

Case Report

Trichotillomania Treatment Based on Trauma: Case Report

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Abstract

Trichotillomania is characterized by recurrent pulling out of hair. It is a chronic disorder that causes functional impairment. Although trichotillomania has been known for a long time, no algorithms for its treatment have been created by now. In its etiology, trauma has also been suggested in addition to other factors. In this case study, a trichotillomania patient of 27 years with increasing severity accompanied by a history of trauma is reported. As medical treatment, aripiprazole augmentation was used, and for trauma therapy, EMDR (Eye Movement Desensitization and Reprocessing) was applied. The effects working through the trauma had on the treatment of our case was observed and discussed.

Keywords: Trichotillomania; Trauma; EMDR; Aripiprazole

1. Introduction

Trichotillomania is defined as hair pulling behavior at a level of severity that impairs functionality, having recurrent nature and resulting in hair loss. It often has a chronic course. In DSM-IV-TR, it is classified among “Impulse Control Disorders” whereas in DSM-5, it is in the category of “Obsessive Compulsive and Related Disorders” [1]. Trichotillomania is often accompanied by embarrassment, avoiding social environment and decrease in self-confidence [2]. Patients may hide their hair loss by various methods such as different hair styles, makeup and wigs [3]. The etiology of trichotillomania has not yet been fully clarified. Hair pulling behavior has been considered as a coping mechanism for avoiding stressors and unpleasant thoughts [1]. It is also considered that trauma plays a role in the development of trichotillomania and that trichotillomania patients attempt to divert their focus from traumatic memory towards hair pulling in order to reduce their anxiety based on traumatic memories [1,4,5]. Drug therapy, cognitive and behavioral therapies and habit reversal training are approaches which have been under study in terms of trichotillomania [6].

This case study handles a trichotillomania case with a traumatic experience and a long history of treatment, experiencing functional impairment. The benefits obtained in our case by working on the trauma through EMDR in addition to the augmentation therapy with antipsychotics support the literature in terms of the requirement for a multi-perspective approach towards trichotillomania cases.

2. Case Report

S was a 43-year-old married woman with 2 children who had a university degree and had been out of the workforce for the past 8 years. She referred to us with complaints of hair pulling. The patient had experienced a traumatic event at the final grade of secondary school, and about 2 years after this event, the hair pulling behavior started at a time when social stressors were present. The hair pulling behavior had been going on for about 27 years at an increasing rate of severity. The patient was the fifth child in a family of six children. Her mother was a 72-year-old housewife with a primary school degree whereas her father was a 75-year-old retired farmer who also had primary school degree. There was no identified history of neurological or psychiatric disorder in the family. The patient had no history of serious health problems, surgeries or accidents as far as she could remember. She had spent her preschool and primary school years with her family in their village and did not remember any distinct problems pertaining to that period. Due to lack of educational opportunities in her village, she had been away from her family secondary school onwards and eventually received a university degree.

She stated that until the birth of her children, she had almost no memory of the sexual abuse she had suffered in the hands of a relative living in the same household with her who had touched her body at night without her consent when she was 12 years old. After the birth of her children, when she touched her children especially at night (to check whether they were sweating, etc.) she felt as if a hand was stroking her body which caused her to recoil and get away. Due to such sensations, she refrained from touching her children. Although she had no problems about intercourse with her husband, she felt severe distress if her husband touched her at night during her sleep. She told that even though she warned her husband about it, he could not make sense of such warnings and would not act carefully. She did not tell her husband or anyone other than her former psychiatrist about the trauma she had experienced.

The hair pulling behavior had been going on since its onset at high school but she was able to hide the bald patches on her scalp. Before going out, she would paint them with an eye pencil, and if anybody noticed, she would tell them that she was losing hair due to vitamin deficiency. During the period when her traumatic memories resurfaced as triggered by the birth of her children, the hair pulling behavior distinctly increased and the hair loss reached a level that could no longer be hidden. She started covering her hair with a bandanna while going out. Subsequently, she started to cover her hair at home as well since she thought that she would pull out less hair if she noticed her hair infrequently. With the support of her husband, she decided to get treatment. She referred to a psychiatric polyclinic for the first time 10 years ago and continued her treatment for 8 months at the same institution. Afterwards, since

she moved to other cities due to professional reasons, she referred to various other institutions. She took various serotonin reuptake inhibitors for follow-up, and for the last 1 year she had been on sertraline 100 mg.

