatment of trichotillomania – is significantly limited by their adverse side effects profile [24–26]. Therefore, their use should be reserved for cases not responding to other forms of the therapy. Incentive effects of treatment were also recorded after the application of topiramate [27], lamotrigine [28], oxcarbazepine [29] – although the exact mechanism of action of these drugs in the case of trichotillomania treatment is unknown.

The symptomatic treatment – using antipruritic and anti-inflammatory drugs, and sometimes – sedatives and hypnotics – is used mostly by physicians of other specialties (dermatologists, paediatricians). It is worth emphasising that, at the moment, there is no method of pharmacotherapy officially registered for trichotillomania treatment – neither in Poland nor in the world.

Surgical treatment

The role of surgery is limited to complicated cases of trichophagia. The most common method of choice is laparotomy. Less frequently used treatment methods include: endoscopic, laparoscopic, enzymatic treatment, laser techniques [56–59]. Their use, however, involves specific constraints. The use of endoscopic methods is possible in cases where the removal of bezoar by natural way will not result in damaging the digestive tract and is usually reserved for the bezoars of small diameter [57].

The advantage of the laparoscopic technique is less skin trauma and thus – faster healing time and a better aesthetic effect. However, the primary disadvantages of this solution are: a longer procedure time and the risk of contaminated material entering the abdominal cavity and the development of peritonitis [57–59].

Attempts of gastric bezoars enzymatic fragmentation using digestive enzymes (chymopapain, cellulase, acetylcysteine) have shown insufficient effectiveness [56].

In the majority of diagnosed trichobezoar cases treatment of choice is laparotomy. The main advantages of this method are: the ability to remove the gastric bezoars of any size (including spreading into the downstream sections of the gastrointestinal tract – Rapunzel syndrome) and a reduced risk of inflammation as a complication of surgical treatment.

Proposed guidelines

At the moment, there is a lack of clear guidelines on the treatment of trichotillomania cases with or without trichophagia in European literature. The most recent studies of this issue come from American Trichotillomania Learning Centre standards, and are the basis of proposals adapted by Polish guidelines [3]. The above recommendations are an attempt to create a programme of comprehensive care for patients with trichotillomania in Poland. With their creation the knowledge and experience of experts in the fields of child psychiatry, gastroenterology and paediatric surgery was used.

Care regimen

1. The differential diagnosis of patients suspected with trichotillomania performed in multidisciplinary team consisting of: a psychiatrist, a psychologist/psychotherapist, a dermatologist, a surgeon and/or a gastroenterologist. It seems that the person coordinating the work of a multidisciplinary team should be a psychiatrist.
2. Coverage with psychiatric care of each patient diagnosed with trichotillomania; in the context of this care:
 - a. Psychoeducation of the patient, in the case of children/young people – family psychoeducation and (possibly) the environment;
 - b. The psychotherapeutic care – indicated individual cognitive-behavioural therapy with the patient – for the time necessary to achieve symptomatic improvement – confirmed endoscopically;
 - c. Considering pharmacotherapy for comorbid psychiatric disorders, significant intensity of symptoms or no improvement using psychotherapy or inability to apply it;
 - d. In the event of a significant family involvement in the patient's symptoms – considering family therapy;
3. Acquisition of surgical care of every patient with suspected trichophagia; within it:
 - a. The physical examination, laboratory tests, diagnostic imaging of all cases of the suspected trichophagia (indicated diagnostic endoscopy);
 - b. In the case of confirmed trichobezoar – laparotomy;
 - c. After surgery – control gastroscopy after 6, 12, 24 months [60].

Discussion

According to the authors, the basic limitation to the application of these guidelines is the lack of sufficient knowledge about the trichotillomania among physicians of various specialties. Our study is one of the few on this subject, available in Polish literature. One of its main objectives was to bring the issue of trichotillomania to psychiatrists – who probably contact with undiagnosed and/or uneventful cases of trichotillomania the most frequently.

