

CHAPTER 1

INTRODUCTION

1.1 RATIONALE FOR RESEARCH

The term 'trichotillomania' was first used in 1889 by the French dermatologist Hallopeau (1889), to describe an affliction of chronic, self-directed hair pulling in the absence of any obvious skin disease.

More than a century later, the classification and criteria for trichotillomania remained contentious. Although currently considered one of the impulse control disorders, a number of alternative classification schemes have been proposed in an attempt to describe the condition better. Some of these schemes regard trichotillomania as a variant of obsessive-compulsive disorder (Tynes, White, & Steketee, 1990); an obsessive-compulsive 'spectrum' disorder (Jenike, 1989; Swedo & Leonard, 1992); a disorder of abnormal grooming (Swedo & Rapoport, 1991); one of the habit disorders (Mansueto, 1991); or an affective spectrum disorder (Christenson, Mackenzie, & Mitchell, 1991; McElroy, Hudson, Pope, Keck, & Aizly, 1992). The debate continues, but no alternative categorisation for trichotillomania is currently widely supported. A number of these issues are reviewed in Chapter 3 of this report.

Chapter 4 discusses current theories of which none seems to offer a sufficient explanation of the aetiological factors of the illness. The psychodynamic perspective considers the symptoms to be manifestations of unconscious dynamic processes and unresolved conflicts, but the limitations in anecdotal reports on treatment effectiveness render this model less useful in attempts to understand the condition. The cognitive-behavioural model, on the other hand, focuses on explaining what maintains hair pulling once it begins, and several treatment studies have reported effective results. However, the emphasis on specific behaviours associated with the

symptom sometimes leaves the impression that hair pulling and its associated features should be simple and straightforward - which is clearly not the case. In fact, people with trichotillomania often find the indirect psychosocial problems to be the more disturbing aspects of the disorder, and this might actually contribute to patient non-compliance and high relapse rates. From the psychiatric perspective, biological theories have specified a range of neurobiological abnormalities that could underlie trichotillomania, but pharmacological efforts to treat these and other physiological aspects of the disorder have produced inconsistent results. This model does not address the wider-ranging implications of psychological, behavioural, and interpersonal sequelae either.

Despite its high prevalence, trichotillomania has been the subject of relatively few studies. As it appears to be a heterogeneous condition with a range of divergent comorbid conditions, the methodological difficulties in studying the illness have made a generalisation of the available research results difficult and left gaps in both its conceptualisation and treatment. These factors present serious obstacles in the prognosis for the disorder, and it is clear that a more comprehensive understanding of this illness and the people who suffer from it is required to serve this population meaningfully.

The current study targeted a group of individuals who shared the same cluster of symptoms on the DSM-IV, which necessarily implies a medical system of thought. Although both psychiatry and psychology aim to apply unique, field-specific principles to adjustment problems, this study attempted to augment current theoretical conceptualisations of the disorder by describing a number of psychological aspects that accompany trichotillomania.

As described in Chapter 5, Exner's Comprehensive System for the Rorschach provides a well-validated basis for describing various aspects of personality structure and serves

as a rich source of hypotheses on numerous aspects of personality dynamics. Although not a predictive instrument, Rorschach trait variables do provide reasonably accurate longitudinal predictions of personality style. Also, the method has been demonstrated to aid in diagnosing various conditions that involve specific patterns of personality functioning. It has the potential to facilitate a diagnosis of any condition that is determined by or contributes to distinctive personality characteristics (Weiner, 1998). For instance, given trichotillomania's classification as an impulse control disorder, the research group's performance on the Rorschach variables deemed to be related to impulsivity (D, Adj D, FC:CF+C, M, and Lambda) would be interesting. The Obsessive Style (OBS) Special Index could also illuminate aspects of the continuing debate about the disorder's classification as an obsessive-compulsive spectrum disorder.

The Comprehensive System makes well-validated contributions to identifying treatment targets and potential obstacles to making progress in psychotherapy by selecting appropriate treatment modalities and monitoring change over time. It is hoped that this study would elucidate factors that could impact on the illness' relapse rate, and that recommendations for treatment alternatives might emerge from the data.

1.2 OBJECTIVES OF STUDY

In view of the above, the specific objectives of this study have been formulated as follows:

- To explore the personality structure and psychological functioning of a group of people who have been diagnosed with trichotillomania
- To identify commonalities in the cognitive style, self and interpersonal perceptions, capacity for control and stress tolerance, and the affective functioning of the participants in the study with the aid of the Rorschach Comprehensive System.

