

February 2022

## A Case of Trichotillomania With Comorbid Depression And Anxiety

RINI ROY

*JSS Medical College & Hospital, Mysuru, riniroy847@gmail.com*

Sudeep Pradeep Kumar

*JSS Medical college & Hospital, Mysuru, sudeepk@jssuni.edu.in*

Kishor M

*JSS Medical College and Hospital, Mysuru, kishorm@jssuni.edu.in*

Follow this and additional works at: <https://rescon.jssuni.edu.in/djcm>



Part of the [Psychiatry and Psychology Commons](#)

---

### Recommended Citation

ROY, RINI; Kumar, Sudeep Pradeep; and M, Kishor (2022) "A Case of Trichotillomania With Comorbid Depression And Anxiety," *Digital Journal of Clinical Medicine*: Vol. 4: Iss. 1, Article 1. <https://doi.org/10.55691/2582-3868.1004>

This Case Report is brought to you for free and open access by Research Connect. It has been accepted for inclusion in Digital Journal of Clinical Medicine by an authorized editor of Research Connect.

## **A Case of Trichotillomania with Comorbid Depression and Anxiety**

### **CLINICAL HISTORY:**

A 20-year-old adult female engineering student unmarried from a nuclear family of a middle socio-economic status coming from a semi-urban background, resident of Mysore, referred from Dermatology to Psychiatry Outpatient department with hair loss over the scalp in last few years, that was not responding to treatment.

With Informed consent, the patient reported that the problem started in 2016 march while she was preparing for the 10<sup>th</sup> board exam, she felt stressed, though she may not perform well in the exam and may fail. With these kinds of thoughts, she had noticed that she had started plucking hair over the scalp and felt momentarily relieved. Gradually, she had started to pluck her hair when alone or while watching television. She would throw away the plucked hair. Her family members also noticed this behaviour and had scolded her many times.

By 2018, patchy hair loss areas were becoming visible and she began to feel sad and anxious about her behaviour. She tried to control her behaviour by covering her hair with a scarf, wearing a hat but she failed to control the behaviour. She had the guilt feeling that she was plucking hair, sadness, sleep disturbance, not interested in doing things which she enjoyed earlier, avoided social contact. So, she consulted the department of Dermatology, in their history taking she revealed her hair-pulling behaviour and anxiety, so they referred her to the Department of Psychiatry. Consultation liaison is an important process that benefits patients in optimal care. The Dermatologist referred the patient to psychiatry for further treatment. And they refer to do the needful as per the psychiatry department procedure. The patient conveyed her father had a history of depressive episodes and her elder sister was physically challenged and had Intellectual Disability.

## **INVESTIGATIONS (Assessment):**

### Mental Status Examination

The patient had normal MSE with preoccupied with anxiety, sadness about her condition

HAM-D: A score of 22 was obtained, indicating moderate depression.

HAM-A: A score of 19 obtained indicate moderate anxiety.



**Figure-1** shows the severity of the hair-pulling behaviour

## **FINAL DIAGNOSIS:**

Based on WHO- ICD10 criteria

**F63.3-Trichotillomania:** Noticeable hair loss due to a recurrent failure to resist impulses to pull out hair. Hair pulling is usually preceded by monitoring tension and is followed by a sense of rejection and gratification.

## **DISCUSSION:**

Trichotillomania is a chronic disorder characterized by repetitive hair pulling, driven by escalating tension, and causing variable hair loss that is usually but not always visible to others.

[4] The formation of trichobezoars hairballs accumulating in the alimentary tract from hair pulling and swallowing was described in the late 18<sup>th</sup> century. [3] The term trichotillomania was coined by a French dermatologist, Francois Hallopeau, in 1889. There is no pre-existent skin lesion or inflammation and hair pulling is not secondary to any delusion or hallucination. [5] Community prevalence studies suggest that trichotillomania is a common disorder with a point prevalence estimate of 0.5% to 2.0%. in adolescence, the lifetime prevalence is reported as high as 3.5% female ratio to be about 9: 1. [2]

In trichotillomania, the triggers to pull the hair may include a range of affective variables such as sadness, a motivational state, or anger. [1] Pulling may reinforce these depressive emotions or conversely may serve to arouse people from lethargy or a motivational state (Mansueto 1991). Although depression is common and predicts problems with the quality of life, the functional impairment often found in patients with trichotillomania has often been attributed, in substantial part, to associated anxiety. [2]

The condition needs to be recognized early in the dermatology department as most patients present there.