In the initial examination; she had her hair covered with a bandanna, and when she slipped it during the examination, it was observed that her hair was cut rather short and there were occasional bald patches on her scalp. At the beginning of the interview she was rather anxious, but it was observed that she got more confident and eager as the interview progressed. Her mood was depressed and her affection was problematic. Her attention and memory were evaluated as normal. She experienced flashbacks involving the feeling that her own body was touched when she touched her sleeping children. In the content of her thinking, life disturbances due to the traumatic experience and complaints were identified. Her insight was full.

Her vital signs were normal. The results of the neurological examination and other system examinations were normal. Laboratory findings (hemogram and biochemistry) were evaluated as normal. Upon psychiatric evaluation, the patient was diagnosed with Trichotillomania (Hair Pulling Disorder) and Post-Traumatic Stress Disorder (Delayed Expression) under DSM-V. The treatment continued with Sertraline 100 mg which the patient had been currently on, and Aripiprazole 5 mg was added. The high score the patient had in the Clinician-Administered PTSD Scale (CAPS) also supported the diagnosis of Post-Traumatic Stress Disorder. The patient expressed her intention for receiving treatment and was introduced into the psychiatric polyclinic follow-up. The patient was given psychoeducation about the diagnosis made. It was decided that the patient was suitable for EMDR (Eye Movement Desensitization and Reprocessing). A treatment plan was prepared by informing the patient on the nature of traumatic experience and EMDR. A safe place was formed by working on the safe place requirement. The disturbing image to be processed during the EMDR sessions was determined as “a girl (herself) lying on a bed and a man (her aunt’s son) touching her while she is asleep.” Her negative belief was “I am inadequate and guilty (I didn’t do everything I could)” whereas her positive belief was “I am strong and innocent (I did everything I could)”. She identified the feelings she had when she thought of the event and her negative belief as anger, sadness and guilt as well as a lump in her throat and body. The degree of disturbance caused by this feeling was determined through a Subjective Units of Disturbance Scale (SUD) (a scale of 1 to 10 increasing as the disturbance escalates). On the other hand, the intensity of her belief in the positive belief determined was measured by a Validity of Cognition Scale (VOC) (a scale of 1 to 7 increasing as the belief strengthens).

At the beginning of the first EMDR session, the SUD score was identified as 8 whereas the VOC score was measured as 2. At the end of the session, the SUD score was determined as 4 and the VOC score as 6. At the beginning of the second EMDR session, the SUD Score (0-10) was identified as 2 whereas the VOC score (1-7) was identified as 4 for “I am strong” and 1 for “I am innocent”. At the end of the session the SUD score was identified as 0, and the VOC score was found as 7 for “I am strong” and 1 for “I am innocent”.

She showed up for the next meeting with her hair uncovered for the first time and stated that she could inhibit the hair pulling impulse by 80%. She considered that the effect of the event she experienced had subsided and that her distress when she checked on her children at night to see if they had sweat on their back diminished by 50%. Even when she had flashbacks, they were shorter and less strong. A third EMDR session was scheduled.

During the third EMDR session, the focus was on the negative thought of "I am guilty". At the beginning of the session the SUD score was determined as 0 and the VOC score as 1 whereas at the end of the session they were 0 and 7, respectively. Afterwards, monthly interviews were held for 4 months. In the final interview, she stated that she felt touched only once when she placed a towel on her child's back but it was quite mild and ended quickly. She also stated that the urge to pull out hair had diminished and even when it emerged, she was able to prevent herself from doing it. It was observed that her hair had visibly grown. She indicated that her perspective about the traumatic event had changed. She had full belief in the fact that she was not guilty about this event and did the best she could. She was only mulling over the fact that perhaps she should have stayed with her family rather than going away for education as the stressful event that she had experienced had occurred when she left her family. She considered that her children were now old enough for her to start planning about joining the workforce and indicated that her social participation was improving and she was feeling better. A decision was made to continue with the medical treatment consisting of Sertraline 100 mg and Aripiprazole 5 mg as well as the monthly follow-ups.

3. Discussion

Trichotillomania is a disorder that results in loss of functionality in all aspects of life. In terms of its etiology and treatment algorithm, there remain areas that still require large scale research. Our case study defines a trichotillomania case that has progressed on the basis of a traumatic experience accompanied by social stressors. It was observed that the patient had not sought treatment for a long time following the onset of the hair pulling behavior. It was considered that the patient's traumatic memories became more distinct upon the birth of her children resulting in an increase in the severity of trichotillomania. Feelings of guilt and inadequacy about her traumatic experience were prominent. The behavior of hiding hair by covering it and restricting social participation in order to cope with the outcome of trichotillomania were identified.