1.3 DEFINITIONS

For the purposes of the current study, personality structure is considered the relatively stable nature of people as can be inferred from their current thoughts and feelings. According to Weiner (1998), the thoughts and feelings elicited by specific situational circumstances constitute personality states. He regards people's abiding disposition to conduct themselves in certain ways, to constitute personality traits that comprise a broad range of fairly stable characteristics and orientations.

On the other hand, people's psychological functioning (or their personality dynamics) refers to the manner in which one's personality states and personality traits interact to influence each other. It also describes how a person's nature is affected by underlying needs, attitudes, conflicts, and concerns. These dynamic aspects influence people to think, feel, and act in certain ways at particular times and in particular circumstances (Weiner, 1998).

The Rorschach Comprehensive System describes people's personality structures and psychological functioning as they relate to specific characteristics of the components of the total personality, including:

- Their capacity for control and stress tolerance, which has to do with the available adaptive resources to cope with demands and to manage stress
- Information processing, which is how people pay attention to their worlds
- Cognitive mediation, which is how people perceive the objects of their attention
- Ideation, which is how people think about what they perceive
- Affective functioning, which is how people deal with emotional situations, and how they experience and express feelings

- Self-perception, which pertains to how people view themselves
- Interpersonal perception, which involves the way people perceive and relate to others.

The composite elements of these aspects are described in more detail in Chapter 5.

1.4 SCIENTIFIC CONTRIBUTION

It is envisaged that an exploration of trichotillomania patients' personality structures and psychological functioning would be particularly meaningful when cognisance is taken of the potential benefits of the outcomes of such a study.

It is believed that any project that explores the complex relationship between hair pulling and its associated features has the potential for immediate clinical application. People who seek help could benefit from validation of the commonalities across individuals with the same problem. This could in turn alleviate feelings of isolation and shame. Bearing such commonalities in mind, clinicians could conduct comprehensive, targeted assessments of how these factors manifest in individual patients' lives. Also, this study's outcome could facilitate adjustment of current psychotherapeutic modalities and interventions to accommodate common aspects.

Once the disorder is better understood, identification of commonalities could open doors for future research to determine, for example, if any of these factors remit after pulling; whether they have to be addressed directly or indirectly, concurrently or subsequently; and if specific treatments should be developed and/or implemented to address these issues.

CHAPTER 2

CHARACTERISATION OF TRICHOTILLOMANIA

2.1 INTRODUCTION

When Hallopeau (1889) first described the condition of chronic, self-directed hair pulling, he coined the term 'trichotillomania' from the Greek words thrix for hair, tillein that refers to the action of pulling out, and mania which means madness, to capture the essential characteristics of the disorder.

2.2 DIAGNOSTIC CLASSIFICATION AND CRITERIA

Trichotillomania entered the American Psychiatric Association's diagnostic classification system almost a century after Hallopeau's first case documentation when the third revised version of the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) was published in 1987. At that time, it was grouped under Impulse Control Disorders Not Otherwise Specified.

The DSM-IV added a stipulation on the distress or impairment associated with the disorder, and classified trichotillomania with the other impulse control disorders (pyromania, kleptomania, pathological gambling, and intermittent explosive disorder) (American Psychiatric Association, 1994). A DSM-IV diagnosis of trichotillomania now requires that the following criteria be met:

- A. Recurrent pulling or failure to resist urges to pull out one's hair, resulting in noticeable hair loss
- B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour
- C. Pleasure, gratification, or a sense of relief when pulling out hair

- D. The disturbance is not better accounted for by another mental disorder (e.g. those involving delusions or hallucinations where hair loss is self-induced) and is not due to a general medical condition (e.g. dermatological)
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning.

2.3 EPIDEMIOLOGY

Limited epidemiological research has been done on trichotillomania among the general population. Based on extrapolations from clinic referrals, it has initially been judged a rare condition (Diefenbach, Reitman, & Williamson, 2000). However, more recent epidemiological data suggest that hair pulling as a symptom and trichotillomania as a syndrome are relatively common.

In one of the first studies on the prevalence of trichotillomania in a non-clinical group, Christenson, Pyle, and Mitchell (1991) found a lifetime prevalence of 0.6% in a sample of 2,534 male and female college students. When less stringent DSM criteria were employed, 1.5% of these males and 3.4% of the females reported patterns of pathological hair pulling (Diefenbach, Reitman, & Williamson, 2000).

