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International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

Trichotillomania (Hair-Pulling Disorder): A Rarely Reported Disorder with an Onset Linked to Dandruff: (A Case Report)

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Doi : https://doi.org/10.55248/gengpi.5.0824.2124

ABSTRACT

Trichotillomania (TTM) is a debilitating psycho-dermatological disorder characterised by a repetitive, uncontrollable urge to pull one's hair, leading to variable hair loss that may be visible to others, psychological distress, and functional impairment.

A case of a lady aged 22 who initially presented to a dermatologist with an 8-year history of an uncontrollable recurrent pulling of her hair from the head following successful treatment of dandruff. She presented in the psychiatry outpatient department following a referral from the dermatology outpatient clinic with an 8-year history of recurrent pulling of her hair from the head, which resulted in visible hair loss in the frontal and central regions of her head.

The diagnosis of our patient was established based on his history, clinical and dermatologic evaluation, DSM-V diagnostic criteria, and the eventual elimination of a possible differential diagnosis. She has commenced clomipramine with significant improvement.

Keywords: ***Trichotillomania, dandruff, hair-pulling disorder, Nigeria***

Introduction

The term Trichotillomania (TTM) was coined by French dermatologist Francois Hallopeau in 1889. (1) Trichotillomania (TTM), sometimes known as "hair-pulling disorder," is a debilitating psycho-dermatological disorder characterised by an uncontrollable urge to pull one's own hair, leading to psychological distress and functional impairment. Hair-pulling can involve any site on the body where hair grows, but most often affects the scalp, eyebrows, or eyelashes. (2)

Although TTM has been in the medical literature for over a century, it was not officially included in the Diagnostic and Statistical Manual (DSM) as a mental disorder until 1987. (3) It was classified under impulse control disorders not elsewhere specified in DSM-III-R. In DSM-5, Trichotillomania was classified under obsessive-compulsive and related disorders. (4) Conversely, in the international classification of diseases (1CD-10), TTM was classified under habit and impulse control disorders while ICD-11 included it under body-focused repetitive behaviour disorder. (5)

The prevalence of TTM may be underestimated because of the shame and accompanying secretiveness, especially in this part of Northern Nigeria. We could not find a study that estimated the occurrence of this disorder in Nigeria. However, studies in other parts of the world have estimated a lifetime prevalence of 0.6 to 1 percent in the general population and 3.4 percent in women. (6)

We report a case, probably the first of its kind, of a 22year old female student with an 8years history of recurrent hair pulling without other associated features of TTM like trichophagy, skin picking, or lip biting but with a history of feeling the urge to pull hair from other individuals by finding opportunities to do so surreptitiously.

Case presentation

A 22-year-old single undergraduate female university student who presented in the psychiatry outpatient department was referred from the dermatology outpatient clinic with an 8-year history of recurrent pulling of her hair from the head, which resulted in visible hair loss at the frontal and central regions of her head. There was usually an urge preceding the act of pulling hair, which she occasionally resisted, but with increasing feelings of tension, while the act of pulling off the hair is associated with a sense of pleasure or relief. There was a visible overgrowth of hair in the occipital region of the head, which she has been using scissors to cut in order to reduce the length. The extracted hair was neither chewed nor swallowed but discarded. She has made several attempts to stop, with the maximum duration of resisting the pulling of her hair lasting for less than one-week intervals. There are no reports of pulling hair from other parts of her body. The patient had no history of nail-biting, skin picking, lip chewing, or any impulse control disorder such as pathological stealing (kleptomania) or pathological fire setting (pyromania). There was a history of feeling occasionally anxious, especially when meeting new people or going into a crowded place, but no history of palpitations, tremors, sweeting, or dry mouth. There is no history suggestive of obsessive-compulsive disorder, mood disorder, or psychosis. There was neither a history of substance use nor a history of suicidal ideation. The patient was worried about her condition as she avoided opening her hair in the presence of other people due to shame. She had no known history of mental illness. She is not diabetic nor is she hypertensive. She hails from a polygamous family. Her mother is the first of two wives. She has six full siblings and 3 half siblings. Her mother has a history of recurrent depressive disorder. However, no family history of trichotillomania. Pregnancy, delivery, neonatal, and developmental milestones history was uneventful. She did averagely well in her primary and secondary schools. She started studying degree in nursing however patient was withdrawn in the fourth year. She then transferred to degree in Zoology and is currently in her third year. She has no forensic history and her premorbid personality was described as friendly, religious, and enjoyed reading books and watching television.

