The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 10, Issue 4, October- December, 2022
DIP: 18.01.037.20221004, DOI: 10.25215/1004.037
https://www.ijip.in

Case Report

Psychological Management of Trichotillomania Using Eclectic Approach: A Case Report

Sangita Kumari[1]*, Masroor Jahan[2]

ABSTRACT

Trichotillomania is a condition that gives people a strong desire to pull out their hair. People having this condition pull their hair from the scalp, eyebrows and other areas of body. Ms. X was 18 years old female, B.Com 1st year student, with a history of hair pulling; feeling good when gets scolded, and in scratching and pressing wound since the past 4 years, and since last one year problems increased. She started eating soil and developed social withdrawal, low mood and negative cognitions. Beck Depression Inventory (BDI), Sack's Sentence Completion Test (SSCT), Human Figure Drawing Test (HFDT) and Thematic Apperception Test (TAT), were administered for assessing depression, identifying conflicts, and personality dimensions of the patient. The findings revealed mild level of depression, moderate level of conflict, negative cognitions, sad mood and inadequate ego structure. The environment was mostly perceived as depriving, dominating and unsupportive. Based on problem areas, psycho-education, supportive therapy and cognitive behavior therapy was done using eclectic approach in 12 sessions. Patient showed significant improvement in her symptoms and developed positive attitude towards family members and significant others. Improvements were maintained after 6 months follow-up period.

Keywords: *Trichotillomania, Behavior Therapy, Cognitive Restructuring, Interpersonal Psychotherapy.*

In the 5th edition of the DSM (DSM-5, 2013), trichotillomania was included in the chapter on Obsessive-Compulsive and Related Disorders with obsessive compulsive disorder (OCD), excoriation disorder, body dysmorphic disorder, and hoarding disorder.

Trichotillomania is a clinical condition, which is concerned with pulling owns hair from the scalp, eyebrows and other areas of body. Patients have significant and frequent hair loss and marked functional impairment. These behaviours increase during the stressful situation, anxiety and during depression. It includes the criterion of an increasing sense of tension before pulling the hair and relief when pulling the hair. It has a high overlap with post-traumatic stress disorder. It shows poor self-esteem, poor eye contact, emotional instability, and lack of capacity for decision making and lack of assertiveness within the individual.

[1]Ph.D Scholar Department of Clinical Psychology RINPAS Kanke Ranchi
[2]Additional Professor & Head of Department of Clinical Psychology RINPAS Kanke Ranchi
*Corresponding Author

Received: August 10, 2022; Revision Received: November 06, 2022; Accepted: November 13, 2022

Introvert persons are at more risk than extrovert person. They experience academic, occupational as well as psychological difficulties, poor quality of life, feeling physical unattractiveness, depression, shame and feeling of low self-worth. Person tries to avoid social situation like party.

In Trichotillomania Impact Project (TIP) Woods et al. (2006) explored phenomenology, functional impairment, and treatment utilization. A summary of treatment seeking in the sample suggested that pharmacotherapy was the most commonly received treatment, followed by behavior therapy.

Behavioral interventions for trichotillomaina have generally included three core elements; awareness training, stimulus control and competing response training (Franklin & Tolin, 2007). Habit reversal training with stimulus control (Gupta & Gargi, 2012), acceptance enhanced behavior therapy (Fine et al., 2012) and response prevention (Massong et al., 1980) etc. have been found effective in the psychological management of Trichotillomania. Keuthen et al. (2015) provided intensive cognitive behavioural training focusing on in-person or videotaped didactics, role playing, and case presentations with supervision upon request and reported increased self-reported utilization of skills.

Since Trichotillomania has associated psychological distress and impact on overall daily functioning, based on problem areas, psycho-education, supportive therapy and cognitive behavior therapy was planned using eclectic approach.

CASE REPORT

Miss A, 18 years old, female, studying in B.Com 1st year, belonging to middle socio-economic status, residing in urban area was brought to out patients department of Psychiatric hospital by her father. She had complaints of hair pulling, good feeling when getting scolded, good feeling in scratching and pressing wound since 4 years, eating sail, living alone, low mood, poor self confidence. Total duration of illness was four years; symptoms increased during last one year.