Trichotillomania is now considered a chronic condition, and is thought to be as common as schizophrenia. Its prevalence rate is conservatively estimated to be at least 1% of the total population (Soriano et al., 1996).

Swedo and Rapoport (1991) have suggested a bimodal age of onset for trichotillomania, with its typical occurrence either in early childhood or in adolescence. Swedo states that, in the majority of cases of early-onset trichotillomania, the symptoms appear before the age of two and often during infancy. Similar to thumb sucking and rocking, it occurs mainly at bedtime when the child is tired or bored, and during periods of separation or other stress.

In these cases the hair pulling is often associated with other self-soothing behaviours, and is considered more of a habit disorder that remits at school-going age (O'Sullivan, Keuthen, et al., 1997). On the other hand, 'classic' trichotillomania appears either in later childhood (after age eight) or early adolescence and older. The hair pulling is then more severe and resistant to treatment, and is often accompanied by a set of ritualised behaviours and considerable psychological distress.

Christenson, Mackenzie, and Mitchell (1991) found the mean age of onset for trichotillomania in a large sample of adult hair pullers to be 13 years.

Dawber (1985) found a male predominance (3:2) in early childhood trichotillomania. This ratio appears to change with later onset trichotillomania, with the predominance in females by a margin of 4:1. This finding was confirmed in a series of 145 sequential patients where males predominated in the preschool age group (Ratner, 1989).

Muller (1987) reported that 62% of the patients with onset before age six were boys, whereas 70% of the total distribution of chronic hair pullers were female. Although most patients who seek treatment for trichotillomania are women, especially in adolescent and adult populations, this unequal distribution could reflect underlying gender differences and the social acceptability of hair loss and help-seeking behaviour. Christenson, Mackenzie, and Mitchell (1994) suggest that although the lifetime prevalence of trichotillomania may be equal between men and women, men were perhaps more likely to seek treatment if other psychiatric problems were present, or if their hair pulling was more focused (see par. 2.5) or compulsive in nature.

No conclusive evidence on the long-term natural course of trichotillomania has been reported. Based on clinical history summaries and self-reports by patients who had sought help, O'Sullivan, Mansueto, Lerner, and Miguel (2000) report the course for typical patients (i.e. 40-year old, white, middle-class women with early adolescent

onset of the disease) to be chronic, with numerous remissions and exacerbations in the severity of their hair-pulling symptoms.

2.4 COMORBIDITY

Despite the clinical perception that patients who have been diagnosed with trichotillomania do not have significant secondary psychopathology (Winchel, 1992), research has established that other psychiatric disorders are more prevalent in groups diagnosed with trichotillomania than would be expected in the general population.

Christenson, Mackenzie, and Mitchell (1991) found a comorbid lifetime prevalence rate as high as 82% for Axis I disorders. Christenson, Chernoff-Clementz, and Clementz (1992) cite reports on trichotillomania that include cases of comorbid depression, psychotic disorders, eating disorders, and mental retardation. Diefenbach and colleagues (2000) state that comorbid mood, anxiety, and addictive disorders are most common on Axis I. They also cite studies where rates as high as a 20% lifetime prevalence for eating disorders and 23% for body dysmorphic disorders have been found. However, consistent with these and other studies that demonstrated a wide range of psychiatric comorbidity, no single Axis I diagnosis has consistently been associated with trichotillomania (Diefenbach et al., 2000).

Prevalence estimates of comorbid Axis II disorders are higher than have been found in the general population (Schlosser, Black, Blum, & Goldstein, 1994), but not higher than found in other psychiatric populations (Christenson, Chernoff-Clementz, & Clementz, 1992). Despite earlier findings of comorbidity with passive-aggressive and hysterical features (Sorosky & Sticher, 1980; Schnurr, 1988), obsessive-compulsive and schizoid personality disorders or features (Winnik & Gabbay, 1965; Chauhan, Jain, & Dhir, 1985) and borderline personality organisation (Galski, 1983; Greenberg & Sarner, 1965), no single personality disorder has been consistently associated with trichotillomania. Christenson, Chernoff-Clementz, and

Clementz (1992) also found that people with trichotillomania showed less Cluster A symptomatology than psychiatric controls, and there has been no difference in Cluster B and Cluster C pathology between the trichotillomaniac and nontrichotillomaniac groups.

Trichotillomania appears to be commonly associated with other problematic behaviours such as nail biting, skin picking, nose picking, picking at acne, lip biting, and cheek chewing (Christenson, Mackenzie, & Mitchell, 1991).