Another limitation to the application of these recommendations is the insufficient availability of medical services in Poland. With a long time waiting for an appointment with a psychiatrist (and especially – with a children and youth psychiatrist) and still a high reluctance to visit the doctors of this specialty among a significant segment of the population, it seems necessary to involve also other physicians (including paediatricians, family doctors, dermatologists) in the process of diagnosis and treatment. In the paediatric population, representing a significant percentage of chronic patients, it would be necessary to involve also non-medical personnel, performing the care of this group – including: teachers, educators, psychologists and school counsellors. As a consequence – it would be advisable to increase awareness of the disorder among these professionals.

Difficulties in implementing the recommendations are also submitted by a psychotherapeutic care, which is the basis of trichotillomania treatment. In Poland, there is a shortage of qualified cognitive-behavioural psychotherapists. CBT therapists with experience in working with children and young people constitute even a smaller group. The availability of free treatment in this trend, as well as any other form of psychotherapy including paediatric/youth patients and their families is limited to a few centres located in large cities.

In this situation, an intermediate solution might be a care provided by psychologists and non-cognitive-behavioural therapists who, through psychoeducation, establishing a therapeutic relationship, work on the reduction of accompanying affective symptoms, involvement of patient's family in the treatment process and cooperation and coordination with other specialists (such as paediatricians, GPs), could contribute to a symptomatic improvement in trichotillomania. Development of materials that provide basic information on the disorder, and proposed simplified therapeutic regimen, developed on the basis of HRT might be assistance to these professionals.

Another, important limitations to the application of these guidelines are represented by a potential iatrogeny of proposed diagnostic and therapeutic procedures. The use of the gastroscopy as a routine procedure should be limited to the cases in which an interview and/or a physical examination clearly confirm the diagnosis of trichophagia. In doubtful cases the use of less invasive imaging techniques (ultrasound, X-ray with contrast media) seems to be more reasonable. An in-depth diagnostics is indicated only after confirmation of an obstacle in the gastrointestinal tract. Decisions regard-

ing control gastroscopy tests should be undertaken in collaboration with the doctor coordinating treatment (usually a psychiatrist).

An essential component of a comprehensive treatment of complicated cases – unfortunately, difficult to perform during multi-centre treatment – is the cooperation of specialists (psychiatrist, psychologist/psychotherapist, dermatologist, surgeon and/or gastroenterologist). The preferred solution would be to carry out the treatment in major paediatric centres with appropriate facilities.

Conclusions

This publication contains the most important information about trichotillomania and trichophagia and practical advices to doctors dealing with these issues in their daily practice. It seems that the knowledge about the disease is insufficient among most of practicing psychiatrists, dermatologists and other physicians. Hence – its diagnosing is insufficient and an incidence of medical complications and the risk of serious disturbances in social functioning of affected patients are higher.

No medication of proven effectiveness makes trichotillomania treatment significantly difficult. However, this does not diminish the role of the psychiatrist in the process of diagnostics and treatment. The tasks of the doctor include: a multi-axial psychiatric diagnosis, systematic evaluation of the mental state and deciding on the necessity and type of concomitant mental disorders treatment, monitoring somatic status and referring patients for diagnostic tests (alone or in cooperation with the paediatrician/internist) and coordination of the treatment process.

The authors have attempted to create guidelines in cases of a suspected disease, a confirmed diagnosis and disease complications – highlighting the importance of care provided by a multidisciplinary team. Given all mentioned constraints and difficulties in the implementation of the proposed recommendations – in our opinion it still remains valid to create binding guidelines in trichotillomania. The need for further research on the effectiveness of other forms of psychotherapy and pharmacotherapy in the treatment of the BFRB cluster disorders is also worth emphasising.

The authors of the study will be grateful for comments of practicing colleagues on the proposed guidelines that could be used to create their final version – taking into account the realities of health care in Poland, as far as possible.

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