Trichotillomania: A Possible Therapeutic Strategy for the Family Doctor

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For some years now, trichotillomania has been recognized as a psychopathologic condition [1]. It does not respond well to any one specific treatment modality, whether pharmacologic or different psychotherapy techniques [1]. Severe cases are usually treated by psychiatrists over a long period [2]. We report a case of trichotillomania that was treated within a family practice setting using family intervention techniques. Ten years follow-up revealed no recurrence.

Patient Description

An 11 year old boy presented to his family physician due to three episodes of loss of consciousness during the previous 10 days. A complete physical examination and comprehensive laboratory and imaging investigations did not reveal any pathology. Distinct areas of hair loss were observed on the scalp.

The patient's history revealed that he was an only child. His parents divorced when he was 3 years old and he moved with his mother to live with her parents. His grandfather took over the father's role. Initially he saw his real father twice a year, for a day each time, but then all contact was discontinued. When the patient was 10 years old his grandfather died suddenly, and 3 months later the patient immigrated to Israel with his mother and grandmother. During the subsequent year, the boy learned the language (Hebrew) and was successful academically; he was tough but socially very isolated. He never invited

friends home and was not allowed to play outside. He spent most of his time watching television. Occasionally, on Sunday afternoons, he would accompany his mother outside to sit and gossip with some of his mothers' friends. He would insist that his mother be with him when he was at home. When his mother once invited a male work colleague, the boy had such a temper tantrum that she never dared repeat it.

After a family assessment was completed, it was decided that the family doctor would have a 1 hour session with the boy at home, doing "male" activities. The last half-hour included the boy's mother, and the discussion was focused on the father, the grandfather, and the meaning of loss. After six sessions, it was agreed that the boy could play football in the neighborhood, and his mother could go out alone once a week. The boy was also introduced to the trainer at the local sports center, and was taken on as an assistant. At the same time it was observed that his hair-pulling had virtually ceased. A month later the mother met a widower, and this time the boy welcomed him into the family circle. Today, 10 years later, the mother is happily married, the boy has a sister 11 years younger than him, and trichotillomania has never reoccurred.

Comment

Trichotillomania is defined by the DSM IV as hair-pulling resulting in noticeable hair loss. It occurs in up to 4% of the general population and is more common in females under the age of 17. The etiology is unknown, but it is more common in people who have suffered significant loss including separation during childhood [1]. The condition warrants treatment for various reasons, the esthetic one notwithstanding. The severe form of the condition is quite uncommon and is very difficult to treat [2–4].

In our patient the following observations were made after the initial assessment:

- The boy had trichotillomania, diagnosed by exclusion of other possible causes of alopecia. Hair-pulling was observed.
- The issue of loss had not been resolved in the family.
- The boy had no father figure in the critical prepuberty stage of development.
- The boy and his mother were too enmeshed for any sort of independent development.

Considering these initial observations collected during the first few meetings, the following treatment strategies were adopted:

- Creating a differentiation between the various family members.
- Understanding the hidden conflicts.
- Defining the roles and boundaries.
- Developing trust.
- Developing more appropriate feedback patterns between the family members.

In conclusion, various treatment modalities for the alleviation of trichotillomania have been described. Medications such as antidepressants and lithium afford a benefit of short duration only, if at all [3]. Other treatment modalities include psychoanalysis, behavioral hypnosis, and family therapy [2,4,5]. We discuss a technique of family therapy used successfully to treat a severe case of trichotillomania by the family physician. We suggest that even in severe cases of trichotillomania, and certainly in the less severe types, consultation with the family doctor is appropriate and perhaps even beneficial. His prior knowledge and understanding of the family dynamics and relationships and the trust that he has with the family may give him a therapeutic advantage.

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