Reprinted from the German Journal of Psychiatry http://www.gjpsy.uni-goettingen.de ISSN 1433-1055

Case Report

Familial Trichotillomania Responding to SSRIs

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Abstract

Trichotillomania is term used to denote an irresistible urge to pull one's own hair. It is classified under 'Habit and Impulse Disorders'. There are few reports of familial occurrence of trichotillomania but none on response to the same SSRI among family members afflicted with trichotillomania. We present a young girl with trichotillomania, who had a family history in her mother. Both responded to fluoxetine. The patient also received two different SSRIs, fluoxetine as well as escitalopram at different times and responded to both of them (German J Psychiatry 2013; 16(1): 51-53).

Keywords: Trichotillomania, familial, SSRIs, fluoxetine, escitalopram

Received: 10.11.2011
Revised version: 11.3.2013
Published: 24.7.2013

Introduction

Trichotillomania is a term which was first introduced by a French dermatologist, Hallopeau in 1889, to denote an irresistible urge to pull one's own hair. It is reported to be more common in females, with prevalence rates of 0.6% (Christenson et al., 1991). The peak age at onset is 12–13 years, and the disorder is often chronic and difficult to treat (Walsh and McDougle, 2001). It can cause complications including infection, permanent loss of hair, repetitive stress injury, carpal tunnel syndrome (Frey et al., 2005), and gastrointestinal obstruction with bezoars as a result of trichophagia (Bouwer and Stein, 1998; Bhatia et al., 1991). Familial occurrence of trichotillomania has been reported among siblings (Kerbeshian & Burd, 1991) but not among parent and child simultaneously. We present a young girl with trichotillomania, who responded to two different SSRI's - fluoxetine as well as escitalopram.

Case Report

Ms. A, a seven year old girl was brought by her parents with marked hair loss on her scalp over a period of three months. This was due to repetitive hair-pulling while watching television or sitting idle. On most occasions, the child would not tell any reason and said that she plucked out her hair absentmindedly. The family members reported that initially such instances of hair-pulling usually occurred on two or three occasions but over a period of one month, especially after beginning of her half-yearly school examinations, the episodes of hair-pulling increased in frequency and in addition to this, at the times when the patient did not pluck out hair from her scalp, she would be seen rolling out her hair-ends over her fingers. The family members used to thrash the child when she was seen plucking or rolling her hair, believing that punishment might help in reducing this behavior. But to their dismay, hair-pulling and hair-rolling increased in frequency. On advice of a relative, the patient was brought for psychiatric consultation. The child entered the consultation room wearing a colorful hat and greeted us. As the child was not answering to most of our questions, we decided to interview the child alone, after obtaining consent from her parents. The initial part of the interview consisted of few general queries regarding her school and home, and when the rapport was established with the child, we started questioning about her hair-pulling and hair-rolling behaviors. She admitted that, though on most occasions, she did these acts unintentionally, but on few occasions, she reported a sense of tension release when she would pull out hair from her scalp. Premorbid temperament revealed a cheerful young girl, who performed well in academics, obeyed elders, re-

spected discipline and had no difficulty in making friends at school. The physical examination revealed marked hair loss over frontal and parietal areas of scalp without any associated scarring. Eyebrows and eyelashes were normal. The mental status examination revealed a cheerful, well dressed and groomed young child. Her speech was normal and affect was euthymic. Assessment of thought revealed preoccupation with hair loss on her scalp. Perception did not reveal any abnormality and cognitive functions were found to be intact. The past history was unremarkable. There was no history of sexual abuse but the history of trichotillomania was present in her mother, when she was 16 years old. Her mother was treated from the same center with fluoxetine 20–40 mg/day for six months and showed remission in habit after two months. There was no family history of any other psychiatric disorder.

The patient was started on fluoxetine 10 mg/day, which was increased to 20 mg/day after four weeks, and on follow-up at 6 weeks, the patient exhibited noticeable improvement. Hair-pulling behavior had reduced significantly with significant regrowth of scalp hair. The improvement continued till three months when her parents stopped the drug. After four weeks, the patient again resorted to hair-rolling and hair-pulling behaviors. She was brought again, when another psychiatrist started her on tablet escitalopram 5 mg daily ten days back but without any improvement. The dose was increased to 10 mg/day to which she again showed a remarkable improvement within five weeks.

Discussion

The International Classification of Diseases, 10th edition by the World Health Organization (1992) classifies trichotillomania under Habit and Impulse Disorders, as a condition "characterized by noticeable hair loss due to a recurrent failure to resist impulses to pull out hairs, preceded by mounting tension and followed by a sense of relief or gratification". In DSM-IV (American Psychiatric Association, 1994), it is categorized as an impulse control disorder not elsewhere classified (Code-312.39). Although rising tension and subsequent pleasure, gratification, or reliefs are integral to the current diagnostic criteria for trichotillomania, many people with debilitating hair pulling do not endorse these criteria (Christenson et al., 1991; American Psychiatric Association, 1994). There are similarities between the phenomenology of hair pulling and those of OCD compulsions, insofar as the behavior is in response to urges and can be anxiety relieving, is driven and repetitive, and is sometimes symmetrical in nature (Stein et al., 1995; Grant and Potenza, 2006).Trichotillomania is also being considered as an obsessive compulsive spectrum disorder (Swedo et al., 1989; Ferra'o et al., 2009; Stein et al. 2010). The present case reported that on most occasions, especially in the beginning she pulled her hair unintentionally and over a course of time, the act of hair-pulling resulted in relief in tension. Consequently, the act of hair-pulling which was unintentional to begin with became consciously performed acts that relieved stress. Therefore, there is need that the existing diagnostic criteria for trichotillomania is made more flexible with respect to the specific criteria that require the act of hair-pulling be preceded by a sense of mounting tension and followed by a sense of gratification. There is also need to include familial tendency in the classification (Kerbeshian & Burd, 1991). Many studies had reported high comorbid psychopathology in the form of major affective disorder, anxiety disorder and drug overdose or alcohol abuse (Kerbeshian & Burd, 1991; van Minnen, 2003; Lenane et al., 1992) or history of sexual abuse (Kerbeshian and Burd, 1991), but in the present case there was no comorbid psychopathology or history of sexual abuse. Familial trichotillomania has been reported among siblings but not among a parent and the child. Moreover, both mother and daughter responded to same drug.

A form of psychotherapy called habit reversal training may be an effective treatment for trichotillomania. This type of therapy helps you learn how to recognize situations where you're likely to pull and how to substitute it by other behaviors, such as clenching your fists for a period to "freeze" the urge, or redirecting your hand from your hair to your ear. Another treatment, acceptance and commitment therapy (ACT), helps people learn to accept their hair-pulling urges while at the same time teaching them how to avoid acting on their impulses (Duke et al 2010; Stein et al., 2010). A double-blind study using the drugs clomipramine, olanzapine and SSRIs, including fluoxetine, paroxetine, and others, either alone or in combination with behavior therapy including stimulus control have been reported to be useful in the management of trichotillomania (Swedo et al., 1989; van Minnen, 2003; van Ameringen et al., 2010) but our patient exhibited improvement with two different SSRIs – fluoxetine as well as escitalopram. This is the first case report highlighting the usefulness of two different drugs of same class (i.e. SSRIs) in trichotillomania in a single patient and that also in a child.

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The German Journal of Psychiatry ISSN 1433-1055 http:/www. gjpsy.uni-goettingen.de
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