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Case Report

Trichotillomania Comorbid with Schizophrenia

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Abstract

Background and Objective: Trichotillomania as a comorbid disorder with schizophrenia has been described rarely. Available data suggests that in some subjects the hair pulling behaviour is secondary to psychotic symptoms. We aim to present a case of trichotillomania in a young adult with schizophrenia to add to the scarce literature available on this comorbidity. Case Description: The hair pulling behaviour in the index case was due to a strong urge, which was relieved by the behaviour and was not secondary to any psychotic symptoms. The course of trichotillomania was independent of the course of psychotic symptoms in the index case, i.e. the partial improvement in psychotic symptoms was not accompanied by improvement in hair pulling behaviour, whereas the latter responded partially to administration of fluoxetine in addition to an antipsychotic agent. Conclusion: The index case suggests a true comorbidity between schizophrenia and trichotillomania (German J Psychiatry 2010; 13 (3): 154–156).

Keywords: trichotillomania, hair pulling, schizophrenia

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Introduction

Trichotillomania (TTM) is a disorder characterized by repetitive hair pulling, driven by escalating tension and causing variable hair loss that is usually – but not always – visible to others. Currently TTM is classified as an impulse control disorder (Woods et al., 2006). However, in recent times in view of similarity between the treatment used (both pharmacotherapy and cognitive therapy) and the similarity in neurobiological underpinnings between TTM and Obsessive Compulsive Disorder (Chamberlain et al., 2009), there is a debate as to classify TTM as an obsessive–compulsive spectrum disorder. At present there is reasonable evidence to suggest that selective serotonin reuptake inhibitors are useful in the treatment of TTM (Woods et al., 2006).

Co-morbid psychiatric problems are common in children and adults with trichotillomania (Malhotra et al., 2008; Rajmohan, 2009). In addition, repetitive hair pulling may occur in several mental disorders like obsessive–compulsive disorder, depression, borderline personality disorder as well as mental retardation (Krishnan et al, 1985). However, repetitive hair pulling/trichotillomania have been described in subjects with schizophrenia in few case reports only (Giersz, 1984; Kahkonen, 2002; Rajmohan, 2009; Sethi et al., 1982; Tsai & Chang, 1998). Case reports suggest that selective serotonin inhibitors (SSRIs) may be useful in the treatment of trichotillomania in subjects with schizophrenia, also when used along with antipsychotics (Kahkonen, 2002).

We present a case of trichotillomania in a young adult with schizophrenia to add to scarce literature available on this comorbidity and discuss the relationship between hair pulling and psychopathology in subjects with schizophrenia.

Case Report

Miss A., aged 29 years, a single home maker, educated up to intermediate level, belonging to a nuclear family of middle

socio-economic status, from an urban area, with no family history of any mental disorder, was admitted to the inpatient unit with a diagnosis of schizophrenia (DSM-IV, 295.90). She had a chronic illness of 13 years duration with insidious onset. During the initial 3 to 4 years, she was noticed to be socially withdrawn, would not show any interest in studies and career and shrugged away from household responsibilities. Later on, during the course of the illness she developed auditory hallucinations of commenting and commanding type, hallucinatory behaviour, developed bizarre somatic delusions, delusion of love and formal thought disorder.

About 7 years after the onset of her psychotic illness, she was observed to be pulling her scalp hairs. Initially, she tried to hide her hair pulling behaviour, and when confronted, she would refuse the same, but later on started pulling her hairs even in the presence of unknown people, and when stopped from doing so, she would become angry. When asked, she would just say that "pulling of hairs gives her some relief". Over the years, the course of hair pulling kept on fluctuating. At times she would develop baldness of the occipital, parietal/frontal and temporal regions of the skull, and at times her hairs would grow up to 2 to 3 inches. Due to the baldness arising due to her hair pulling, the patient started using a cap, which she would wear throughout the year. The indulgence and severity of hair pulling did not have any temporal correlation with the severity of symptoms of schizophrenia, that is even when there was partial improvement in psychotic symptoms, hair pulling behaviour continued at the same severity. Trials of antipsychotic drugs did not affect the severity or progression of hair pulling during any time in the course of the illness. About 6 months prior to her inpatient admission, both her psychotic symptoms and hair pulling behaviour worsened, she started pulling hairs from her legs, arms and axillae.

There was no history of thought withdrawal, somatic passivity, delusional perception, made affect, made volition, made impulse, manic symptoms, depressive symptoms, ingestion of hair, or local skin pathology of her scalp.