2.5 PHENOMENOLOGY

The unique experiences associated with this disorder vary across patients, but some common elements regarding its phenomenology have been documented.

Hair pulling occurs at any of one or more body sites. Christenson, Mackenzie, and Mitchell (1991) determined that the most common hair-pulling site was the scalp, followed by the eyelashes, eyebrows, and pubic hair. Most patients pull from more than one area.

The hair-pulling phenomenology is similar for men and women (Christenson, Mackenzie, & Mitchell, 1994). However, as with other psychiatric disorders where the symptoms increase during the luteal phase of the menstrual cycle, the hair pulling could exacerbate during the week prior to menstruation (Keuthen, O'Sullivan, Hayday, Peets, Jenike, & Baer, 1997).

A number of negative affective states and sedentary or contemplative activities have been identified as cues that frequently prompt or exacerbate hair pulling (Christenson, Ristvedt, & Mackenzie, 1993). Although many patients present with a mixed clinical picture that has elements of both types, O'Sullivan, Keuthen, and colleagues (1997) have identified two predominantly different styles of hair pulling. Christenson differentiates between them as follows:

- Focused hair pulling is phenomenologically similar to the rituals found in obsessive-compulsive disorder (OCD). It could incorporate the need for hair-pulling symmetry or attempts to pull hair with unique textures or qualities. Focusing on pulling often forfeits attention to necessary tasks. Focused hair pulling is associated with mounting tension before pulling or when attempting to resist the urge to pull, followed by a sense of relief. This is the dominant style of hair pulling among approximately a quarter of the patients (O'Sullivan, Keuthen et al., 1997).
- The other major style of hair pulling has been described as automatic or habitual, and it is not associated with a prodromal sensation or hair-pulling urge. Approximately three quarters of the patients with trichotillomania reported automatic pulling as their predominant style of hair pulling (O'Sullivan, Keuthen et al., 1997). Such pulling often occurs in the context of pensive leisure activities in which absorbed attention to a specific task is required while the patient is relatively inactive. These activities include watching television, speaking on the telephone, lying in bed at night in a state of anticipation or contemplation, reading, or driving.

Hair pulling is frequently ritualistic (Swedo & Rapoport, 1991). A hair that 'does not feel right' - too wiry, kinky, crooked, straight, or otherwise different - would be located, plucked out, and examined. Christenson, Mackenzie, and Mitchell (1991) found that about 48% of the people with trichotillomania would engage in some form of oral behaviour after pulling - running the hair across their lips, biting off the root, or eating the hair (trichophagy). Complete chewing of pulled hair occurs in 33% and hair ingestion in 10% of trichotillomania patients. This behaviour could give rise to serious medical conditions, including dental erosion, carpal tunnel syndrome, and skin infections. Hairballs (trichobezoars) in the stomach and large intestines could cause anorexia, stomach pain, anaemia, obstruction, peritonitis, and mortality if untreated (Christenson, Mackenzie, & Mitchell, 1991).

Hair-pulling sessions could vary from 4-5 hours during which several hundred hairs would be pulled, to brief episodes with only a few hairs pulled at a time. However, this could recur several times in the course of a day. Pulled hairs are sometimes piled before they are discarded.

Most trichotillomania patients do not experience pain during hair pulling. Christenson, Raymond, and Faris (1994) investigated the hypothesis that increased pain thresholds might serve a permissive function in the development and/or maintenance of trichotillomania, but found no significant difference in either pain detection or pain tolerance thresholds between the control group and trichotillomania patients.

Most of these patients take great pains to conceal the bald areas by clever use of make-up, hairstyle, or head coverings, and many avoid outdoor activities, interpersonal contact (social and occupational), intimate relationships, and scenarios where the problem might be exposed.

One destructive consequence of chronic hair pulling is the effect it has on the patient's appearance and sense of self-control. Others are the attendant secrecy and feelings of shame and humiliation, and the sense of isolation that negatively impacts on a patient's self-concept and self-esteem (O'Sullivan, Keuthen et al., 1997; Soriano et al., 1996; Townsley Stemberger, McCombs Thomas, Mansueto, & Carter, 2000).

Despite a better understanding of the disorder during the past decade, the pathology of trichotillomania seems to span several disciplines. Many of the complexities of its characterisation and phenomenology consequently remain unclear.