Mental states and physical examinations were essentially normal. Scalp examination revealed low-cut hair with areas of hair loss, more at the vertex. A diagnosis of trichotillomania was made using both the DSM-5 and ICD-11 diagnostic criteria. Management followed a biopsychosocial approach. Baseline investigations, including kidney and liver function tests, were done, and specific investigations like dermoscopy were also requested. She was educated on her condition and has been on tabs of clomipramine 50mg daily along with sessions of behavioural therapy (Habit Reversal Training, HRT) and was advised on regular follow-ups. As of the time of writing this case, she has started improving as the frequency of hair pulling has reduced.

Discussion

Trichotillomania generally has its onset at puberty and is far more common in females. (7) Similarly, in this case, we had a female patient whose condition started when she was 14 years old, around the time she attained menarche. The diagnostic criteria of trichotillomania in the DSM-5 require a recurrent pulling of one's hair that results in hair loss; repeated attempts to decrease or stop hair pulling; the hair pulling causes clinically significant distress (socially, occupationally, and in other important areas of functioning); the hair pulling or hair loss should not be due to any other medical conditions; and the hair pulling is not due to symptoms of another mental disorder.(8) Our patient's condition has fulfilled all the diagnostic criteria mentioned above. She had recurrent hair pulling that has resulted in significant hair loss; she had made several unsuccessful attempts to stop; and she had no other medical or mental illnesses that could better explain the behaviour. Furthermore, the condition caused her personal and social distress due to the accompanying shame that prevented her from opening her hair in the presence of other people. According to numerous studies, hair pulling in TTM is associated with a sense of tension before the pull, followed by a sense of relief afterward. (9) Such is the case with our patient; she reported feeling a tingling sensation and a sense of tension, which were immediately followed by relief after hair pulling. An estimated 35–40 percent of patients with TTM chew or swallow the hair that they pull out at one time or another.(10) However, our patient had no such history. There was never a time she chewed or swallowed the hair.

There have been reports of people with trichotillomania feeling the urge to pull fibers, hairs, and strands from pets, toys, or objects in their environment, (11) however, despite our search in different databases, we have not come across any studies on TTM patients pulling other people's hair. In this case, our patient reported feeling the urge to pull other people's hair, and she gets the same satisfaction from pulling her own hair. She usually carries out the pulling act on unsuspecting victims, mostly her family and friends. Sometimes pulling was done while they were sleeping, other times while they were wide awake but under the guise of helping them comb or loosen their hair. In terms of management, various components of cognitive-behavioural therapy are the most widely ecognized. For example, habit reversal therapy (HRT) is relatively well-established in the treatment of TTM. (12) Additionally, serotonin reuptake inhibitors are frequently prescribed for the treatment of TTM, but meta-analyses have shown that only clomipramine appears to be effective. (13) The patient in this report was managed using both habit reversal therapy as well as oral clomipramine at the dose of 25miligram (mg) daily. She was advised to be regular on follow-up.

Conclusion

The diagnosis of our patient was established based on his history, clinical and dermatologic evaluation, DSM-V diagnostic criteria, and the eventual elimination of a possible differential diagnosis. Although rarely reported, it is treatable, and individuals with this disorder should present for early treatment to prevent the possible development of other comorbid psychiatric disorders like depression and anxiety disorder. While on treatment, the patient's symptoms are being monitored using both the clinician rating scale (Psychiatric Institute Trichotillomania Scale, PITS) and the patient rating scale (Massachusetts General Hospital Hairpulling Scale, MGH-HPS).

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