Case Report

Cognitive Behavior Therapy with habit reversal-An adjunct to pharmacotherapy in Trichotillomania: Case series

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Introduction

Trichotillomania (TTM) is a psychological disorder that involves repetitive pulling of hair to the point of noticeable loss[(1)]. Before engaging in the behavior, patients with the hair-pulling disorder may experience an increasing sense of tension and achieve a sense of release or gratification from pulling out their hair[(2)]. Different subtypes of trichotillomania have been described, focused hair pulling and automatic hair pulling. In DSM V (Diagnostic and Statistical Manual of Mental Disorders, 5th Ed.), it was for the first time characterized as Obsessive-compulsive and related disorders (OCD), because of some overlapping features with OCD. In ICD-11 (International Classification of Diseases), it is classified under Body focused repetitive behavior disorders.

Habit Reversal Training (HRT) has been the traditional behavioral approach and is generally accepted as a suitable treatment for the habitual nature of automatic pulling[(2)]. Hair pulling disorders by nature are associated with stigma and appearance-related issues; making them pivotal to be referred to the psychiatry department enabling further screening and treatment at the earliest. Thus, we are discussing two case reports of Trichotillomania of the same age group and sex, first referred from the dermatology department and the second with primary consultation of the psychiatry department were assessed and treated.

Case 1

A 20 year old, unmarried female, an engineering student, referred by dermatology department, presented with hair loss for last three years. Hair pulling was evident in the last eight months and occasional low mood and restlessness, loss of interest in pleasurable activities in the last 3-4 months. During the COVID-19 pandemic, due to lockdown, there were restrictions for outdoor movement; thus, her parents noticed that she was pulling her hair and on being questioned, she denied that. Gradually after 2-3 months patient herself noticed bald patches on the scalp and then realized that she is herself pulling her hair. During this time patient also became very preoccupied about her appearance. On being questioned by her friends and family, her hair pulling habit increased in intensity and frequency. According to the patient, she spends most of her time during the day pulling her hair over the scalp. She also reports that she cannot control the urge to pull her hair and reports she fails to understand why she feels like pulling her hair. She was embarrassed about it and hence started covering her scalp with a scarf whenever she went out. She often avoided social gatherings and meeting friends and family.

Mental Status Examination

The patient was wearing a scarf over her head, was occasionally avoiding eye contact. Her speech was spontaneous, relevant. Affect was depressed and restricted. Her thinking revealed an impulsive urge about pulling her hair and there was distress on refraining it. Patient reported gratification after pulling her hair. No obsessions or compulsions were noted. Anhedonia and ideas of helplessness were present. No psychotic features were noted.

On examination

Sparse and short hair was present over the scalp and an ill-defined circular patch of approximately 3 cm diameter was present over the left side of the scalp. No hair loss was present at any other site. No other abnormality was detected on General Physical and Systemic Examination. Laboratory tests were within normal limits. Her scores on the Hamilton anxiety rating scale (HAM-A) was 6 and Hamilton Depression rating scale (HAM-D) was 10, NIMH (National Institute Of Mental Health) Trichotillomania symptom severity scale was 14 and NIMH Trichotillomania impairment scale was 8 (Severe).

Diagnosis

She was diagnosed as Trichotillomania (Habit and Impulse Disorders, ICD 10) with a mild depressive episode.

Interventions

The patient was started on Tab. Fluoxetine 20mg, Tab. Clonazepam 0.25 mg and other nutritional supplements. Simultaneously, in this case, Habit Reversal Therapy (HRT) was also initiated. The clinical psychologist who was trained for the same initiated the therapy.

In the first session, the patient and relatives were given

psycho-education about the nature of the disease and were made to understand and accept her habit of hair-pulling. The patient was counseled regarding the differences between her internal urge to pull her hair and the External activity of actually pulling her hair. She was also advised regarding self-monitoring (time spent in hair pulling, triggers leading to hair pulling) and was asked to maintain a thought diary.

The second session mainly focused on reflecting the nature of the urge to pull her hair, on the reason to pull her hair, what exact thought process she undergoes before carrying out the activity were discussed i.e. what events make her feel anxious, what triggers her urge to pull her hair, etc. In the thought diary, she was advised to write the thoughts that came to her mind when she felt like pulling her hair and the emotions she would go through then.

For the third session, the events documented in the thought diary were discussed. She was taught about competing responses "i.e. making a fist or clenching her teeth for a minute whenever she felt the urge to pull her hair", during the respective events that she mentioned.

