

Case Study

## Trichotillomania: A Case Study

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### ABSTRACT

Present study is about Trichotillomania. As per APA (2013) Trichotillomania diagnostically is an impulse control disorder which shows some overlap with compulsive features of OCD (Obsessive compulsive disorder) and some with BDD (Body dysmorphic disorder). Trichotillomania is usually as a result of first exposure to some hair pulling event and relating it with unhelpful cognitions which eventually lead to a vicious cycle. Therapeutically, it is important to investigate how the first exposure to a random hair pulling event gets associated with a series of unhelpful thoughts that make the patient think that until they pull hair, the anxiety and physical discomfort will not be reduced.

**Keywords:** *Trichotillomania, Case Study*

**T**richotillomania diagnostically is an impulse control disorder which shows some overlap with compulsive features of OCD (Obsessive compulsive disorder) and some with BDD (Body dysmorphic disorder) (APA, 2013). The cycle which leads patients to compulsively pull hair to relieve anxiety shares its features with OCD. However, some patients have imagined or perceived defects in physical abnormalities shares clinical features with BDD (Body Dysmorphic disorder) (APA, 2013). Most common pre-occupations concern appearance in general, hair, chin, facial features and eyebrows. Patients with Trichotillomania (TTM) compulsively pull hair out of root from places such as scalp, eyebrows and eyelashes. In severe cases, some patients have been noted to pull hair from pubic/ perirectal region too. In other cases, patients ingest hair compulsively after plucking them. This often leads them to undergo an intestinal surgery (Franklin, Zagrabbe & Benavides, 2011).

### *The Patient*

A 17 year old boy A.G was referred to the dermatology department (Shalby Hospitals) with complaints of increasing bald patches in the scalp region. The dermatologist advised him to go for an ultrasound of scalp. No organic cause of baldness was found. However, it came to

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notice that A.G had been pulling off his hair. With immediate effect, he was referred to the psychiatry department (Shalby Hospitals).

Assessment was done by a psychiatrist and a psychologist CBT specialist. Hemogram, Renal & Liver function tests were done and were normal. USG abdomen was done to rule out trichophagia (hair ingestion) A.G was eventually diagnosed with Trichotillomania. His mood was euthymic and he acknowledged hair pulling as a problem he wanted to get out of. Insight and self care were good, but over time, TTM had resulted into depression.

On a scale of severity, A.G's hair pulling fell between moderate to severe. Although the patient was not ingesting hair, he used to compulsively pull hair which had resulted in baldness of almost 1/3<sup>rd</sup> of his scalp. The consequent guilt he experienced, made him feel depressed, unfocussed on studies, and perform poorly in academics.

The problem of hair pulling, as reported by the patient had started first two years back when he had noticed his mother plucking her brows with tweezers at home. Upon asking his mother, she had told him that unkempt growth of hair made one look unattractive. Thus, it was a must to keep hair trimmed and short. This had somehow reinforced the belief in him that his scalp and brow hair needed trimming and he needed to do it by pulling it.

Further assessment by the psychiatrist & psychologist revealed that high level of tension & discomfort which led him to pull hair. Pulling hair resulted into instant gratification which lasted for a short duration. This would again give rise to the feeling of discomfort. Thus a vicious cycle of hair pulling and low mood had been formed.

### **Treatment Protocol**

NICE (National Institute for Clinical Excellence) guidelines propose that CBT (Cognitive behavior therapy) with HRT (Habit reversal therapy) alongside pharmacotherapy is the main stay treatment for Trichotillomania. The same was applied to our treatment (Sah, D.E, Koo, J & Price, 2008; Franklin et al, 2011).

### **Pharmacotherapy**

Medical treatment was commenced with Fluoxetine (SSRI) at 20 mg per day. Clomipramine (tricyclic antidepressant) at 75 mg and non sedating anti anxiety medicine Etizolam (Benzodiazepine) at 0.5 mg at night were started as primary treatment. Vitamins, minerals and keratin protein medicines were prescribed by the dermatologist to aid in rapid re-growth of hair.

After two weeks, partial positive response was seen in A.G's hair pulling habit. Improvement was also noted in parameters of depression, sleep, appetite and concentration in studies.

The psychiatrist, seeing the positive response, titrated the dose to optimal: Fluoxetine 40 mg per day in divided doses, Clomipramine 150 mg per day in divided doses and Etizolam was continued at the same dose. A.G was asked to start regular psychotherapy sessions along with medicines.