The case presented here is a typical example of trichotillomania the patient have the comorbid condition of anxiety and depression the family history suggestive of depressive episodes in elder sister in the initial period the hair-pulling was due to anxiety related to exam and studies after that she had hair loss which causes severe distress and she tried to avoid social contacts, became more concern about the pulling behaviour, her distress related to the behaviour lead her to check about the behaviour and the learned about trichotillomania which made her consult the dermatologist from their procedure they got to know about the hair-pulling behaviour,

anxiety, and another family history so they referred to psychiatry for further treatment procedure from their side they prescribed medication for hair-loss(hair growth) consultation-liaison is an important process that benefits patient in optimal care. The Dermatologist referred the patient to psychiatry.

As the treatment part, she has been started with medication and non-pharmacological treatment. Non- pharmacological treatment includes psycho educate the patient related to the condition comorbid condition, epidemiology, prevalence, management. [7] Then start with cognitive behaviour therapy, relaxation exercise including JPMR, Habit Reversal Training Introduced- Habit Reversal Training is an evidence-based highly effective behavioural therapy for people with unwanted repetitive behaviour, [9] HRT has five parts which are awareness training, competing for response training, motivation, and compliance, relaxation, generalization training[8]. Based on the follow-up and the symptom reduction the management can be varied[10]. In this case, the patient did not follow up the treatment after a few sessions she discontinued but in that session, the improvement was noticed especially the hair-pulling was reduced also the social anxiety was reduced may be due to symptom reduction she was not turned up.

### **CONCLUSION:**

The above mention case of a 20-year-old adult female who presented with complaints of hair pulling, hair loss, anxiety, and sadness for the past 5 years. The assessment and history are suggestive of trichotillomania, also the patient is having anxiety and depression. The relevance of the case is to understand the manifestation of trichotillomania. The case included non-pharmacological treatment like CBT, habit Reversal Training.

**REFERENCES:**

1. Chavan B, Raj L, Kaur H. Management of trichotillomania. *Indian Journal of Psychiatry*. 2005;47(4):235
2. Grant J, Odlaug B. Clinical characteristics of trichotillomania with trichophagia. *Comprehensive Psychiatry*. 2008;49(6):579-584.
3. Grant J. Trichotillomania (hair-pulling disorder). *Indian Journal of Psychiatry*. 2019;61(7):136.
4. Hautmann G, Hercogova J, Lotti T. Trichotillomania. *Journal of the American Academy of Dermatology*. 2002;46(6):807-826.
5. World Health Organization (WHO). (1993). *The ICD-10 classification of mental and behavioural disorders*. World Health Organization.
6. Crosby J, Dehlin J, Mitchell P, Twohig M. Acceptance and Commitment Therapy and Habit Reversal Training for the Treatment of Trichotillomania. *Cognitive and Behavioral Practice*. 2012;19(4):595-605.
7. Grant J, Chamberlain S. Trichotillomania. *American Journal of Psychiatry*. 2016;173(9):868-874.
8. Rothbaum B, Ninan P. The assessment of trichotillomania. *Behaviour Research and Therapy*. 1994;32(6):651-662.
9. Sadock B, Sadock V, Kaplan H. Kaplan & Sadock's synopsis of psychiatry. 10th ed. Philadelphia: Wolter Kluwer/Lippincott Williams & Wilkins; 2007.

10. Swedo S, Leonard H. Trichotillomania: An Obsessive Compulsive Spectrum Disorder?.  
Psychiatric Clinics of North America. 1992;15(4):777-790.