

CASE REPORT

Trichotillomania : Exploring Clinical Presentations and Treatment Approaches

Srivaramangai Kumaresan¹, Iniyan Selvamani², L.Lavanya³, Raman K⁴

¹ Final year postgraduate, Department of Psychiatry, Saveetha Medical College and Hospital, Saveetha Institute of Medical and Technical Sciences (SIMATS), Chennai - 602105, India.

² Professor, Department of Psychiatry, Saveetha Medical College and Hospital, Saveetha Institute of Medical and Technical Sciences (SIMATS), Chennai - 602105, India.

³ Assistant Professor, Saveetha Medical College and Hospital, Saveetha Institute of Medical and Technical Sciences (SIMATS), Chennai - 602105, India.

⁴ Professor, Department of Psychiatry, Saveetha Medical College and Hospital, Saveetha Institute of Medical and Technical Sciences (SIMATS), Chennai - 602105, India.

ABSTRACT

This case series examines trichotillomania (TTM), a mental health disorder characterized by hair-pulling behaviour. Ten participants meeting Diagnostic and Statistical Manual of Mental Disorders -5th edition criteria for TTM were assessed for clinical characteristics, treatment modalities, and outcomes. Results showed varied symptom severity and prevalent comorbid anxiety and depression. Treatments included habit reversal therapy, cognitive-behavioural therapy, and pharmacotherapy, with heterogeneous treatment responses observed. Despite limitations like a small sample size, the study highlights the need for personalized interventions and long-term follow-up strategies to address TTM's complexity. By presenting individual experiences and treatment outcomes, this series aims to reduce stigma, promote further research, and enhance clinical management for improved well-being.

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Corresponding Author:

Iniyan Selvamani MD

Email: iniyanmbbs@gmail.com

Tel : +91 9962133994

INTRODUCTION

Trichotillomania also known as hair-pulling disorder, is a mental health condition characterized by recurrent, irresistible urges to pull out hair from one's scalp, eyebrows, eyelashes, or other areas of the body. This hair-pulling behaviour typically results in noticeable hair loss, which can cause significant distress and impairment in social or work functioning. Trichotillomania is a relatively common mental health condition, with an estimated lifetime prevalence of 1.14% to 2.0% in the general population. It is more prevalent among females than males, with a female-to-male ratio of approximately 3:1(1). Classified under Obsessive compulsive related disorder under ICD 11 and DSM 5. The disorder typically begins in adolescence or early adulthood, with the average age of onset around 13 years old. The

primary symptom of trichotillomania is recurrent hair-pulling episodes. These episodes can range from brief moments of pulling to extended sessions lasting several hours. Hair-pulling behaviour is often triggered by stress, boredom, or emotional distress. Additional symptoms of trichotillomania may include: biting or chewing the pulled hair, repeated unsuccessful attempts to stop hair pulling, difficulty focusing or completing tasks due to the urge to pull hair, and feelings of embarrassment or shame about noticeable hair loss.

This revision ensures smoother transitions and improved readability. The exact cause of trichotillomania is unknown, but it is believed to be a complex disorder influenced by a combination of genetic, biological, and psychological factors. Some potential contributing factors include genetics, alterations in certain brain chemicals, such as serotonin and dopamine, may play a role, underlying mental health conditions. For some patients, hair pulling may serve as a maladaptive coping mechanism for stress or anxiety(2). Trichotillomania is sometimes associated with other mental health

disorders, such as obsessive-compulsive disorder (OCD), anxiety, or depression. enhance our understanding of TTM, identify patterns and trends, and inform the development of effective treatment strategies. By sharing individual experiences, we can raise awareness about trichotillomania and empower individuals to seek help and improve their quality of life. This also emphasise the treatment approaches and identify potential areas for further research as it is a complex and often underrecognized mental health condition that can cause significant distress and impairment.

