

Trichotillomania in Schizophrenia

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ABSTRACT

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Trichotillomania is a disorder characterized by chronic hair pulling that often results in alopecia. Co-morbid psychiatric problems are common in children & adults with trichotillomania.

Here we report a case of trichotillomania in a 28 year old man with schizophrenia. A 28 year old married, currently unemployed male from a low socio economic Muslim family with a 12 year history Schizophrenia- paranoid (suspicion, fear and hearing voices) presented in our clinic. He had a history of plucking his hair for the past 6 years resulting in a bald patch.

The patient admitted and was put on haloperidol 5mg and slowly increased to 15 mg, and by the end of one week, his psychotic symptoms came down and the patient no longer had any delusions or hallucinations, but he continued plucking his hair.

Keywords: Trichotillomania, Schizophrenia

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Trichotillomania is a disorder characterized by chronic hair pulling that often results in alopecia. In ICD 10 (WHO 1992) Trichotillomania is classified in the habit and impulse control disorders along with pathological gambling, pyromania and kleptomania. The hair pulling is usually preceded by anxiety and is followed by a sense of relief.

Co-morbid psychiatric problems are common in children & adults with trichotillomania. In a series of children with hair pulling behaviour, 60% was shown to be having overanxious disorder according to DSM III R criteria. (Reeve EA et al, 1992) Trichotillomania is reported to occur among patients with OCD, schizophrenia, depression, borderline personality disorder as well as mental retardation. (Krishnan KRR et al, 1985) In patients with hair pulling behaviour it is prudent to inquire about trichophagy because it can lead on to rare but potentially life-threatening condition called trichobezoar. Here we report a case of trichotillomania in a 28 year old man with schizophrenia.

CASE REPORT

A 28 year old married, currently unemployed male from a low socio economic Muslim family with a 12 year history Schizophrenia- paranoid (suspicion, fear and hearing voices) presented in our clinic. He had a history of plucking his hair for the past 6 years resulting in a bald patch. Reportedly, he plucks three to five hairs at

a time, and when asked the reason for this behavior, he would reply that this decreases the buildup of heat in his head. He initially used to pluck hair from different regions of the scalp, leaving multiple bald patches, but for the past one year this has been restricted to the left side of the scalp, leaving a large patch of alopecia on that side. There was no history of eating the hair. He was on irregular treatment with antipsychotics and patient the patient was off drugs for the past 6 months, and presented with an exacerbation of psychotic symptoms. The pattern of hair pulling was constant throughout the last 6 years and this had no relation to the exacerbation and remission of symptoms, or drug treatment.

On examination the patient was well dressed but poorly groomed with poor rapport. He had delusions of persecution and reported second person hallucination (hearing a female voice criticizing him). He was irritable with preserved affect and revealed that he gets a build up of heat in the head, the left side and then he plucks three to five hairs which results in decreased heat and pleasurable sensation. He was not bothered by the habit and made no attempts to resist it. A large patch of alopecia was present on the left side of scalp extending from the forehead to the vertex and a few centimeters from the near the midline to the left. There was no local inflammation, and patient denied any itching or pain.

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A diagnosis of Schizophrenia- Paranoid with trichotillomania was made according to ICD 10. The patient admitted and was put on haloperidol 5mg and slowly increased to 15 mg, and by the end of one week, his psychotic symptoms came down and the patient no longer had any delusions or hallucinations, but he continued plucking his hair. Covert desensitization, behavior modification and other psychological treatments were not possible due to patient's non-cooperation. He was discharged with the same dose of antipsychotics with plans to start SSRI on review but was lost in follow up.

DISCUSSION

Trichotillomania is considered to be a rare disorder according to most authors. In a study of mental health centre patients, it was found that 0.5% of 1368 patients had the problem. (Manino F & Delgado RA, 1969) At the other extreme it is estimated that 2 – 3% of general population may be affected. (Azrin NH & Nunn RG, 1978)

Though all ages can get affected, the most common presentation is in the adolescent group. (Christensen GA et al, 1991) In young people with the problem, the sex difference in prevalence may not be much significant. (Muller SA, 1987)

Though trichotillomania was reported to occur with many psychiatric disorders including OCD, depression, schizophrenia, borderline personality disorder & mental retardation (Krishnan KRR et al, 1985), the exact prevalence rate was not reported. Other co morbid conditions reported include dissociative experiences (Lochner C et al, 2004), dementia (Mittal D et al, 2001), and Parkinson's disease (Mina A et al, 2003). It can also occur as a rare manifestation of partial seizures. (Mangaloli S & Vilhekar KY, 2003)

Rare cases of mental retardation and cerebral palsy as co morbid condition was also reported and the evaluation of these cases revealed that hair pulling behaviour are maintained by automatic reinforcement (Rapp JT et al, 1999). In a study on 22 compulsive hair pullers, nearly two third met the criteria for anxiety & mood disorder and more than one half met the criteria for personality disorder. Nearly three quarters of first degree relatives were reported to have a psychiatric disorder and about 5% were reported to be hair pullers. (Schlosser S et al, 1994)

Current treatment strategies involve a multi model approach. Some of the SSRIs especially citalopram and

fluoxetine (Messiah FS, 1993) and drugs like Venlafaxine (Ninan PT, 2000) and Clomipramine (Takei A, 2000) are reported effective. Antipsychotics like Haloperidol (van Ameringen M et al, 1999) were also suggested. In some cases a combination of SSRI with a typical antipsychotic may be warranted. Recently there are reports of resistant trichotillomania treated with risperidone augmented with fluvoxamine (Gabriel A, 2001)

Hypnotherapy coupled with relaxation techniques was suggested as a primary treatment modality especially in children (Cohen HA et al, 1999). Individual & combined behavioural, cognitive and family therapy was suggested for trichotillomania and other OCD spectrum disorders (Neziroglu F et al, 2000)

END NOTE

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