The data available about the treatment of trichotillomania is not sufficient for creating an algorithm. The results of preclinical studies and respective psychopathological hypotheses do not correspond to positive outcomes in the clinical field [7]. Although antidepressant treatment is considered as the first choice, the studies have shown that antidepressants are useful for depression and anxiety symptoms that accompany trichotillomania, yet fail to provide any stable positive results in terms of trichotillomania [8]. In a study examining the efficacy of serotonin reuptake inhibitors through randomized control studies, the effect obtained on the basis of all antidepressants used in the treatment of trichotillomania have been reported to be of medium extent [9]. In the light of the pathophysiological similarities between tic disorders and trichotillomania, it is considered that antipsychotics regulating dopamine would be effective in trichotillomania treatment. In addition to olanzapine which is the most extensively studied

substance, haloperidol, risperidone and aripiprazole which have been handled in more restricted studies, have proven to be effective and also been recommended to be taken into consideration especially in resistant cases [8,10]. In a resistant trichotillomania case, the use of aripiprazole alone was reported to provide positive results that were maintained for 24 months [11]. In the use of antipsychotics, especially metabolic side effects constitute problems that should be taken into consideration. In our case, the patient was already on sertraline 100 mg. The long-term history of the case as well as the follow-ups made at various institutions in the past 10 years have been influential in planning an augmentation therapy, and an aripiprazole treatment was prioritized in order to reduce metabolic side effects. The medical aspect of treatment in our case involved the addition of Aripiprazole therapy as an atypical antipsychotic in addition to sertraline 100 mg. Another aspect of treatment involved processing the identified traumatic experience. It was observed that a positive response was obtained by processing the trauma and the negative thoughts through EMDR. As the hair pulling behavior of the patient gradually subsided following the EMDR sessions, it is considered that the patient's traumatic experience had contributed to the development of trichotillomania in our case. Furthermore, the augmentation therapy conducted in our case by the addition of aripiprazole supports the effect of antipsychotics as determined in previous reports on trichotillomania [6-11]. It has stood out in this case study that a multifaceted treatment planning should necessarily be considered in trichotillomania cases.

References

1. Sevinçok L, Doğan B. Trikotilomani (Saç Yolma). Tükel R, Demet MM, ed. Obsesif Kompulsif ve İlişkili Bozukluklar, 1. Baskı, Ankara: Türkiye Psikiyatri Derneği Yayınları (2017): 167-194.
2. Diefenbach GJ, Tolin DF, Crocetta J et al. Assessment of Trichotillomania: A Psychometric Evaluation of Hair-Pulling Scales. *Journal of Psychopathology and Behavioral Assessment* (2005):0882-2689.
3. Diefenbach GJ, Tolin DF, Hannan S et al. Trichotillomania: impact on psychosocial functioning and quality of life. *Behaviour Research and Therapy* 43 (2005): 869-884.
4. Azrin NH, Nunn RG. Habit-reversal: A method of eliminating nervous habits and tics. *Behaviour Research and Therapy* 11 (1973): 619-628.
5. Özten E, Hızlı Sayar G, Eryılmaz G, et al. The relationship of psychological trauma with trichotillomania and skin picking. *Neuropsychiatric Disease and Treatment* 11 (2015): 1203-1210.
6. Konkan R, Şenormancı Ö, Sungur MZ. Trikotillomani: Tanı, Farmakoterapi ve Kognitif Davranışçı Terapisi. *Klinik Psikofarmakoloji Bülteni* 21 (2011): 265-274.
7. Sani G, Gualtieri I, Paolini M, et al. Drug Treatment of Trichotillomania (Hair-Pulling Disorder), Excoriation (Skin-picking) Disorder, and Nail-biting (Onychophagia). *Curr Neuropharmacol* 17 (2019): 775-786.
8. Johnson J, El-Alfy AT. Review of available studies of the neurobiology and pharmacotherapeutic management of trichotillomania. *J Adv Res* 7 (2016): 169-184.
9. McGuire J.F., Ung D., Selles R.R., et al. Treating trichotillomania: a meta analysis of treatment effects and moderators for behavior therapy and serotonin reuptake inhibitors. *J Psychiat Res* 58 (2014): 76-83.

10. Jones G, Keuthen N, Greenberg E. Assessment and treatment of trichotillomania (hairpullingdisorder) and excoriation (skinpick-ing) disorder. *ClinDermatol* 36 (2018): 728-736.
11. Jefferys D, Burrows G. Reversal of trichotillomania with aripiprazole. *Depress Anxiety* 25 (2008): E37-E40.

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