For the fourth session, again the events documented in the thought diary were discussed. The patient seemed more confident about challenging her thoughts. Stress on using the competing response was reiterated.

In the fifth session, the focus was on making the patient realize that her behavioral choice is different from her thoughts and subsequently discussing the idea that action and behavior depend on the values of the patient and not automatic thoughts[2].

The patient was made aware of the idea that habits can be changed, new habits can be formed, and it was her choice to do so. This improved patient's confidence which further was helpful. Also, awareness regarding the cost of her habit in other areas of her life was discussed in the subsequent sessions. Although HRT spans for six sessions, we kept the sessions flexible and fluid, discussing each idea as the patient's state allowed.

Oral medications were continued at the same strength, which also aided in reducing the anxiety and low mood due to the after-effects of hair-pulling.

Case 2

A 14 year old female, studying in 9th standard came with her father to the psychiatry outpatient unit. She presented with complaints of pulling out hair from the scalp in the last one year, decreased appetite, and decreased sleep for the last 4-5 months. A year back patient's parents started noticing that she is pulling hair from her scalp and on being questioned she said she did not know why she was doing so. Around 1-2 months later when the volume and length of her hair decreased, her parents also started scolding her. After around 2 months of her parents noticed her hair pulling habit, her parents started stopping her constantly whenever she would pull her hair. The patient says that she realizes that she pulls her hair but is unable to resist it. They also started hitting her sometimes for the same, thus she would pull her hair in their absence. Her parents also took her out without letting her cover her scalp so that she feels shameful and stops pulling her hair, after which the patient was embarrassed about her appearance and would avoid any interaction or going out. The patient started feeling extremely low and self-absorbed and would cry frequently.

Mental Status Examination

The patient was sitting with a downward gaze. She was getting tearful occasionally. Her speech was non-spontaneous. Affect was depressed, tearful, and restricted. Her thinking revealed ideas of helplessness and anhedonia. Passive death wishes were also expressed. Impulsive ideas about pulling her hair and distress on being denied doing it were present. She also reported that her anxiety was relieved by pulling her hair. No obsessions were noted. No psychotic features were noted.

On examination

There were scattered, short scanty hair over the scalp (left >right). No hair loss was present at any other site. No other abnormality was detected on General Physical Examination and Systemic Examination. Laboratory tests were revealed within normal limits. Scores on the scales for this patient were as follows: HAM-A (Hamilton Anxiety Scale)-13, HAM-D (Hamilton Depression Scale) -21, NIMH(National Institute of Mental Health) Trichotillomania symptom severity scale – 20, and NIMH Trichotillomania impairment scale - 9 (Severe).

Diagnosis

Trichotillomania (Habit and Impulse Disorders, ICD 10) with a moderate depressive episode

Interventions

The patient was started on Tab. Fluoxetine 20mg which was gradually increased to 40 mg, Tab. Clonazepam 0.25 mg at night. This case was treated with additional focus on therapy regarding her depressive features. Cognitive distortions were identified and worked upon. She was also referred to a dermatologist.

In the first and second sessions focus was on the acceptance of the disease by the patient. She was given psycho-education regarding the nature of the disease and the course of her treatment. The patients' parents were counseled regarding the same and guided as to how they can support the patient and change their behavior towards the patient. They were also given psycho-education regarding the repercussions of physically harming the patient. The initial focus was on the supportive management of depressive features.

In the third session, the patient was asked to identify her feelings and emotions when those negative thoughts came to

her mind and their association with the external habit of hair-pulling. She was asked to write in detail about her day, the time she spent pulling her hair, the events that trigger her to do so; what did she feel when other people were around her, etc.

Further, the fourth session focused on handling the emotions, identifying cognitive distortions, and modifying the thoughts in the concerned situation. The patient was taught to build up a challenging thought against her existing one in the situations she documented. She was taught how she can use the new thoughts to modify her current situation, further helping her.

Further sessions focused on setting goals for the patient and reaching them in terms of differentiating between external habits and internal urges. The patient was now asked to document the time spent in resisting the urge and judge whether the techniques being used to resist the urge were useful. The patient was encouraged to self-introspect while still maintaining the thought diary.

In subsequent sessions, the patient was positively reinforced as the time spent in hair pulling started decreasing and resisting the urges became easier. Her confidence seemed to be building up a little. The patient started actively taking part in her treatment in the terms of a thought diary, understanding her illness, and compliance towards therapy and medications.