The patient was born out of normal full term delivery. She has one elder sister and one younger brother. Birth and early childhood was uneventful. Patient was introvert and had difficulty in close emotional ties. Patient's younger brother has critical attitude towards her. She had good relationship with sister, however, she does not share her problems with sister. She rarely talks to her father regarding any demands. Communication with father is switchboard (via mother). She had good interpersonal relationship with her mother. She mostly tells her mother about all her problem. Family has sufficient resources for basic living facilities.

HISTORY OF PRESENT ILLNESS

She was apparently maintaining well before 4 years. She was in 9th std. One day her classmate told that her 2-3 hair has got spiked. She could not set those hairs so pulled that hair out and after that she felt very good. Whenever she was alone or she was studying or whenever feels sad and tensed she started pulling her hairs. After that she gradually became habituated to it for seeking relief from tension. Later on it became a compulsive act. She kept that hair in her books, under her bed and her closet. When her family members noticed reduced hair, she told them that her hair is falling. She was taken to a dermatologist and took medicine. She did not disclose about her hair pulling to the treating consultant. No improvement was noticed.

She also feels good whenever she get scolding, by pressing the body's wound and scraping it. Before one year she liked smell of soil of her farm and started eating it occasionally. Patient's daily functioning, social interaction, academic performance, and interest in extra-curricular activities deteriorated. She had disturbed biological functioning. Her predominant affect was sad. Her academic performance and interest in extra-curricular activities deteriorated. When her mother was cleaning her room, she found the farm soil under her bed but patient told that she has no idea from where this soil came. One day by chance her father saw her pulling hair. Then parent came to know about patient's problems. They got upset and brought her for treatment.

INITIAL OBSERVATION AND ASSESSMENT

Mental status examination of the patient revealed negative cognition, preoccupation with hair-pulling and depressed affect. Patient was at times restless. Beck Depression Inventory (BDI), Sack's Sentence Completion Test (SSCT), Thematic Apperception Test (TAT), and Human Figure Drawing Test (HFDT) were administered to assess psychological aspects. Behavioural analysis was done. Overall findings suggest that patient had mild level of depressive symptoms suggesting low mood, sense of failure, lack of satisfaction, guilt feelings, irritability, feeling of hopelessness, lack of interest, loss of appetite and self-punitive thoughts. Patient had moderate level of conflict in the areas of 'attitude towards father', 'interpersonal relationship', and 'fear of self-assertion'. Personality dimensions revealed high aspiration, low energy level, self-orientation, emotional focus and immaturity. Patients had high need for achievement, affiliation and nurturance. Patient had fear of disapproval, and rejection. Patient had weak ego structure. Rationalization and reaction formation were commonly used ego defense mechanisms. The environment was mostly perceived as depriving, dominating and unsupportive. However, the future was mostly perceived as hopeful.

Main predisposing factors identified were poor coping with situation, introvert nature, stress and poor problem-solving ability. Maintaining factors were helplessness, sense of failure, poor self-confidence and emotion focused coping. These factors led to problems like pleasure after pulling-out hair, scratching, eating soil, social withdrawal, behavioural deficits and negative cognitions. Main protective factors were caring, and supportive family members who were motivated for patient's psychological management.

Therapy Process

An eclectic approach was followed for therapy. Based on identified problems, therapy sessions focused on psychoeducation to patient and parents regarding patient's problem, improving social functioning, structuring routine activities, teaching stress management, coping and problem solving, assertiveness training, and modifying cognitive distortions. Therapy was done in 12 sessions (10 individual sessions and 2 conjoined sessions with patient and parents). Duration of each session was approximately 45 minutes, initially twice a week then once in a week.

After establishing a therapeutic alliance, detail psychoeducation was given to patient. Patient also attended conjoint sessions of psychoeducation along with parents. Patient was provided a non-judgmental environment to express her thoughts and feelings using ventilation and reassurance.

To improve activities of daily living and psychosocial functioning, activity scheduling was done incorporating all relevant activities. Patient was taught relaxation, coping skill and

problem solving for managing stress and improving skills to deal with daily life situations. Since patient had difficulty in expressing her feelings effectively and dealing with interpersonal situations, assertiveness training and social skill training were given. Cognitive restructuring was done to modify negative cognitions.

When the therapy was started, patient and her parents both had little hope of change, however, she was compliant for the sessions. After initial two sessions, change in patient's behavior was noticed and she actively got engaged in the overall management plan. After completion of sessions of therapy, patient gained confidence. Improvement in coping and problem-solving ability was reported. Her social interaction, negative cognition, and anxiety improved. She was doing her day-to-day activities in organized manner. These improvements were maintained after 6 months of follow-up period.