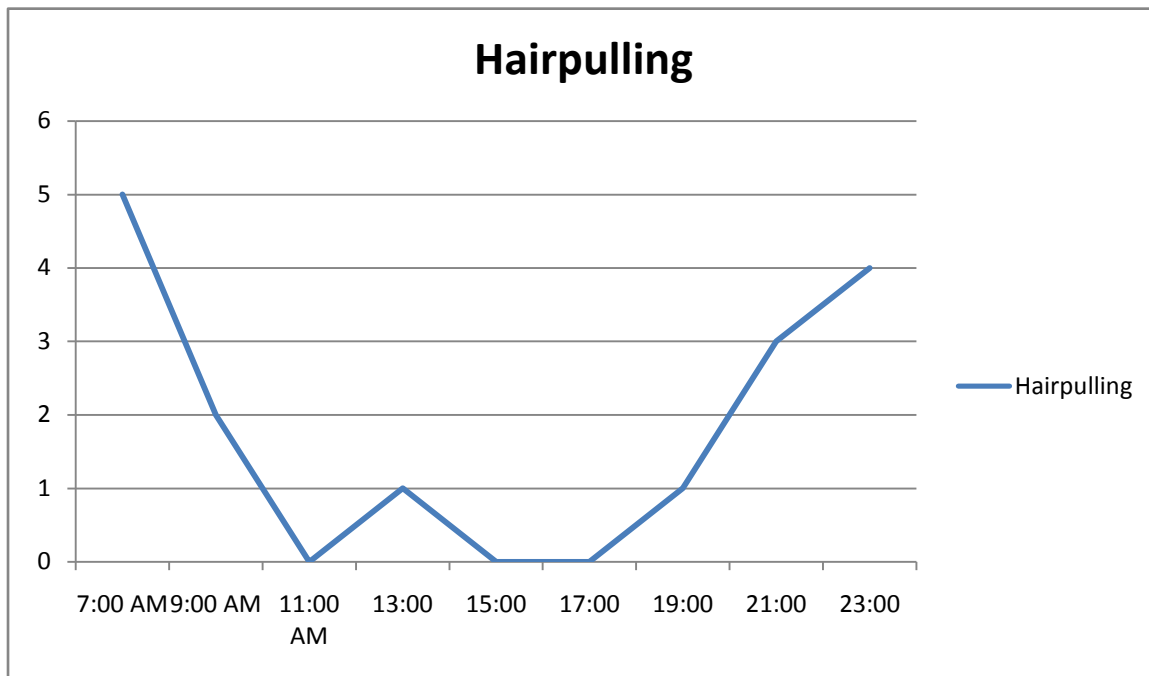
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### **Psychotherapy Plan**

As per NICE guidelines, it was decided that cognitive behavior therapy with HRT (Habit reversal therapy) component and ERP (Exposure and relapse prevention) was planned.

A.G was asked to keep a record of his daily hair pulling.

The following table shows his hair pulling record on a daily basis.



**Table 1.1 shows the time of the day when A.G was most susceptible to hairpulling.**

It can be seen from the table that hairpulling was maximum during the morning when he was getting ready and exposed himself to the mirror. The patient reported that his scalp and brows were what occupied his attention first. Therapeutic work from here on would be focused on improving self image while looking into the mirror. Throughout the day, there is a steep decline in hair pulling as daily activities and study occupy his time. However, after school hours, when he was comparatively free at home or involved in homework (which he describes as an uninteresting task), his hairpulling increased again until bed time (when he was relatively unoccupied).

In one of the early sessions, A.G reported depression upon understanding the extent of his hair pulling and the harm he was causing himself. After this, his desire to make attempts to stop hair pulling increased which was a benefit to therapy.

### **Psycho-Education**

The patient was explained how he had developed a vicious cycle of releasing immediate tension by hair pulling which provided very short term gratification and the next bout of desire to pull hair would be even more intense and intolerable than the previous one. He had thus reached a point where urges and discomfort were not tolerated at all.