Discussion

Trichotillomania was first described in 1889 by Hallopeau. It is currently ranked among habit and impulse control disorders[3]. Age at Trichotillomania onset varies from 9-13 years and is more common in females. In Trichotillomania, hair pulling can be performed in response to negative affect, and further lead to emotional relief in the short term. But this further strengthens the act of pulling in the long term. In further follow-up, we assessed the improvement in depressive symptoms and concurrently rated the trichotillomania. Many adolescents with Trichotillomania express great fear that their classmates and friends. They discover their bald patches and evaluate them negatively[4]. The management of trichotillomania has seen many advances in the last few years with cognitive-behavioral therapy (CBT) gaining popularity which includes HRT. Expert opinion is convergent with the treatment outcome literature in supporting the use of CBTs that include HRT as the first-line option in Trichotillomania. It is also now generally accepted that SSRIs (Selective Serotonin Reuptake Inhibitor), although potentially useful to address comorbid symptoms of anxiety and depression, are not considered first-line treatments for pulling[5].

A similar case with history of pulling hair since age of 8 years revealed no significant improvement over 8 years with treatment of combination of antidepressants. The patient developed drug resistance. The case study highlighted the efficacy of behavior therapy in trichotillomania even in case with multiple drugs resistant. However, the study also suggested need of more studies comparing HRT and pharmacotherapy to evaluate their relative efficacy. The study also suggested that the dual treatment options must also be evaluated[6].

If there is an underlying mood or anxiety disorder that contributes to hair pulling, or if therapy alone has failed, then medication usually a SSRI in addition to HRT, is often most successful[7]. HRT when initiated along with pharmacological treatment, proved to be beneficial to the patient in terms of understanding the nature of the disease, building insight, and working towards breaking the habit. Giving the patient enough time to self-introspect and absorb new thoughts seemed to be the key in the cases discussed above. HRT along with the focus on CBT also enabled both the patients discussed here, in gaining social support from friends and family, discussing the illness with them, and thus deal with the fear and embarrassment.Psychiatric comorbidities like mood and anxiety disorders, eating disorders, substance use disorders, and personality disorders are commonly observed along with trichotillomania[8,9]. In these cases, patients presented with trichotillomania along with depressive features. A combined approach including Psycho-education, CBT (habit reversal therapy) with SSRI's proved to be beneficial.

Usually, these patients present to a dermatologist, making it very crucial that they are referred to a psychiatrist, enabling an early and pro-active assessment and treatment. Also, both the cases discussed above showed a marked improvement on starting habit reversal along with pharmacotherapy, thus making it the mainstay treatment protocol.

Conclusion

Pharmacological management along with cognitive and behavioral therapy when applied together, was effective and promising in the treatment of trichotillomania.

Declaration of patient consent

For the first case we have obtained all appropriate patient consent forms from the patient and for the second case from the caregiver (father) with assent taken from the patient. The Patient/caregiver understands that the patient's name and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflict of interest: Nil

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References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (4th Edition), Text Revision. American Psychiatric Association, DC, USA (2000).
2. Crosby JM, Dehlin JP, Mitchell PR, Twohig MP. Acceptance and commitment therapy and habit reversal training for the treatment of trichotillomania. Cognitive and Behavioral Practice. 2012 Nov 1;19(4):595-605.
3. Pinto AC, Andrade TC, Brito FF, Silva GV, Cavalcante ML, Martelli AC. Trichotillomania: a case report with clinical and dermatoscopic differential diagnosis with alopecia areata. Anais brasileiros de dermatologia. 2017 Jan; 92:118-20.
4. Franklin ME, Zagrabbe K, Benavides KL. Trichotillomania and its treatment: a review and recommendations. Expert review of neurotherapeutics. 2011 Aug 1;11(8):1165-74.
5. Flessner CA, Penzel F, Board TL, Keuthen NJ. Current treatment practices for children and adults with trichotillomania: consensus among experts. Cognitive and Behavioral Practice. 2010 Aug 1;17(3):290-300
6. Gupta S, Gargi PD. Habit reversal training for trichotillomania. International journal of trichology. 2012 Jan;4(1):39
7. Trainor K. Treating trichotillomania in children and adolescents: CBT versus medication. American Journal of Psychiatry. 2007 Oct;164(10):1610-1
8. Christenson GA, Mackenzie TB, Mitchell JE. Characteristics of 60 adult chronic hair pullers. Am. J. Psychiatry 1991; 148, 365–370.
9. Christenson GA, Chernoff-Clementz E, Clementz BA. Personality and clinical characteristics in patients with trichotillomania. J. Clin. Psychiatry 1992 53, 407–413.