to work toward extinguishing the pulling behavior. Medication should be used cautiously, and if there are no signs of improvement or a worsening of symptoms, consideration should be given to the discontinuation of medication and strengthening of CBT.

Trichotillomania causes tremendous pain for those who sufferer from the disorder as well as their families. Certainly, more research in this area is needed given the complexity, comorbidity, and range in severity of the disorder. A multimodal approach should be emphasized.

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KATHLEEN TRAINOR, Psy.D.
Boston, Mass.

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Samuel R. Chamberlain and Isobel Heyman Reply

TO THE EDITOR: We thank Dr. Trainor for her thoughtful letter regarding the treatment of trichotillomania in children and adolescents. Dr. Trainor suggests that CBT incorporating habit-reversal therapy rather than medication should be used as a first-line treatment for young people.

To our knowledge, there have been no controlled treatment trials (psychological or pharmacological) in childhood or adolescent trichotillomania (1). Our review of available treatment trials in adults with trichotillomania revealed a superiority of CBT relative to waiting-list comparison or pill-placebo. However, treatment studies were typically conducted in academic research settings not representative of most outpatient clinics and did not control for nonspecific therapeutic factors such as time spent with the practitioner. Pharmacological studies we identified were few, with small sample sizes and limited power to detect treatment effects. There was some evidence to support treatment with the serotonin reuptake inhibitors (SRIs) clomipramine or citalopram. As noted in our review, it is difficult to generate treatment algorithms on the basis of such a limited evidence base.

We concur with Dr. Trainor regarding the need for careful screening. Comorbid depression in trichotillomania is likely to interfere with habit reversal, since it requires substantial patient motivation. Consideration of pharmacotherapy in the presence of comorbid depression in young people requires caution. In children with depression, SSRIs have been linked to increased suicidality and suicidal thoughts. There is ongoing debate regarding the risk/benefit ratio in this group, with some studies suggesting an unfavorable balance and others suggesting that these drugs should retain a treatment role (2, 3). SSRIs appear to be effective and well-tolerated in the treatment of childhood obsessive-compulsive disorder (OCD), and several (sertraline and fluvoxamine [4, 5]) are licensed for this purpose in the United Kingdom.

In addition to efficacy and safety, patient preference, treatment availability, and the deleterious consequences of *not* intervening in a timely fashion need to be taken into consideration (6). For adults with trichotillomania, pharmacotherapy may be preferred over CBT incorporating habit reversal. SRIs are widely available and are relatively inexpensive to administer, while tailored CBT (especially incorporating habit reversal) is not widely available. In adults, concurrent OCD or depression would further favor intervention with an SRI (e.g., clomipramine or citalopram) (7). For children and adolescents with trichotillomania, greater caution over the use of pharmacotherapy is required. SRI treatment in youth should be carried out in close consultation with the patient and his or her parents or guardians, with regular monitoring and screening for suicidal ideas or behaviors.

Dr. Trainor raises important diagnostic issues, since many patients do not endorse the strict DSM-IV criteria related to growing tension before hair pulling and subsequent relief. Rather, hair pulling is often undertaken during relaxation or in a habitual and dissociative fashion. A broader conceptualization of trichotillomania, recognizing the role of affect dysregulation, behavioral addiction/compulsivity, and impaired top-down cognitive control has been suggested (8). Such a conceptualization may inform amendment of the diagnostic criteria for trichotillomania in any forthcoming classificatory revision.

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SAMUEL R. CHAMBERLAIN, M.A.
Cambridge, United Kingdom
ISOBEL HEYMAN, M.D.
London, United Kingdom

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Psychiatric Disorders as Social Constructs: ADHD as a Case in Point

TO THE EDITOR: The article by Guilherme Polanczyk, M.D., et al. (1), in the June 2007 issue of the *Journal,* provides important insights pertaining to the worldwide prevalence of childhood attention deficit hyperactivity disorder (ADHD). Dr. Polanczyk et al. convincingly argued that symptoms of ADHD may have a more constant geographic prevalence than previously thought. However, the accompanying editorial may have overestimated the implications of these findings (2).

