Original Article

Trichotillomania: Case study of an adolescence

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Abstract

Background:Trichotillomania (TTM), a disorder of impulsive hair pulling that occurs in both adults and children alike. It is a disorder of impulsive control. Method: a case of an adolescent male, 13 years, with diagnosed TTM referred from Department of Psychiatry to the Department of Clinical Psychology, which investigates about the cause, occurrence of the hair picking problem. Result: Its management leading to improvement in the severity of symptoms is taken up to better understand the disorder and its treatment modalities. Other factors playing role to worsen the problem were also explored and taken into consideration at the time of management. Habit reversal and cognitive behavior therapy are found effective for the treatment.Conclusion: The presented case here is a successfully managed. TTM case using a package of behavior psychotherapy. Moreover, the habit reversal technique helped the client to recover well through the treatment process. However, it would have not been possible without the cooperation of his social settings (family members and teachers

Keywords: Trichotillomania, Impulse control, Habit Reversal, Cognitive Behavior Therapy.

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Introduction

Hallopean, dermatologist in France propounded the term TRICHOTILLOMANIA originally to explain alopecia - baldness caused by self-traction of hair but later the term encompasses the syndrome of pathological hair pulling as stated by H Kaur in the article named Management of trichotillomania.

In the fifth edition of /Diagnostic and Statistical Manual of Mental Disorder// (DSM 5) by American Psychiatric Association(APA, 2013), the big addition for TTM is the fact that this disorder as well the related disorders now have their own chapter in Obsessive and Compulsive Disorder (OCD) section. However, in ICD-10 (International Classification of Disease-10) it is classified under habit and impulsive control disorder.

Efforts have been made in past to identify effective treatment of TTM in various directions with different levels of success. Pharmacotherapy helps target the biological aspect of the disorder that may be related to compulsive as well as impulsive behavior and therefore have the role of serotonin reuptake blocking medications addresses Swedo and colleagues in their study done in 1989.The mix of pharmacotherapy leads to best evidence in improvement of

symptoms.

The very first task in the intervention for the disorder under behavior approach is to focus upon the motoric response i.e. the pulling out of the hair from the skin which could be done using the technique of Habit Reversal Training (HRT) as a chief treatment element. Researchers like Sayer and Kagan (2014) in their work have demonstrated the use of behavioral and cognitive behavioral techniques for example HRT, Relaxation, stimulus control and others to be effective in the treatment. No matter how positive is the result of their use in the treatment there is always a chance of relapse thus indicating the need for motivational enhancement

Case Report

A 13 year adolescent male presented to the psychiatry outpatient department with symptoms of hair pulling. He is a student of class IX, belonging to middle socio economic status residing in rural regions of Jind District.

He was being brought by his grandfather who claims his grandson to be in a habit of pulling his scalp hair whenever have some sort of tension. The patient confirms for the same adding the complaint of scalp itching and trichophagia in the central posterior parietal regions. On further interviewing the patient reveals that whenever he have either something to focus upon or have nothing at all to do at hand, he worries leading to an intense desire to pull his scalp hair, he states of experiencing a sense of relief after doing the act. Also his grandfather discloses that he had similar symptoms one year back and the treatment they seeked from the dermatologist helped him get relief at that particular time. He came into the world after a full term normal vaginal delivery at hospital. His birth cry was immediate as well as normal and he achieved all milestones of development within time. No psychiatric illness was found in family history.

Behavioral Observation

Patient, 13 year adolescent male looks like his stated age. He was dressed well as per the culture and weather and greeted the interviewer. Rapport could be established with him. Hehave sustained and aroused attentionon Mental Status Examination. Proper eye contact was made and maintained and he took active part during the interview and testing sessions.

Assessment

Before initiating with the therapeutic intervention for TTM patient's IQ was being assessed using Malin's Intelligence Scale for Indian Children (MISIC) and Vineland Social Maturity Scale (VSMS) for social Quotient. His IQ was found to be 90 i.e. average intellectual functioning also his social quotient was in average category.

Functional Analysis

To get a detailed account of TTM and its relationship with physical and social environment a detailed semi structured interview was taken which included what happened before, during and after the hair pulling incident? When did it usually happens? Information for the same was seeked from family members as well as teachers in school.

Factors taken up while planning for the treatment included antecedents to pulling, the actual behavior of pulling hair and the consequences of pulling. This was then used to confirm settings where hair pulling is practiced, senses involved (usually visual and tactile), time and activities leading to the behavior. Moreover it was focused on identifying discriminative stimuli that influence the targeted behavior including both the external and internal stimuli. External stimuli so found in this case includes washroom and sitting alone in room for long duration while the internal includes free hands, deep thinking upon something.

TRICHOTILLOMANIA TREATMENT PHASES

PHASE I: DOING ASSESSMENTS AND FUNCTIONAL ANALYSIS

Hair pulling is to be targeted and also orientation of the client is needed to make him identify the functional componentsleading to same.

