Case Report

Trichotillomania in a Patient with Psychosis

Dr. Suresh Kumar Mehta
Prof. and HOD, Dept. of Psychiatry
Pacific Medical College and
Hospital, Bhillo ka Bedla, Udaipur

Dr. Pinki Trivedi
Clinical Psychologist and Counselor,
Dept. of Psychiatry, Pacific Medical College
and Hospital, Bhillo ka Bedla, Udaipur

Dr. Neeraj Kumar Tripathi
Clinical Psychologist and Counselor,
Dept. of Psychiatry, Pacific Medical College and
Hospital, Bhillo ka Bedla, Udaipur

Dr. Shivani Bhardwaj
Assistant Professor, Dept. of Dermatology
Pacific Medical College and Hospital,
Bhillo ka Bedla, Udaipur

Dr. Divya Sharma
Senior Resident , Dept. of Dermatology
Pacific Medical College and Hospital,
Bhillo ka Bedla, Udaipur

Dr. S. K. Sharma
Consultant Psychiatrist , Dept. of Psychiatry
Pacific Medical College and Hospital,
Bhillo ka Bedla, Udaipur

ABSTRACT

Trichotillomania also known as hair pulling disorder is a sub category of obsessive compulsive spectrum disorder characterized by repeated hair pulling from various sites with an increased tension prior to hair pulling and the person gets relief following the act. Trichotillomania is not always a focused act but in fact hair pulling occurs in impulsive episodes . Trichotillomania has two subtypes namely "automatic" versus "focused" hair pulling. Various psychiatric disorders are associated with cases of Trichotillomania.4

A case of 30 year old male patient was presented in our psychiatric out patient department and he was diagnosed to suffer from Trichotillomania with Psychosis.

Keywords: Trichotillomania, Hair Pulling Disorder, Psychosis

INTRODUCTION

Trichotillomania (TTM) or compulsive hair pulling also called as hair pulling disorder is a psychiatric disorder. It usually presents with urge of pulling out one's own hair. It is classified under Obsessive compulsive and related disorders (OCRD) category of DSM-5 and ICD -11 Systems of the disease classifications (American Psychiatric Association, 2013)[6]. There is an irresistible urge to pull hair. The commonest areas for hair pulling are head and areas around the eyes. The name for this disorder was created by Francois Henri Hallopeau in 1889.[11]

There can be strong family history of the disorder. It is more common with obsessive compulsive disorder. Episodes of pulling may be preceded by abounding anxiety. Similar picture can be seen in Body Dysmorphic Disorder (however it can be differentiated by the fact that people remove hair so as to improve their look) or it can be confused with a case of Alopecia Areata. Many psychiatric problems can be associated with a case of Trichotillomania that usually presents for the first time in adulthood.

Depression, Anxiety disorders, Obsessive Compulsive Disorder and Psychosis are the common psychiatric disorders known to present concomitantly with trichoti1lomania. Trichotillomania can involve multiple sites but in most of the cases it usually involves one or two sites. The most *common hair* pulling site is scalp and then is followed by the eyebrows, eyelashes, face, arms, and legs in descending order. Very rarely it can involve areas like the pubic area, beard underarms, and chest[11]. Most of the children pull hair from scalp area.

In Trichotillomania three clusters were identified, namely :1) Simple TTM- means cases without any comorbidities 2) Depressive TTM- means cases with comorbid Major Depression and 3) Complex TTM- means cases with combinations of the investigated comorbidities.[12]

In Trichotillomania, usually one hair is pulled out at a time and single episode may last from minutes to hours together. This urge to pull hair

may diminish or totally vanish in an individual with time but recurrence or relapse is common.

Clinical examination of these patients with Trichotillomania exhibit hair of differing lengths. There can be broken hair with blunt ends, broken mid-shaft hair or some uneven stubble or some tapered ends of re-growing hair. We can usually see normal hair density and usually hair pull test is negative. It is not easy to pull out the hair and an unusual shape will be found in areas of hair pulling.

Individuals with trichotillomania definitely present with secondary psychological effects. There can be avoidance and isolation, the fear of socializing, shyness, low self-esteem and shame[11]. They may also be worried about negative attention. Some people diagnosed with trichotillomania try to prevent this negative reaction by wearing hats, wigs, false eyelashes or eyebrow pencil. Additional stress can worsen the condition.