The statement that a constant prevalence of ADHD symptoms argues in favor of "ADHD's identity as a bona fide mental disorder, as opposed to a social construction" (2, p. 856) may be misinterpreting the nature of psychiatric nosology. The concept of a disorder and its diagnostic criteria are social constructions by definition, and the fact that a group of symptoms has a constant geographic prevalence has little to do with what leads these symptoms to be considered a diagnostic entity. Twin pregnancies, for example, are observed worldwide with limited prevalence variation; however, being a twin in some indigenous cultures in Africa and South America could lead a child to be left to die or to be attributed with supernatural powers, whereas the same biological occurrence has far less relevance in modern Western society. Thus, universal phenomena can be viewed as normal or dysfunctional according to cultural beliefs.

Perhaps the best way to judge whether ADHD is a social construction, therefore, is not to look at the worldwide prevalence of its symptoms, but rather to evaluate the prevalence of its recognition and treatment. In this area, differences are striking. The per capita consumption of methylphenidate in the United States between 2003 and 2005 was approximately six times greater than that of Australia, eight times greater than that of Spain, and 18 times greater than that of Chile (3). If the prevalence of hyperactive symptoms is indeed similar among these countries, this probably means that a "hyperactivity disorder" deserving treatment in one country is seen by parents and physicians as a nonmedical condition (perhaps at the higher end of the "childhood activity spectrum") elsewhere.

It is in defining such a diagnostic threshold that lies the social construction, as the boundaries of normality in a given region are set by psychiatrists (by choosing and applying diagnostic criteria) and society (by recognizing symptoms as deserving of medical care). Thus, it is probably not useful to ask whether DSM-IV has too low a threshold for ADHD or whether ICD-10 has too high a threshold, since there is little evidence of a biological threshold to be identified; the definition of such a threshold is the collective social duty of physicians, parents, and society. It is crucial that we acknowledge not only the existence of this construction, but also the responsibilities inherent in taking part in it. Symptoms might be constant throughout the world, but it is how we view them that will give them meaning and define the care of children worldwide.

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OLAVO B. AMARAL, M.D.
Porto Alegre, Brazil

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Drs. Polanczyk and Rohde Reply

TO THE EDITOR: We appreciate the thoughtful views of Dr. Amaral. It is of paramount importance to discuss the perceptions of physicians and patients concerning mental health disorders. This is the only way that we can counter the stigma surrounding them. Cultural stigma is an important barrier to recognition and treatment of illnesses, particularly mental disorders, including ADHD. Nevertheless, economic factors seem to be a major impediment to their successful management. In the United States, a survey of more than 100,000 families revealed that uninsured children and children of racial/ethnic minority populations were less likely than others to be receiving medications for ADHD (1). There is a significant gap between the needs and provisions of mental health services in virtually every country, especially in developing countries (2). In a Brazilian sample of 100 nonreferred subjects identified with ADHD in schools, only three subjects were currently receiving treatment (3). The same findings were revealed in a Venezuelan community survey, in which only 4% of children identified with ADHD by researchers were receiving treatment (unpublished study by Montiel-Nava et al. available upon request from the authors).

As Dr. Amaral points out, it is true that "universal phenomena can be viewed as normal or dysfunctional according to cultural beliefs." Psychiatric diagnostic criteria are based on conceptual theories, but not only on such theories. Empirical evidence supports the validity of ADHD diagnostic criteria, as well as the validity of several other medical conditions, even if specific cultures legitimize their occurrence as "normal" or "desirable." For instance, there is a higher prevalence of obesity among individuals of Pacific Island cultures compared with those of European ethnicity (4). This is probably related to economic factors and a cultural desire for bigger bodies (4). Nevertheless, the link between obesity and several adverse outcomes is well established, supporting its validity as a medical condition.

It has been demonstrated that the variability of estimates of ADHD prevalence in diverse locations around the world seems to be largely explained by methodological artifacts and not by demographic differences. This indicates that