Beginning with self-monitoring

PHASE II: IDENTIFICATION AND TARGETING MODALITIES

The client and the therapist work mutually to identify the potential modalities to be targeted

PHASE III: IDENTIFICATION AND IMPLEMENTATION OF STRATEGIES

Therapist works upon to identify the best treatment strategies for the targeted modalities as per the findings in behavioral analysis so done for the client

Training the clients for using strategies for minimum of 1 weekduration

PHASE IV: EVALUATING AND DOING MODIFICATION IF REQUIRED

The therapist then needs to evaluate the effectiveness of the accepted strategy and move in next step for treatment

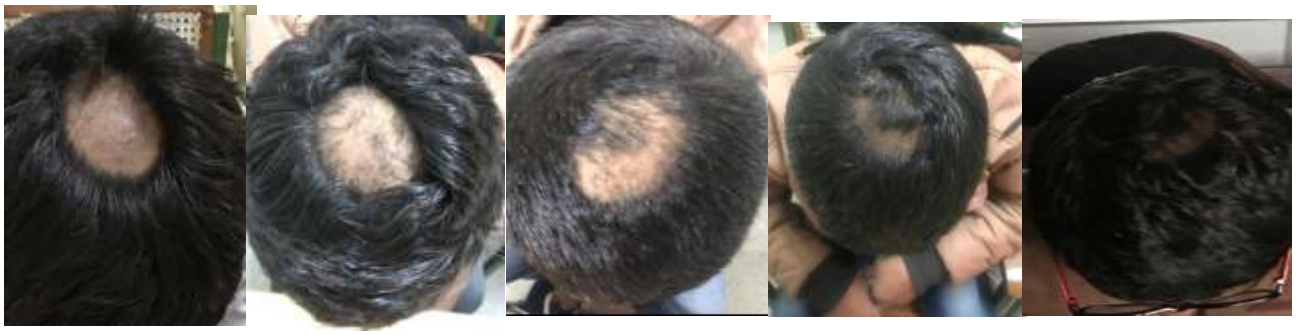
Later all the gathered information from the functional analysis was then organized into a system that leads to a way specific treatment techniques.

Management Techniques used

To begin with client and his grandfather was psycho-educated about his assessment reports as well as his illness (TTM), course, outcome and treatment modality of non-pharmacological nature.

Through functional analysis, it was clear that our patient shows this behavior when he has no work or he is very much worried about the illness. It was found that he practice the behavior mostly in home settings. So, all the information was shared with parents and teachers and asked for their cooperation in the therapeutic intervention. All goals were divided into short goals and family was told to pay attention towards the activities of the individual keenly.

*Self-monitoring*is one among the core techniques used to improve awareness in the client as it increases attention to the problematic behavior itself, the situational context in which it occur and the consequences they lead to. Self-monitoring has been found as a powerful intervention in and itself for such behaviors. Individuals make clear up front that self regulation data would be reviewed with the professional in each and every session and its eventuality may increase the patient's motivation to be very careful to the detailing of hair pulling as said by T N Hannan in 2005. The technique continues to



play role throughout the complete intervention procedure, since changing in them can lead to change in pulling pattern which must be observed and taken care of.

The other used component of CBT for TTM for the present case was *Competing Response training* (CRT). Azrin and Nunnin 1980 propounded CRT as a component of HRT. They stated that nervous system influencedhabits persists partially as they act ousts conscious awareness whereas on the other hand in some cases they cause over development of the muscles used to perform the nervous habits.

CRT involves behavior that are easy for person to implement and motorically inconsistent with pulling off hair/skin in most of the cases. From the n number of such techniques we used for our purpose were squeezing of stress ball, squeezing a pencil in school premises during classes, making a fist and putting one's hand into his pocket.

Also behavioral monitoring diary and activity scheduling was also found very effective.

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Results And Discussion

Trichotillomania is a disturbing condition for not only the patient but also for family members.

The case study was made an attempt to highlights the psychotherapeutic interventions. The client in the present study had academic pressure and low frustration related to the illness. He had maladaptive coping and remained aloof socially. In this context Silverman (1999) proposed that taking in the consideration the relevant factors of the individual of each case (e.g., intrapersonal and interpersonal difficulties, personality factors etc), provides with a complete list of probable correlates for the expert professional to give importance to during therapy. Habit reversal training proved to be useful in helping to reduce the hair pulling behavior because the child was regular for therapy and family members were supportive. Eventually, exposure therapy, the term which is being borrowed from the language of Obsessive Compulsive Disorder is used in preliminary research to help patients with trichotillomania. The therapy consisted of a four-component approach based on the concept that hair-pulling is maintained by negative reinforcement similar to compulsions associated with Obsessive Compulsive Disorder. The primary component checks the client's hair-pulling pattern; the second

component includes the formation of a hair-pulling hierarchy by the mutual work of client and therapist; the third component uses exposures based on the client's hierarchy; and the fourth component addresses emotion dysregulation.

After six months follow up he reported that he had not pulled any hair.

Conclusion

This case was found very useful to understand the disorder and its management in an adolescent. Use of functional analysis have turned vital as it clears a lot to both the client and therapist, giving a direction for intervention procedure. Though suitability of management intervention varies from client to client but for this very client self monitoring turned out to be very influential. Moreover the habit reversal technique helped the client to recover well through the treatment process. However it would have not been possible without the cooperation of his social settings (family members and teachers)

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