TRICHOTILLOMANIA WITH PICA AND OBSESSIVE SYMPTOMS: A PHENOMENOLOGICAL OVERLAP

Nimisha Doval, M. S. Bhatia*, Aparna Goyal and Rashmita Saha

Department of Psychiatry, University College of Medical Sciences & Guru Teg Bahadur Hospital, Dilshad Garden, Delhi-110095, India.

ABSTRACT

Trichotillomania (TTM) is a disorder characterized by an uncontrollable urge to pull one’s own hair, usually preceded by mounting tension and followed by a sense of relief. Common co-morbidities with TTM include anxiety disorders, more commonly OCD, mood disorders and substance use disorders. TTM is characterized by repetitive behaviour limited to hair pulling, so there seems to be phenomenological overlap between TTM and OCD. Pica is defined as the persistent consumption of nonnutritive substances like clay or mud. It has also been described as an obsessive spectrum disorder. We report an interesting case that had TTM, obsessive symptoms and pica that has not being reported.

KEYWORDS: Trichotillomania, Pica, Obsession, Treatment, SSRIs.

INTRODUCTION

Trichotillomania (TTM) is a disorder characterized by an uncontrollable urge to pull one’s own hair, usually preceded by mounting tension and followed by a sense of relief. It generally involves the scalp, but may also involve the eyelashes, eyebrows, axillae and other regions.[1] It has been classified as an impulse control disorder in ICD 10[2] and in DSM - IV.[3] TTM is characterized by repetitive behaviours limited to hair pulling, so there seems to be phenomenological overlap between TTM and Obsessive Compulsive Disorder (OCD). Also, many patients of OCD have symptoms of hair pulling and vice versa.[4] Common co morbidities with TTM include anxiety disorders,[5] more commonly OCD; mood disorders,[6] and substance use disorders. The individual either may focus intensely on the hair pulling, in response to an urge, bodily sensation or cognition, or the pulling may be done unconsciously,
Pica is defined as the persistent consumption of non-nutritive substances like clay or mud. Pica has been documented commonly in association with pregnancy and iron deficiency as well as with mental retardation, schizophrenia, autism and other psychiatric disorders. However, research has shown that Pica, like TTM, also has some phenomenological and psychobiological similarity with obsessive spectrum disorders.[8,9] There are few case reports of co-occurrence of TTM and pica in children[10,11], but none has been reported in adolescents. We report a case of young adolescent girl with TTM, pica and obsessive symptoms.

CASE REPORT
Miss A, eighteen year old female belonging to middle socioeconomic status, studying in 12th class was referred to Psychiatry Outpatient Department from Dermatology, where she had presented with her mother with complaint of a bald patch in her scalp, developed since the past 6 months. Detailed history exploration revealed that whenever patient felt itching on her head, she felt the urge to pull her hair. She would try to resist the urge, but would be unable to do so. Patient also reported relief after pulling the hair. Initially, she would do it only once or twice in the entire day, but over 2-3 months, the frequency of hair pulling increased to 5-6 times in the day. Later the patient revealed that she had also started doing so unconsciously. When the bald patch over scalp started becoming visible, the patient started using a scarf to hide it (Figure). She would not store or eat the pulled out hair. There was also history of eating plaster of Paris (POP) and mud since the past 6 months. The patient reported that she had the urge to eat the mud, which she could not control despite attempts to do so. Initially she would only have a few grams of mud daily. The family members did not notice this behavior earlier, but later, when there was a patch on the wall, they realized that the patient was eating POP from the wall. Patient also gave a history of feeling dirty on seeing a utensil scrubber in the kitchen and drain cover in bathroom since the last 5-6 months. Because of this she would not wash vessels when needed, even if her mother would keep insisting her and also would quickly take a bath and come out. There was no history of any other recurrent intrusive thoughts or acts. There was no past or family history of psychiatric illness. There
was no history of any substance abuse. No psychosocial or interpersonal stressors were revealed.

On examination patient was conscious, oriented to time, place and person and had normal vitals. There was no significant finding on general physical, systemic or central nervous system examination. On local examination, a discrete patch of alopecia on the left side of the scalp (a type of traction alopecia) was present. Short, broken hairs of variable length were present, palpable as stubble. There was no evidence of scaling or inflammation, the hair at the margin was not easily pluckable and the hair over the rest of scalp was normal in texture and strength. Examination of the mucous membranes, nails, oral cavity and abdomen was normal. Mental status examination revealed a thin built young girl with adequate grooming and normal psychomotor activity. Speech was normal in rate, volume and tone. Mood was reported as anxious and affect was anxious. There was no abnormality of perception. Thinking revealed urge to pluck hair, eat POP, obsessions of contamination, avoidance of triggers. Insight was present.

Lab investigations revealed reduced haemoglobin, reduced serum iron levels.

On the basis of history and Mental State examination, a diagnosis of Trichotillomania with Pica with obsessive symptoms was made as per ICD -10 criteria. The patient was started on Capsule Fluoxetine 20 mg raised to 40 mg along with Clonazepam 0.5 mg for anxiety. On four weeks follow up, there was improvement in the urges to pull hair and obsessive thoughts.
DISCUSSION
In the aforementioned case, the patient had a constellation of symptoms of TTM, pica and obsessive symptoms. Initially TTM was classified as an impulse control disorder, but since patients experienced a repetitive behaviour with a compulsive urge and impaired inhibition of the behavior, there has been a paradigm shift in the understanding of TTM. In the recent DSM 5, TTM has been moved to OCD spectrum disorder. Also there seems to be considerable phenomenological overlap and comorbid occurrence of TTM and OCD and pica. But the occurrence of all three disorders is not commonly reported. Also pica has been reported with TTM, but most cases have been seen in children.[13]

The management of these patients needs a holistic biopsychosocial approach. A comprehensive management includes pharmacotherapy with cognitive behavior therapy (CBT). This include a variety of specific techniques like awareness training, self-monitoring, aversion, covert sensitization, negative practice, relaxation training, habit-reversal training, stimulus control and overcorrection.

The patient and family were psycho-educated about the illness and explained the management plan. Fluoxetine has been found to show improvement in OCD. SSRI’s have been reported in case reports for management of pica as well as TTM.[12,13] Also the patient was taught stimulus control, habit reversal and awareness training as the patient was also doing it unconsciously at times. Over a period of 4-6 weeks, there was a gradual reduction in the symptoms of TTM, pica and obsessive symptoms.

Such patients require a detailed exploration of history and possible psychosocial factors, including stressors leading up to a constellation of symptoms. Addressing the internal conflicts and stressors are as important as pharmacological management for a comprehensive management of the patient and to prevent relapse of symptoms.

CONCLUSION
Trichotillomania with OCD and Pica in a teen is a very rare occurrence creating a possibility of psychobiological overlap among the three different set of disorder with different management approaches. Hence it becomes imperative to look into the different factors contributing to such an occurrence.
REFERENCES