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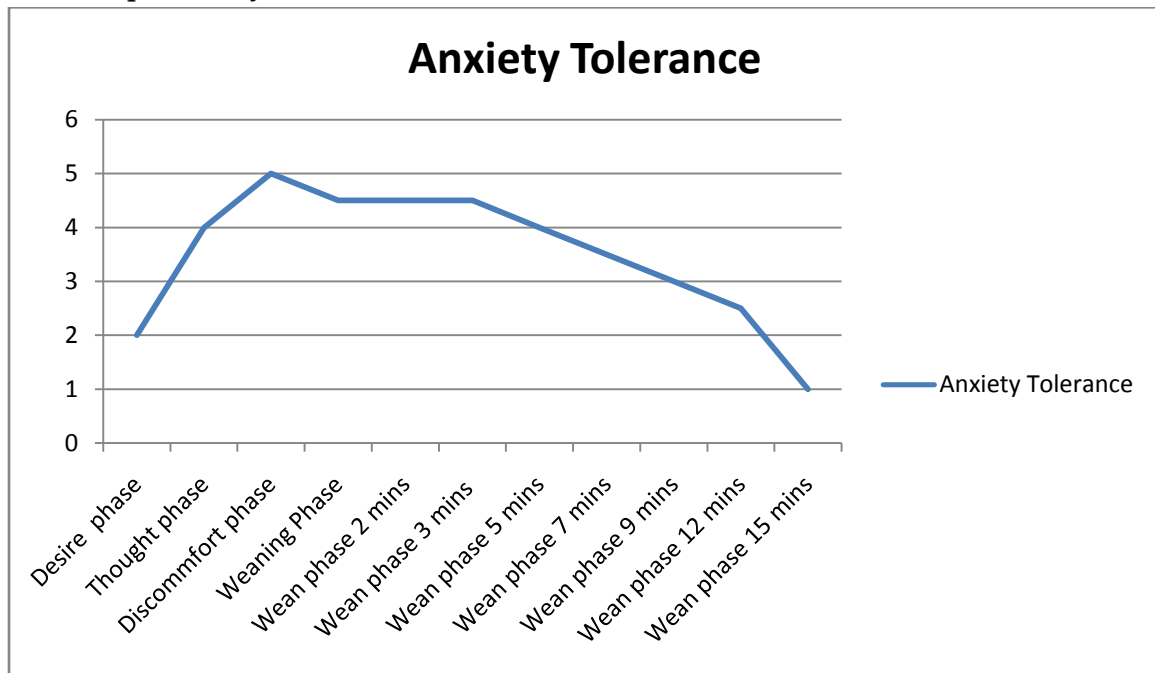
### *Anxiety Tolerance*

When the desire of hair pulling overcame him, he reported experiencing anxiety (restlessness, perspiration, intense desire, palpitations and negative thoughts). To stop these unpleasant thoughts & physiological sensations, he needed to pull hair.

Alongside, Etizolam, on an SOS basis to relieve physiological discomfort, he was taught to tolerate anxiety and try not to act impulsively upon his desire to pull hair. He was explained that this was a part of behavioral experiment. Every effort to tolerate anxiety may not be successful, but he could improve it by repeated practice. Anxiety tolerance was a major part of therapeutic intervention.

Initially, tolerating anxiety while resisting the urge to pull hair was not totally successful, A.G noticed that the more he tolerated discomfort, it did not grow. It reached a plateau and then declined steadily. This explains why some of his efforts at tolerating anxiety were successful.