Trichotillomania can be an effect of underlying frustration. But in long term, embarrassment about hair pulling can lead to severe emotional distress and painful isolation, which in long run can lead to co-occurring psychiatric disorder. Hence prompt and urgent professional help is needed in coping with this problem[17].

Here we are presenting an interesting case of Psychosis with Trichotillomania in a middle-aged male patient.

CASE REPORT

A 30 years old Mr. Y was brought to psychiatry outpatient department by his brother and father for evaluation in view of history suggestive of abnormal behavior, not working, not taking interest in routine daily activities, irritability at times, sleeplessness and weight loss since 4 to 5 months. The patient was apparently alright about 5 months ago when he developed all above symptoms gradually. There was history of family disputes with spouse prior to the onset of the illness. There is history of tobacco addiction but no alcohol or other substance abuse. In addition, relatives noticed loss of hair on scalp. There was no history of fever, any infection, convulsions unconsciousness, any skin pigmentation or drug reactions.

There is no history of any other major psychiatric or medical illness in the past. Family history also did not reveal any major physical or mental illness. Father reported sensitive, emotional nature of the patient since childhood. Patient has been educated upto tenth standard and is working as a farmer.

On evaluation, patient showed symptoms and signs of psychosis. He had anxiety and the affect was inappropriate and was not correlated with the mood. Blunting and poverty of thoughts were there. Judgment and insight were partially impaired. The mental status examination revealed no other major abnormal findings. His higher neurological functions were normal and he was relevant. On probing, he revealed that he gets an urge and pulls out his own hair since last 4 to 5 months. He could not control his urge and was feeling tense till he pulled out his hair. (Figure 1 To 4) There was no associated itching on the scalp.

Figure 1

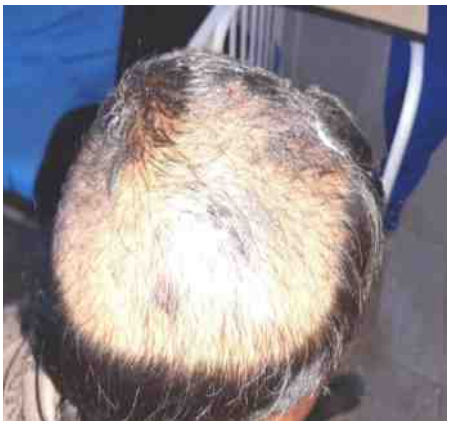

Figure 2

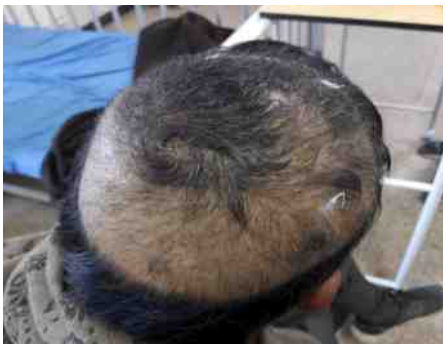

Figure 3

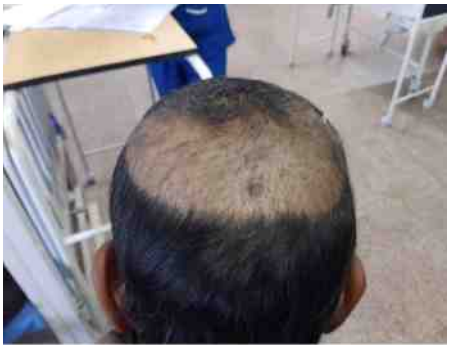

Figure 4

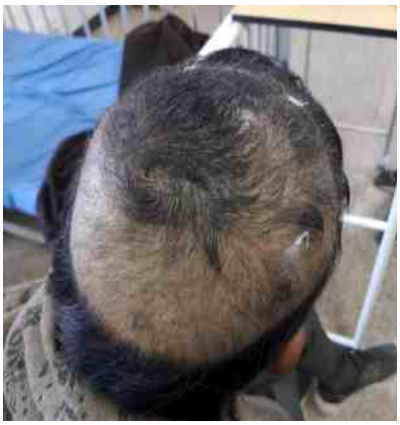

Figure 5

Figure 6

A diagnosis of Psychosis with Trichotillomania (Complex TTM) was made after thoroughly investigating the case. His routine blood counts, BSL, renal profile, thyroid function tests, NCCT Brain, liver function tests, VDRL, HIV test, EEG and ECG were normal.

