TRICHOTILLOMANIA- A CASE REPORT

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ABSTRACT

BACKGROUND

A case of adolescent female presented with 3 years history of urge to pull hair of scalp, which relieved after hair pulling with mild depressive and moderate anxiety symptoms. Patient was started on a combination of Fluoxetine 40 mg orally and psychotherapy including Habit reversal training. Considering varied psychosocial factors associated, it is advisable to have a broader outlook for diagnosis and management of the patient. The combined approach of psychopharmacology and psychotherapy recommended than an isolated approach and evidence for pharmacotherapy cannot be undermined, especially when associated depressive features are present.

KEYWORDS

Trichotillomania, Habit Reversal Training, Stimulus Control.

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BACKGROUND

Trichotillomania is an impulse control disorder characterised by intense and repeated urge to pull out hairs with a mounting tension before and a sense of relief afterwards.[1] ICD-10 (World Health Organisation, 1993) classifies trichotillomania under Habit and Impulse Disorders as a condition, "characterised by noticeable hair loss due to a recurrent failure to resist impulses to pull out hairs, preceded by mounting tension and followed by a sense of relief or gratification." Trichotillomania is 7 times as prevalent in children as in adults with a peak prevalence between the ages of 4 and 17 years.[2] Hair pulling can occur in any area of the body where hairs grow. The scalp is the most common area, followed by the eyelashes and eyebrows.[3] The alopecia that results from hair pulling can range from small undetectable areas of hair loss to total baldness. It can cause a child to experience distress and may result in moderate impairment in social or academic functioning[3] and it may occur in several mental disorders like obsessive-compulsive disorder, depression, borderline personality disorder as well as mental retardation.[4] Additionally, trichotillomania may result in impairment in other important areas of functioning, such as family relationships. Most of the cases present to psychiatrists only after multiple visits to dermatologists and general physicians with complaints of hair loss and remains undiagnosed for a substantial duration. Its clinical presentation is varied and in most aspects remains a poorly understood clinical phenomenon[5] with no formal treatment algorithm.[6]

CASE REPORT

Ms. NG, a 17-year-old single female, a 12th standard student belonging to a nuclear family of middle socioeconomic status was referred to the Psychiatry outpatient department by the dermatology clinic where she presented with complaint of alopecia. The inquiry revealed history of recurrent pulling out of her scalp hair resulting in patchy hair loss for 3 years. It is associated with an urge and a sense of tension immediately before pulling out the hair or when attempting to resist the behaviour which got relieved on pulling out the hair. There was no history of biting or swallowing of the hair. She developed decreased self-confidence due to her problems and started avoiding social gatherings. She started missing her classes and had disturbed family life. On mental-status examination she was cooperative and communicative; she had mild depressive and anxiety symptoms, but no suicidal thoughts. Patients HDRS score and HARS score were 10 denoting mild depressive episode and 18 denoting moderate anxiety respectively. Patient had no evidence of psychosis. A diagnosis of Trichotillomania was made as per International Statistical Classification of Diseases and Related Health Problems, 10th Revision criteria.[1]

Patient was managed with a combination of pharmacotherapy and psychotherapy with weekly follow ups. She was started on Cap. Fluoxetine 20 mg and gradually hiked to 40 mg.

PSYCHOTHERAPY

In the 1st session, Ms' NG was psycho-educated about trichotillomania. The relationship between her distress and hair pulling was established as well as insight into her behaviour was ensured. She was explained about the therapy model of Habit Reversal Training and Stimulus Control and briefed about the possible course of management. In the second session, previous session was reviewed and in depth enquiry revealed that hair pulling was reinforced in multiple ways. First, the most common antecedent events to hair pulling were anxiety and boredom, often associated with academic stress and external cues. In school, she experienced the act of hair pulling as a cue to distract herself from her academic tension. In addition, the physical sensations of touching her hair apparently were a catalyst (cue). She had developed an awareness of the habit and often resisted pulling. The patient was introduced to progressive muscular

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relaxation to alleviate her acute anxiety episodes and was asked to do it on a daily basis. In the third session, replacement behaviours including cue-controlled relaxation and postural modifications such as avoiding postures which gets her hand to touch her hairs in her routine activities as much as possible. As described above, the active treatment consisted of an amalgam of behavioural and cognitive procedures as well as several components of habit reversal training in particular. Formative evaluation efforts were conducted throughout the intervention phase and necessary adjustments and revisions were made in the followup sessions to promote the best possible outcome. Moreover, the content and focus of individual sessions often included the discussion and review of important contextual factors and interpersonal developments. Review of the rationale and types of replacement or competing behaviours that would help decrease her symptoms was constantly done over next sessions. Focus was also directed toward any associated cognitive symptoms. The patient started showing significant improvement in frequency and associated anxiety over this 6-week period with HDRS and HARS scores dropping to 6 and 12 respectively and the management is ongoing.

Figure 1. Fresh Lesion at the site of pulled hairs.

DISCUSSION

Trichotillomania is a complex disorder with a diverse presentation that is difficult and challenging to treat. Therefore, assessment data should be multifaceted including both self-report data and more objective means (e.g. pictures) of measuring clinical outcomes. Studies on the pharmacotherapy of trichotillomania remain inconsistent[7-9] with no pharmacological management found to be clinically effective constantly. Behaviour therapy, especially Habit Reversal Training and Stimulus Control (HRT Plus) has been suggested to be an effective treatment in these cases.[10-12]

In light of the empirical data in support of behavioural conceptualisations and treatments of trichotillomania, it is advised to use such behavioural methods including habit reversal procedures during the course of therapy. Moreover, the context in which the treatment is conceptualised, taking into account the relevant individual factors of each case (e.g. family-of-origin issues, interpersonal difficulties), provides a full menu of potential correlates for the practitioner to consider during therapy. The treatment model of Habit reversal training attends to the diverse and idiosyncratic nature of factors that encourage and perpetuates hair pulling; however, symptom improvement can be due to the reducing emotional distress and value-laden self-judgments about having psychiatric symptoms.[13]

The distress is addressed not only through the psychotherapeutic intervention (Habit Reversal Training, Progressive Muscular Relaxation and Psychoeducation), but also by biological intervention in the form of Selective Serotonin-Reuptake Inhibitors (SSRIs), which was Fluoxetine in this case. Though Selective Serotonin-Reuptake Inhibitors (SSRIs) generally do not appear to be efficacious in reducing hair pulling symptoms per se.[14] The combination of pharmacotherapy and psychotherapy is recommended than an isolated approach and evidence for pharmacotherapy cannot be undermined, especially when associated depressive features are present.

CONCLUSION

Given that trichotillomania is not necessarily rare, but variable depending on a number of contextual factors it is recommended that clinicians pay close attention to the idiosyncratic variables in combination with broader treatment principles when providing treatment to those suffering from trichotillomania.

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