CHAPTER 3

CONTENTIOUS ISSUES IN TRICHOTILLOMANIA

3.1 INTRODUCTION

As mentioned before, trichotillomania is currently classified as an impulse control disorder. Some clinicians believe, however, that the criteria set by the DSM-IV could also identify individuals suffering from different psychopathological or pathophysiological conditions (Koran, 1999). This classification and criteria of trichotillomania have therefore remained contentious. Several approaches to the categorisation of trichotillomania have since been proposed in attempts to accommodate the divergence ascribed to the different components of the disorder.

This section highlights the main reasons behind the continuing debate about the diagnostic requirements for trichotillomania. A number of alternative classification schemes that are still under investigation are described.

3.2 TRICHOTILLOMANIA AS IMPULSE CONTROL DISORDER

According to Sue, Sue, & Sue (1994), impulse control disorders such as trichotillomania share three characteristics:

- Firstly, people with an impulse control disorder fail to resist an impulse or temptation to perform some act, knowing that the act is considered wrong by society or harmful to them. The impulse may or may not be consciously resisted, and its performance may or may not be premeditated.
- Secondly, most sufferers experience tension or arousal before the act referred to above.
- Thirdly, they experience a sense of excitement, gratification, or release after committing the act. Guilt or regret may or may not follow.

Despite generally fulfilling these requirements, controversy concerning the classification of trichotillomania and its diagnostic criteria persists. A significant percentage of hair pullers do not meet criterion A or B of the DSM-IV's characteristic symptoms of impulse control disorders - a mounting tension before and/or a tension-release or gratification cycle after having engaged in destructive behaviour. In a sample of 60 patients referred for treatment for hair pulling, Christenson and colleagues (cited in (Diefenbach, Reitman & Williamson, 2000) found that 5% did not report mounting tension before pulling, and 12% did not report tension release, pleasure, or gratification associated with pulling.

Based on these results, some researchers (cited in Diefenbach et al., 2000) argue that the current DSM-IV diagnostic criteria may be too restrictive, and that they cast some doubt on the classification of trichotillomania as an impulse control disorder.

Several alternative classifications have since been proposed.

3.3 TRICHOTILLOMANIA AS HABIT DISORDER

Based on resemblances between hair pulling and other nervous habits such as pathological nail biting (onychophagia) and skin picking, some authors believe that trichotillomania could be considered a habit disorder.

Analogous to previously mentioned aspects of trichotillomania's phenomenology, habit disorders mainly occur without conscious awareness, while the individual is attending to another task. These disorders seem to provide some kind of soothing function, but could also cause damage to one's own body (Ninan, Mansueto, Rothbaum, O'Sullivan, & Nemeroff, 1999). Similarities such as these suggest a degree of relatedness between hair pulling and prototypic habit disorders.

Friman (1992) refers to paediatric, behavioural, and dermatological literature on hair pulling to emphasise that it usually presents as a benign habit similar to thumb

sucking (another habit with which it often covaries in children). In these cases the hair pulling is easily treated with behaviour modification, counselling, or even placebo-type interventions (Friman, 1992; Friman & Hove, 1987).

Others do not view trichotillomania as simply a habit. After reviewing more than 40 people with trichotillomania, Mansueto (1991) noted that his data challenged the widespread impression that trichotillomania was a simple nervous habit, and that the problem was instead revealed as a complex disorder with great variation in individual expression.

The issue is complicated by the fact that some habit disorders involve 'empty' behaviours where symptom-oriented approaches are appropriate. Others, such as the trichotillomania case report cited by Oakley (1998), appear to be maintained by underlying anxieties and unresolved issues. In such cases, the habitual hair pulling seems to serve an important psychological function in the individual, but has distressing consequences.

No revised categorisation has therefore been reached to group trichotillomania as a habit disorder. However, a distinction between hair pulling as a behavioural symptom and trichotillomania as a clinical syndrome with substantial psychological sequelae could clarify debated aspects surrounding the disorder's classification as a habit disorder.

3.4 TRICHOTILLOMANIA AS DISORDER OF ABNORMAL GROOMING

Swedo and Rapoport (1991) suggested that trichotillomania could belong to a spectrum of unwanted repetitive species-typical behaviours, and that syndromes such as trichotillomania, compulsive feather picking in birds (Grindlinger & Ramsay, 1991), psychogenic alopecia in cats, and acral lick dermatitis in dogs (Goldberger & Rapoport, 1991) could represent pathological variants of normal

grooming behaviours. These authors believe that the phenomenological aspects of trichotillomania could intimate pathology in the neurobiological mechanisms responsible for grooming behaviours. Specifically, this neuroethological theory proposes that neurological dysfunction causes the preprogrammed grooming behaviours - that are normally under higher cortical control - to be released inappropriately as 'fixed action patterns'.