Dermatological reference was done and they confirmed the diagnosis of trichotillomania after ruling out alopecia areata. Patient and relatives did not give consent for dermatoscopy and scalp skin biopsy, which could have given clear confirmation of the condition. A good skin biopsy can reveal traumatized hair follicles with perifollicular hemorrhage, regenerating normal hairs, fragmented hair in the dermis, multiple catagen hair, empty follicle, and deformed hair shafts.[11]

Patient was started on antipsychotic Tab. Olanzapine 5 mg two times a day, Tab. Sertraline 50 mg two times a day, Tab. Clonazeparn 0.25 mg two times a day and multivitamins. In addition, cognitive behavior therapy and habit reversal training were started. The relatives were counselled regarding the nature of the disease so that patient could be understood well and can get good emotional support. His spouse was called for family therapy and we tried to help improve their interpersonal relationships.

Patient started showing some improvements and was assured about regular treatment and behavior therapy sessions. He reported that pulling of hair had decreased. Regular follow ups and long-term treatment was assured. Follow up with the dermatologist was planned and we expected to get consent for tracheoscopy in near future.

DISCUSSION

Trichotillomania is more prevalent in children with a peak age being between 7-14 years[3]. The cases having childhood onset have better prognosis and the prognosis worsens with the advancing age of onset. About 1-4% of the general population is affected with trichotillomania of various types and females have higher incidence than males[6]. As previously stated, Trichotillomania has higher comorbidity with various psychiatric

disorders such as OCD, Depression, Schizophrenia, Body Dysmorphic Disorder and Anxiety Disorders[4]. But unfortunately, the exact prevalence is not yet clear. Few cases of dissociative disorder[2], Parkinsonism[7] and dementia[5] can also present with Trichotillomania.

In trichophagia, patients in addition to the act of hair pulling, also ingest the hair that they pull. In extreme cases formation of hair ball (trichobezoar) in stomach with gastro internal obstruction as a result of trichophagia can be found. In a study done by Tsai and Chang (1998), repetitive hair pulling behavior was linked to the psychotic state which improved with antipsychotic medications[8]. But such relation between hair pulling behavior and psychosis was not confirmed by many other studies. The neurocognitive model sees trichotillomania as a habit disorder. The basal ganglia are important in habit formation while the frontal lobes are critical for normally suppressing or inhibiting habits-In view of this neuro anatomy and neuro physiology Trichotillomania can be viewed as a habit disorder.

Abnormalities in the caudate nucleus has been suspected in OCD, while another study has shown that some patients with Trichotillomania have decreased cerebellar volume[11]. In our case, occurrence of Trichotillomania with concomitant Psychosis was evident.

Studies support the use of selective serotonin reuptake inhibitors (SSRI) and tricyclic antidepressants like clomipramine in the treatment of Trichotillomania[10]. Addition of antipsychotics and benzodiazepines to SSRIs in our patient gave the best results due to a mix picture of trichotillomania with psychosis with secondary anxiety symptoms.

CONCLUSION

Trichotillomania (hair pulling disorder) is grouped under the obsessive-compulsive spectrum disorder. It presents with self pulling out of the hair from various sites. The hair pulling starts with increased pressure and there is relief of tension following the act. (10) Comorbidity with various psychiatric disorders has been documented. In Trichotillomania three clusters were identified, namely:

1. Simple TTM - means cases without any comorbidities
2. Depressive TTM- means cases with comorbid Major Depression and
3. Complex TTM- means cases with combinations of the investigated comorbidities

Trichotillomania presenting for the first time in adulthood usually arises from another underlying psychiatric disorders. Initiation of the illness has a strong stress associated component[11].

In this 30-year-old male patient presented with hair pulling, psychotic features and behavioral problems, a diagnosis of Complex TTM (Trichotillomania with Psychosis) was made. Patient was thoroughly investigated and treated. Reference to dermatology was given and cognitive behavior therapy along with habit reversal training was initiated. Patient had some improvement. He has been advised to continue regular treatment and follow ups.

Informed consent of the Patient:

The authors disclose that they have obtained all appropriate patient consent forms. In the form, consent has been given by patient for reporting his clinical information and images the journal. The patient and relatives understand that his name and other particulars will not be published and utmost efforts will be made to conceal his identity, but we cannot assure the anonymity.

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Nil

Conflicts of Interest:

Nil.

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