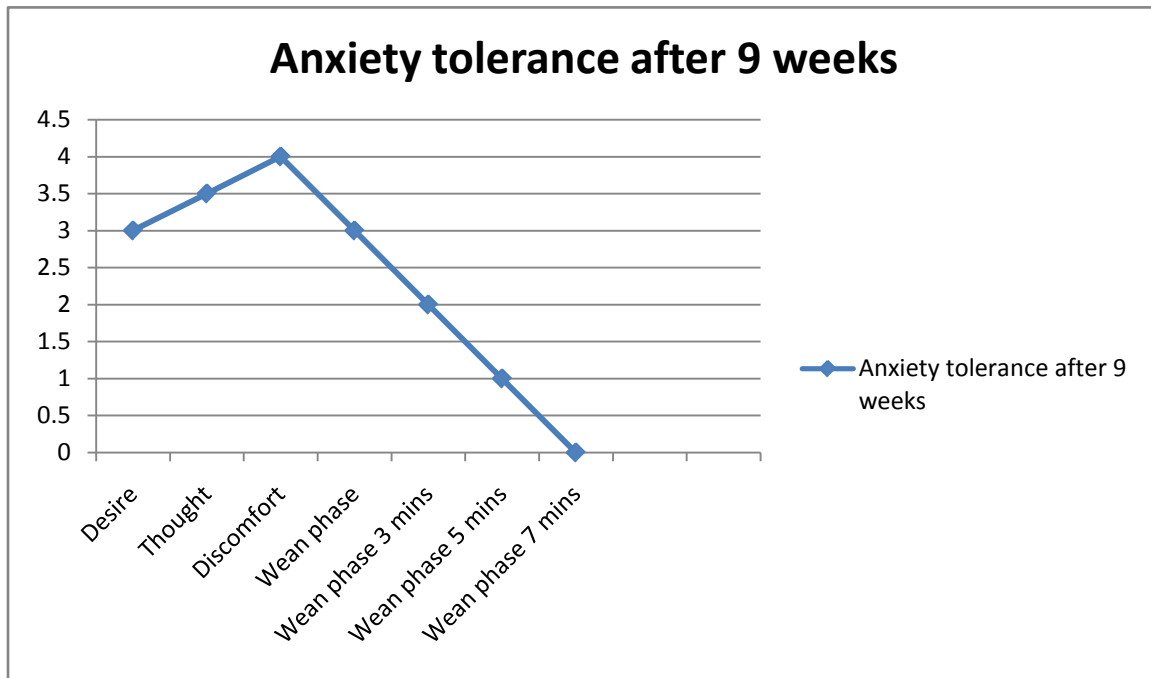
*This is explained by Table: 1.2*



It can be seen how anxiety propels itself to the highest peak during the phase of physiological discomfort (score 5) and then sustains itself for a couple of minutes before slowly accelerating downwards.

With repeated practice over a couple of sessions, the size of the plateau is seen to decrease and anxiety weans off completely within seven minutes as explained by

Table.1.3



**Habit Reversal Training (HRT)**

HRT focuses on concentrating on cues that make patient more susceptible to hair pulling and consciously trying to avoid those. In this way, the patient exerts more control over cues and his own behavior.

It was found that the patient was most susceptible to hair pulling when he was free or doing a seemingly boring task such as studying. However, when he was occupied, the hair pulling rate almost went down to zero. We tried replacing hair pulling by pulling towel threads in order to replace a habit.

Other cues were also outlined and collaboratively, behavior strategies were developed to avoid these. It is explained in the following table.

Cues	Type of Behavior	Alternatives
Visual	Viewing in mirror	Avoid looking in mirror
Tactile	Sensing hair on finger tips	Wear gloves on certain occasions
Location based	Bathroom, Study room	Developing awareness
Activity	Post shower, Study	Replace with thread pulling

**Follow Up**

Medicines were continued at the same dose and psychotherapy continued for 10 weeks. Hair pulling had almost reduced to zero. Last record maintained by the patient showed hairpulling once in 2 weeks. This improvement was maintained consistently for over a

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month. BDI (Beck depression inventory) showed significant reduction in depression parameters. Sleep and appetite had also improved.

Even though improvement had been noted, medication would be continued at a tapering dose until a totally symptom free period of four months would have been achieved because there might be chances of relapse.

### DISCUSSION

Even though CBT is an evidence based therapy alongside pharmacotherapy, it is interesting to note that individual components of CBT which are successful differ from patient to patient. It is however important to note that introducing the patient to distorted beliefs and cognitions in relation to hair pulling because this is what sets the base for impulsive hair pulling in future. In A.G's case, it was noticing how his mother perfecting the eyebrow line with the help of tweezers which made him see the relationship between his imperfect hairline and his need to correct it by pulling off unnecessary hair. It eventually resulted into a permanent state of anxiety and pulling off hair as a means to relieve it.

In cognitive behavior therapy, behavior experiments are of prime importance as they help test patients existing cognitions (beliefs) versus more adaptive beliefs and reverse the vicious cycle. The designs of our behavior experiment was derived from the formulation of A.G's current belief that pulling hair will help him relieve anxiety and that he needs to pull hair because it 'seems' to be growing in unnecessary pattern.

What worked the best for the patient was that as opposed to his belief that his anxiety will go out of control if he doesn't act upon his urge to pull hair, he was able to tolerate anxiety and bodily discomfort very well. Once the anxiety tolerance became a practiced act, he could see that resisting the urge and eventually overcoming it was not as difficult.

Certain aspects from HRT were also equally useful from the viewpoint of recovery. These included overcoming visual cues and replacing hair pulling activity with pulling towel threads.

Also, since the medicines were taken under supervised clinical guidance, the patient's adherence to the prescription was excellent. The medication had no apparent major side effects and with therapy, proved to be an excellent tool to reduce depression and motivate the patient enough to engage in therapy completely.

### CONCLUSION

Trichotillomania is usually as a result of first exposure to some hair pulling event and relating it with unhelpful cognitions which eventually lead to a vicious cycle. Therapeutically, it is important to investigate how the first exposure to a random hair pulling event gets associated with a series of unhelpful thoughts that make the patient think that until they pull hair, the anxiety and physical discomfort will not be reduced.

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A proper combination of psychiatric medication and cognitive behavior psychotherapy helps in reversing this process and reducing the resultant anxiety and depression. It is possible to achieve complete remission in Trichotillomania. However, it would be clinically beneficial to technically improvise on CBT with Trichotillomania as we compile more and more individual case studies done in this area and analyze what aspects worked for each individual patient. In this way, we might be able to develop a form of brief CBT for TTM.

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