While Swedo and Rapoport (1991) admit that phenomenological similarities between hair pulling and some animal behaviours represent a provocative analogy, pharmacological studies in this regard imply homologous mechanisms or neural structures subserving these behaviours. In fact, Grindlinger and Ramsay (1991) found evidence of a link between dysfunctional serotonergic activity and repetitive grooming behaviour in animals, and suggested that this neurobiological approach could provide a model for trichotillomania. However, no conclusive evidence has as yet been proposed for this model.

3.5 TRICHOTILLOMANIA AS OBSESSIVE-COMPULSIVE SPECTRUM DISORDER

Based on the phenomenological overlap with obsessive-compulsive symptoms, it has been suggested that trichotillomania may be conceptualised as either a variant of obsessive-compulsive disorder (OCD) (Tynes et al., 1990), or that it may be a distinct disorder that shares a biological aetiology with the obsessive-compulsive spectrum disorders (Jenike, 1989; Swedo & Leonard, 1992; Hollander & Wong, 1995).

Hollander (1993) coined the umbrella concept of obsessive-compulsive 'spectrum' disorders to describe a group of disorders that share features with OCD in a range of domains, including phenomenology, family history, aspects of clinical course, treatment response, and possibly serotonergic mediation. The obsessive-compulsive spectrum disorders include certain neurological conditions (e.g. Tourette's syndrome, Huntington's disease, Sydenham's chorea, autism, epilepsy); certain eating and

somatoform disorders; variants of OCD; most of the impulse control disorders; depersonalisation disorder; borderline, antisocial, and obsessive-compulsive personality disorders; and the habit disorders of nail biting and skin picking (Hollander & Wong, 1995; McElroy, Phillips, & Keck, 1994).

Another hypothesis purported that obsessive-compulsive spectrum disorders vary along a continuum of compulsivity versus impulsivity, with compulsive disorders reflecting excessive harm avoidance and risk aversion, and impulsive disorders characterised by the minimisation of harm and risk (Stanley & Cohen, 2001). This proposed dimension of obsessive-compulsive spectrum disorders may be particularly relevant to the relationship between OCD and trichotillomania.

Despite suggestions of subclassifications, the general concept of obsessive-compulsive spectrum disorders has recently been criticised as vague, overinclusive, and lacking clear inclusive or exclusion criteria (Stanley & Cohen, 2001).

Notwithstanding the debate, the proposed relationship between trichotillomania and OCD stimulated numerous research investigations to compare the two patient populations. However, researchers have generally found more differences than similarities.

Specifically, trichotillomania and OCD differ phenomenologically in terms of the severity of obsessional symptoms and the perceived pleasure derived from the behaviour (Stanley, Borden, Bell, & Wagner, 1994). The disorders can also be distinguished with respect to stimulus cues (Mackenzie, Ristvedt, Christenson, Lebow, & Mitchell, 1995), attentional focus (Christenson, Mackenzie & Mitchell, 1991), and demographics (Himle, Bordnick, & Thyer, 1995; Mackenzie et al., 1995; Stanley, Swann, Bowers, Davis, & Taylor, 1992).

Himle and colleagues (1995) found that patients who met the criteria for OCD scored higher on measures of psychiatric symptomatology than patients with trichotillomania, including ratings of obsessions and compulsions, general and phobic anxiety, interpersonal sensitivity, depression, and psychoticism.

Stanley and Cohen (2001) report that, although both trichotillomania and OCD are affected by serotonin probes, serotonergic probes produce a euphoric effect in patients with trichotillomania but a dysphoric effect in OCD, as well as an altered response in OCD but not in trichotillomania. Also, trichotillomania (but not OCD) is responsive to pharmacotherapy with lithium (Christenson, Popkin, Mackenzie, & Realmuto, 1991).

Although higher rates of OCD were found in the families of trichotillomania patients relative to the general population (Lenane et al., 1992), OCD rates in families of OCD patients were still higher than in the families of trichotillomania patients (Stanley & Cohen, 2001).

Comorbidity as high as 27% has been reported between trichotillomania and OCD in samples reported by Christenson, Mackenzie and Mitchell (1991) and Schlosser et al. (1994). However, it has been significantly lower in a study conducted by Winchel, Jones, Stanley, Molcho, and Stanley (1992).

These and other results seem to support the validity of conceptualising trichotillomania and OCD as differing behavioural disorders. However, it is clear from all the above that the conceptualisation of the disorder remains undecided.