DISCUSSION AND CONCLUSION

The therapy package used in the present study was selected using eclectic approach. It consisted of psychoeducation, stress management and cognitive behavior therapy. It was effective in symptom reduction and overall improvement in patient's functioning.

Previous studies have mainly focused on using behavioural techniques, and cognitive behavioural techniques. Rothbaum (1992) have also reported effective use of cognitive-behavioral treatment package consisting of habit reversal and stimulus control to control hair-pulling, and relaxation, cognitive techniques, and role-play to manage the stress that often exacerbates pulling. This program has been applied successfully with several clients.

Avoidance is an important component of trichotillomania. Slikboer et al. (2018) assessed type of avoidance in trichotillomania and found that participants with hair pulling symptoms had greater levels of avoidance on each of the five types: 'Avoidance of non-social goals', 'Self-concealment', 'Behavioural social avoidance', 'Avoidance of relationship problem solving' and 'Avoidance of thinking about the future'. Since cognitive behavior therapy focused on avoidance also, it was effective in improving patient's functioning.

As reported by our patient and caregivers, patient was using learnt skills and had improved overall functioning. Improved use of learnt cognitive behavioural skills has been reported by Keuthen et al. (2015). Martin et al. (1998) assessed the effectiveness of a cognitive behavioural treatment programme for trichotillomania and found a significant risk for relapse following successful cognitive behavioral treatment of trichotillomania. Recommendations to address this problem include extending treatment length to achieve greater initial symptom reduction and expanding the focus on relapse prevention strategies. Few prospective follow up studies have demonstrated improvement and relatively low relapse rate after behavior therapy (Gupta & Gargi, 2012)

In our study, the improvement was maintained for a period of six months which shows sustainability of gains from the intervention used (a combination of psycho-education, supportive psychotherapy and cognitive behavior therapy), however, case-controlled studies with a longer follow-up period will provide more insight into sustainability of gains and risk of relapse.

REFERENCES

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. American Psychiatric Association; Washington, DC: 2013.

Fine KM, Walther MR, Joseph JM, Robinson J, Ricketts EJ, Bowe WE, Woods DW. Acceptance-enhanced behavior therapy for trichotillomania in adolescents. Cogn Behav Pract 2012; 19:463-471.

Franklin ME, Tolin DF. Treating Trichotillomania: Cognitive Behavioral Therapy for Hair Pulling and Related Problems. Springer Science and Business Media; NY, USA: 2007.

Gupta S, Gargi PD. "Habit reversal training for trichotillomania." Int J *Trichology* 2012; 4:39-41.

Keuthen NJ, Tung ES, Reese HE, Raikes J, Lee L, Massueto CS. Getting the word out: Cognitive-behavioral therapy for trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder. Ann Clin Psychiatry 2015; 27:10-15.

Massong SR, Erwards RP, Sitton LR, Hailey BJ. A Case of Trichotillomania in a Three-Year-Old Treated by Response Prevention. J Behav Ther Exp Psychiatry 1980; 11:223-225.

Martin JL, Eliabeth EF, Elizabeth AM, Edna H, Foa B. Effectiveness of a cognitive behavioral treatment program for trichotillomania: An uncontrolled evaluation, Behav Ther 1998;29:157-171.

Rothbaum, BO. The behavioral treatment of trichotillomania. Behav Cogn Psychother 1992; 20:85-90.

Slikboer R, Castle DJ, Nedeljkovic M, Rossell SL. Types of avoidance in hair-pulling disorder (trichotillomania): An exploratory and confirmatory analysis. Psychiatry Res 2018; 261:154-160.

Woods DW, Flessner CA, Franklin ME, Keuthen NJ, Goodwin RD, Stein DJ, Walther MR. The Trichotillomania Impact Project (TIP): Exploring Phenomenology, Functional Impairment, and Treatment Utilization. J Clin Psychiat 2006; 67:1877-1888.

Acknowledgement

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interests.

How to cite this article: Sangita, K. & Masroor, J. (2022). Psychological Management of Trichotillomania Using Eclectic Approach: A Case Report. *International Journal of Indian Psychology*, *10(4)*, 406-410. DIP:18.01.037.20221004, DOI:10.25215/1004.037