Her treatment history revealed that she had been treated with risperidone (2–3 mg/day), olanzapine (10–20 mg/day), aripiprazole (15 mg/day), ziprasidone (80–120 mg/day), quetiapine (550–800 mg/day) in the past with partial relief in psychotic symptoms and development of extrapyramidal side effects, weight gain and hyperprolactinemia. At the time of admission to the inpatient unit she was receiving quetiapine 800 mg/day and fluoxetine 40 mg/day. Her psychosocial evaluation revealed a high level of "expressed emotions" and poor social support.

Her physical examination at the time of admission to the inpatient unit did not reveal any abnormality except for her being obese (weight of 80 kg and body mass index of 31.8 kg/m^2) and loss of hair over the occipital, temporal and frontal regions of her scalp. In the mental status examination, the patient had gross incoherence, hallucinatory behaviour and bizarre delusions. On investigation, no abnormality was detected in her haemogram, serum electrolytes, renal function test, liver function test, electrocardiogram, ultrasound abdomen and electroencephalogram.

In the inpatient unit, on the basis of available information, the diagnosis of schizophrenia (DSM-IV 295.90; American Psychiatric Association, 1994) was kept along with a possibility of trichotillomania (DSM-IV 312.39). She was initially started on trifluperazine up to 15 mg/day. Quetiapine was stopped and fluoxetine 40 mg/day was continued. She developed akathisia while on trifluperazine and there was no improvement in her psychopathology. Resultantly, trifluperazine was stopped and she was started on clozapine, which was increased to 225 mg/day along with continuation of fluoxetine 40 mg/day. With this treatment, the patient's psychopathology improved and her hair pulling behaviour was reduced significantly. After stabilization of her psychotic symptoms, when asked about her hair pulling behaviour, the patient revealed that she had a strong urge to pull the hairs, which was associated with tension and anxiety and which would subside only after she pulled her hairs. She also elaborated that this urge would mostly be associated with stress in interpersonal relationships with her family members. She denied any association of her hair pulling behaviour with psychotic symptoms. Based on this information, the comorbid diagnosis of trichotillomania was confirmed.

Besides the pharmacological management, activity scheduling and rehabilitation in the form of attending a "half way home" was done. Patient and family were psychoeducated about the disorder and the issue of "expressed emotions" was also handled. At the time of discharge, her psychotic symptoms were markedly improved and her hair pulling behaviour was reduced significantly.

In a follow-up over the period of 2 months after discharge from the inpatient unit, the patient's psychotic symptoms and hair pulling behaviour were at the same level as they were at the time of discharge. She is attending the "half way home" regularly and functioning well. The repeat haemogram was within normal limits.

Discussion

ICD-10 (World Health Organization, 1993) 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." The diagnosis should not be made if "pre-existing inflammation of the skin" exists or if hair pulling occurs "in response to a delusion or hallucination." In a similar manner, the DSM-IV (American Psychiatric Association, 1994) excludes the diagnosis of trichotillomania if the disturbance is better accounted for by another mental disorder or is due to a general medical condition. In other words, as described by O' Sullivan et al. (1997), chronic hair pulling can result from a variety of conditions, including psychosis, and it often occurs outside the person's awareness, whereas, in contrast, the hair pulling of trichotillomania appears mostly to arise *de novo*. In the index case, the description of hair pulling behaviour is similar to that reported by patients of trichotillomania. Further patient denied any association between hair pulling and psychotic symptoms.

This is in contrast to the previous reports, in which hair pulling behaviour in subjects with schizophrenia had been linked to psychotic states. Tsai & Chang (1998) described repetitive hair pulling in a woman with schizophrenia secondary to tactile hallucinations and delusions of parasitosis, in which hair pulling improved with the use of an antipsychotic alone. In another case description of a patient with schizophrenia, plucking of hairs from eyebrows and moustaches always preceded the exacerbations of psychotic symptoms and hair pulling improved with treatment of psychotic symptoms by phenothiazines (Sethi et al., 1982), thus leading to the assertion by the authors that 'trichotillomania' was a symptom of schizophrenia. In another case report, repeated hair pulling was described in a patient with chronic schizophrenia, in which there was no relationship between hair pulling and psychotic symptoms exacerbation and remission with or without drug treatment (Rajmohan, 2009).

In a previous study, Christenson et al. (1994), studied trichotillomania in 14 male and 128 female psychiatric patients, amongst whom 1 male patient had schizoaffective disorder. They did not find any relationship between his hair pulling behavior and psychosis, as seen in our case.

Case reports suggest that use of selective serotonin inhibitors (SSRIs) may be useful in the treatment of trichotillomania in subjects with schizophrenia also. Kahkonen (2002) described trichotillomania in a female patient with schizophrenia who responded partially to a combination of citalopram and risperidone. Our patient also responded to the combination of clozapine and fluoxetine.

Our case suggests a true comorbidity between schizophrenia and trichotillomania.

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