CASE REPORT

This case series investigates the clinical characteristics, treatment modalities, and outcomes in a cohort of individuals diagnosed with trichotillomania. Ten participants (8 females, 2 males; mean age 14.2 years) meeting DSM-5 criteria for trichotillomania were recruited from paediatric and psychiatric outpatient clinics between 2022 and 2023. Detailed assessments encompassing demographic data, age of onset, severity scales (Massachusetts General Hospital Hairpulling Scale), comorbid psychiatric conditions, treatment history, and functional impairment measures were collected at baseline and follow-up intervals. Findings revealed a mean duration of symptoms of 8.6 years, with varying severity levels across cases. Comorbid anxiety and depression were prevalent. Treatments included habit reversal therapy ,cognitive-behavioural therapy and pharmacotherapy and a combination approach .Substantial heterogeneity in treatment response and relapse rates post-treatment was observed, warranting further investigation. This study underscores the complex nature of trichotillomania, highlighting the need for tailored interventions and long-term follow-up strategies. Limitations include the small sample size and absence of a control group. Nonetheless, these findings contribute to a deeper understanding of trichotillomania and offer valuable insights for clinical management and future research directions in this challenging disorder.



Fig. 1: The image shows a trichobezoar, a large mass of ingested hair filling the stomach of a 15-year-old girl. This condition, often linked to trichotillomania, can lead to symptoms like abdominal pain, bloating, and gastrointestinal obstruction, necessitating medical or surgical removal.

DISCUSSION

he case series provides a comprehensive exploration of trichotillomania (TTM), shedding light on its clinical characteristics, treatment modalities, and outcomes. The demographic data, age of onset, severity scales, comorbid psychiatric conditions, and functional impairment measures collected from the participants offer a nuanced understanding of the disorder(3). The study emphasizes the intricate nature of TTM, highlighting its prevalence, especially among females, and the onset during adolescence or early adulthood. The multifaceted aetiology of TTM is discussed, incorporating genetic, biological, and psychological factors. The study suggests alterations in brain chemicals such as serotonin and dopamine, potentially playing a role in TTM. Moreover, stress, anxiety, and underlying mental health conditions are identified as triggers for hair- pulling behaviour, contributing to the complexity and interconnectedness of various mental health disorders(4).

The association with comorbidities like obsessive-compulsive disorder (OCD), anxiety, and depression underscores the need for a holistic understanding of TTM within the broader context of mental health. Treatment approaches encompassed habit reversal therapy, cognitive-behavioural therapy, pharmacotherapy, and combination strategies. However, the substantial heterogeneity in treatment response and post-treatment relapse rates observed among participants underscores the challenges in managing TTM effectively(5). The study suggests the necessity for tailored interventions and long-term follow-up strategies to address the diverse and evolving nature of TTM.

CONCLUSION

This case series provides valuable insights into the clinical understanding of trichotillomania (TTM) with the results emphasize the complexity of TTM, particularly due to the high prevalence of co-occurring anxiety and depression, pointing to the necessity of adopting a multidimensional approach to treatment for better patient outcomes. The observed differences in treatment responses, along with the significant relapse rates after initial progress, highlight the importance of creating personalized interventions that address each patient's unique needs. The study indicates that relying on a single form of treatment may be inadequate for long-term management, and instead suggests that combining behavioural, cognitive, and pharmacological therapies could provide more durable results.

Additionally, the findings stress the importance of ongoing follow-up to prevent relapse and maintain treatment success, reinforcing the idea that managing TTM requires sustained care beyond the initial therapeutic interventions. While the study's small

sample size and lack of a control group limit its generalizability, it still offers important guidance for clinicians and lays the groundwork for future research into the underlying causes of TTM. In summary, the study's key contribution is in demonstrating the need for individualized, comprehensive treatment strategies tailored to the specific challenges of TTM. These insights urge clinicians to prioritize not only short-term symptom relief but also the long-term maintenance of treatment effectiveness to enhance patients' overall quality of life.

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