

CASES THAT TEST YOUR SKILLS

Since childhood, Ms. D has been compulsively pulling out and eating her hair. Multiple surgeries, financial hardships, and social isolation have not stemmed her behavior. How would you help this patient?

Trichotillomania: A heads-up on severe cases

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HISTORY BALD AT AGE 9

Ms. D, age 41, began compulsively pulling out and eating her hair at age 8. When she didn't get her way at home or was nervous about school, she would sit for hours, pulling and eating a strand or two at a time, ultimately ingesting a clump of hair.

By age 9, Ms. D was bald. In grade school, she often wore hats and scarves to class to avoid teasing from other children about her baldness. In high school, she kept to herself and frequently wore wigs.

Ms. D stops pulling for brief periods and her hair grows out, but she invariably resumes pulling when psychosocial stressors mount. Many of life's normal anxieties—job interviews, work-related stress, social rejection—trigger episodes.

When she is bald, Ms. D pulls and eats hair off her wig. Over the years, she has spent thousands of dollars on custom-made wigs that mask her baldness while feeding her habit.

Ms. D's episodes are increasingly interfering with her life. She has been steadily employed as an office assistant, but does not socialize with coworkers. She has not dated in years, and during an exacerbation leaves home only to go to work. She also

pulls her eyelashes and eyebrows and picks her nails and cuticles.

Ms. D first presented in 1994 after seeing a television segment I did on trichotillomania. At intake, she was wearing a wig and exhibited anxious mood. She also has Crohn's disease; a gastroenterologist monitors her closely.

Ms. D reports compulsive counting and checking but denies other similar behaviors. No immediate family members have exhibited obsessive-compulsive or hair-pulling behaviors. Her father abused alcohol and a sister has a stuttering problem, although Ms. D denies that these have affected her psychologically.

Ms. D's hair-pulling behavior suggests:

- a pica disorder
- an impulse control disorder
- or an obsessive-compulsive disorder?



continued

Box

DSM-IV-TR diagnostic criteria for trichotillomania

- A. Recurrent pulling out of one's own hair, resulting in noticeable hair loss.
- B. Increasing tension immediately before pulling out the hair or when attempting to resist the behavior.
- C. Pleasure, gratification, or relief while pulling out the hair.
- D. The disturbance is not better explained as another mental disorder and is not caused by a dermatological or other general medical condition.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

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Dr. Lundt's observations

Trichotillomania, defined as compulsive pulling of hair, usually begins in childhood or adolescence. Scalp hair is most commonly pulled, but some patients also pull their eyelashes, pubic hair, and other body hair. Some, especially children, have reportedly pulled their pets' hair.

Mansueto et al estimate that trichotillomania afflicts approximately 1.5% of males and 3.5% of females.¹ These estimates, however, do not include persons with the disorder who are too embarrassed to seek treatment.

DSM-IV-TR classifies trichotillomania as an impulse control disorder (*Box*). Although comorbid anxiety and depressive disorders are common, Ms. D did not meet criteria for any other psychiatric disorder.

Trichotillomania often is episodic. Months or years of abstinence is common after periods of exacerbation, usually caused by stress (*Figure, page 97*).

Many clinicians mistakenly consider trichotillomania a benign disorder with few consequences beyond alopecia.² Some patients, however, progress into trichophagia—ingestion of pulled hair. Trichophagia is a form of pica disorder, typically defined as persistent eating of non-nutritive substances. Patients often harbor tremendous shame over their hair-eating behavior and resist psychiatric or medical treatment.²

The undigested hair can form sometimes massive clumps called trichobezoars, which are most common among children and the developmentally disabled.⁴ Persons with trichophagia face a 37.5% risk of forming a trichobezoar.⁵ The mass can cause abdominal pain, nausea, vomiting, and weight loss; complications include GI obstruction, ulceration, perforation, and peritonitis.⁶ An untreated trichobezoar can be fatal,⁷ although such deaths are rare among patients being treated for trichotillomania.

Patients with trichotillomania often respond to medications used to treat obsessive-compulsive disorder, such as clomipramine. Some clinicians believe this agent is more effective than selective serotonin reuptake inhibitors (SSRIs) but more difficult to tolerate. For Ms. D, I started with both.

TREATMENT 'I DON'T NEED MEDICATION'

Initial treatments—including fluoxetine, 20 mg/d for 6 months; hypnotherapy; and clomipramine, 25 mg/d—were unsuccessful. Ms. D was only marginally compliant, believing that she did not need medication.

I referred Ms. D to an out-of-state residential behavioral program specializing in trichotillomania, but she refused to go even as her hair-pulling intensified. Clomipramine was gradually increased to 75 mg nightly, briefly decreasing her pulling, then to 100 mg nightly when symptoms re-emerged. Clomipramine blood levels were monitored with each dosage change to guard against CNS and cardiac toxicity and other side effects (GI complaints, dizziness, cardiac arrhythmias, somnolence).

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After watching for seasonal patterns, I found that Ms. D's hair-pulling worsened during the winter, although no seasonal change in mood was detected. Phototherapy produced initial success, but Ms. D continued to pull her eyelashes.

Eight weeks later, however, Ms. D's symptoms escalated. Clomipramine was increased to 150 mg nightly, resulting in blood levels of 99 ng/mL for clomipramine and 204 ng/mL for the metabolite N-desmethylclomipramine—both within the therapeutic range. As she continued pulling, I added buspirone, 10 mg/d.

At this point, would you:

- **continue clomipramine and increase the dosage?**
- **discontinue clomipramine and start another psychotropic?**
- **or maintain clomipramine at the same dosage and add another psychotropic?**

▶ _____

Dr. Lundt's observations

Drug treatment of trichotillomania has not been studied extensively or long-term, and no consensus exists. Psychoanalysis, cognitive-behavioral therapy (CBT), and hypnotherapy are usually administered with psychotropics.⁸ Patients often respond to treatment at first, then reach a plateau and resume pulling their hair.⁹

Numerous psychotropics are used off-label to treat trichotillomania. Several agents have been shown in clinical trials and case reports to reduce hair pulling/eating behaviors (*Table, page 98*), but these findings are limited by small

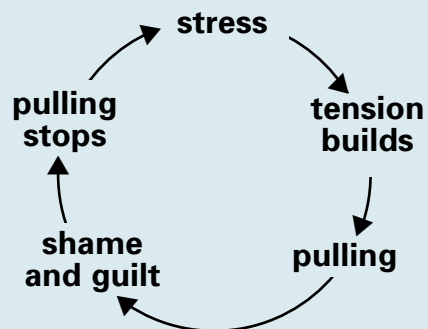
Figure

Trichotillomania: Excessive grooming, habit, or vicious circle?

Some researchers think trichotillomania is a grooming response gone awry, citing animal models of hair pulling.² Others point to hair's cultural role in defining attractiveness, especially in women.

Trichotillomania has been described in psychoanalytic terms as a regression to pregenital levels of psychosocial development.³ It has been thought to be a variant of obsessive-compulsive disorder.

Some people who pull hair describe their behavior as a habit, much like biting nails or cracking knuckles. