TRICHOTILLOMANIA—A BRIEF REVIEW AND CASE REPORT

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Trichotillomania is a compulsive desire to pull out one's hair; infrequently, eyelashes or eyebrows may be involved. Loss of hair from the scalp frequently leads to baldness (Tiling, 1975). After reviewing a large number of behaviour therapy studies it occurred to us that all cases of trichotillomania were of the maladjusted females, ranging in age from early teens to about 40 (Horne, 1977). It is also found in children (Stadeli, 1963, and Ormsby and Montgomery, 1948). However one most unusual case, an adult male, has also been treated (Horne, 1977).

Trichotillomania or any manipulation of ones own body parts has been considered as a manifestation of a conflict situation such as disturbed mother-child relationship, inadequate or deficient communication in the family or a continuous stress in school (Tiling, 1975) or an inadequate emotional satisfaction (Monroe & Abse, 1963; Stockmann, 1962; and Stadeli, 1963). Stressful patterns of life may lead to some setbacks (Schachter, 1961 and Stockmann, 1962). Tilling (1975) had also seen two patients who had psychotic episodes. Bogaert-Titeca & Demaret (1977) on the basis of similarities between history of treatment of patients of nail biting and trichotillomania found that these are ties and learned responses which later become non-adapted are present in a given situation, are reinforced by time and are more resistant to extinction. These are also considered ritual activities, triggered by some attitudes and facilitated by fear affects, aggressivity, or sexual drive. It may also manifest as a symptom of unconscious conflict in sexual area, as a behaviour which is indicative of some stage specific conflict and its transitional fixation (Vlatkovic-prpic, 1977). It is also thought to be a manifestation of regression to pregenital levels of development and incomplete identifications (Philippepoules, 1961 and Stadeli 1963). Nakona (1977) studied the psychodynamics and found that raised inner psychic aggression against the parents (specially mother), self-abhorrance combined with habitual acts like hair pulling or hair fingering were usually present before the onset of this disease. Sethi et al. (1968) had reported one case who had parental separation in early childhood, lack of competitive environment, overindulgence by parents, marital discord, identification with mother to indulge in the service of God, autoaggressiveness and guilt resulting in incomplete identification leading to trichotillomania. The disease may be a manifestation of inhibited aggression which later becomes autoaggressive, which is due to frustrations resulting from non-fulfilment of the basic needs of the child or unspecified organic damage of the brain e.g. minimal brain dysfunction, autism and post-encephalitic syndrome (Harbauer, 1978), while Ormsby & Montgomery (1948) and Freedman & Kaplan (1967) found mental subnormality, generalized dementia, GPI & postencephalitic syndromes associated with trichotillomania. Aleksandrowicz & Mares

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(1978) stated that underlying network of fantasies, mainly of oral impregnation, may be important etiological factor. Among females discontentment about their feminine roles has been stressed by Monroe & Abse (1963) as a causative factor.

Lachapelle and Pierard (1977) studied the microscopic appearance of the hair from the affected scalp area and found few histologic changes and specific markers for traumatic alopecia (Trichotillomania) e.g. empty hair ducts, plucked out hair bulbs, clefts in the hair matrix, catagen involution of empty outer root sheaths, Miescher's trichomalacia in the deep dermis and torn off sebaceous glands. Few other non-specific changes were also reported. This histopathologic picture is variable depending upon intensity of pulling and/or time of biopsy after plucking. However, when inadequate information is available, diagnosis can be supported by biopsy.

Trichotillomania is usually found associated with trichobezoar (Aleksandrowicz and Mares, 1978), so it should always be looked for carefully and treated at the same time.

As regards the treatment of trichotillomania the first aim of therapy should be to remove the immediate causes by improving the child's communicability and combining it with symptom centered behaviour therapy techniques (Tiling, 1975). Mac Laughlin and Nay (1975) treated successfully, in 22 weeks, a case of trichotillomania by positive coverants as a reward for avoidance of an urge to pull and simple response cost for each hair pulled. Bogaert-Titeca & Demaret (1977) have emphasized the similarities in the aetiology and treatment by behaviour therapy between nail biting and trichotillomania and consider them to be tics or learned responses and displacement of activity. Bomstein & Rychtarik (1978) had tried to treat a 21 years female patient by multicomponent behavioural intervention strategy, dependent variables included both quasi-direct behavioural frequency counts (i.e. number of hair pulled) and physical trace, natural erosion measures (i.e. size of bald area) and discussed the findings with regard to situational specificity of the disease.

Sethi et al. (1968) had tried the treatment of one such case by psychotherapy under pentothal in which the patient was given insight into her illness and the possible etiological factors relating to disturbed relationship with parents, extreme degree of hostility towards her step daughter and mother which led to resentment all along the feminine role and feelings of guilt. Gardner (1978) treated successfully a case of hair pulling with hypnotherapy, which the child had learned and practised herself. On reviewing the literature on hypnotherapy it was found that children were usually good hypnotic subjects and parents respond favourably if the process is carried out carefully (Gardner, 1974) and children are more easily hypnotized than adults (London & Copper, 1969, and Morgan & Hilgard, 1973). The contraindications for hypnotherapy are organic cause of the illness or when there is lack of motivation or a symptom serves a purpose of binding severe anxiety or depression (Gardner, 1978).

CASE REPORT

Ms. K., 15 years, unmarried, Hindu female, a student of class VII was referred to us by neurologist. She presented with complaints of headache and dizziness for one year, pulling out her hair for 9 months and abdominal pain for 5 months.

One year back the patient was apparently asymptomatic. Few months before the final exams of class VII she started having headache and dizziness which was almost continuous and uniformly distributed over the whole head. Intensity of headache would decrease or increase without any apparent specific factor and she would, as a result, restrict herself to bed and would not study. Just before the exams. of Class
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VII she had the irresistible desire to pull out her hair which she had expressed to her parents also. This act almost always occurred in the unobserved and unwatched moments and never took place in public places, or when strangers visited her house. She could not prevent herself from this act but at times when she had to postpone her desire in specific moments she would not have any feature of anxiety. Although she said that she would put these pulled out hair into her mouth and then spit them out after sometime, yet she had complaints of dull vague pain in the upper abdomen unrelated to meals or any other factor.

She came from a unitary family of lower middle socio-economic status. She is 3rd in the birth order. She has 3 brothers and 5 sisters. Her father is much less concerned about the children and household problems to the extent that he does not know in which standard a child is studying. Sibling rivalry was also quite a prominent feature. Since all 9 children are under 18 with age differences of 1-2 years, it was only the mother who took care of children but could not devote much time, being a working woman, a teacher in school.

She was born normally at full term, had normal developmental milestones and had no history of neurotic traits. Schooling started at 6 years of age and her scholastic performance was average. Menarche had not yet been achieved. She was sociable, talkative and extrovert premorbidly. She was happy but irritable and short tempered. She was intelligent, and hard working. No habituation or addiction was reported.

Physical examination revealed an area of baldness over the left parieto-temporal region extending over the occiput. Broken hair were noticed with two small areas of inflammation. In the rest of the right side of scalp, hair were very short and scattered. She was keeping her head covered with cloth. General and systemic examination revealed no abnormality. Mental status examination revealed anxious preoccupation with her hair pulling habit leading to distorted outlook. She was feeling quite shy and embarrassed in discussing her problems. There was no evidence of any delusions, obsession or hallucination. Reality orientation was well preserved.

In subsequent sessions she revealed lack of warmth and inadequate communication with her parents which lead to aggressivity against parents. It also appeared that large number of siblings with minor age differences had caused nonfulfilment of basic needs and inadequate emotional satisfaction in early years of life.

Further exploration was continued and insight oriented psychotherapy with behaviour modification was tried. Ms. K. was regularly followed up; at the end of 8 weeks she had shown no significant improvement inspite of our best efforts.

COMMENTS

Literature reports a favourable outcome with rigorous therapy in patients suffering from trichotillomania (Mac Laughlin and Nay, 1975; Bornstein & Rychtarik, 1978; Sethi et al. 1968 and Gardner, 1978) but the present case was a failure. It may be that a difficult family situation existed when participation of other family members was not a possibility. That she belonged to a caste where girls were a burden could have played a role. A warm satisfying relationship was never established.

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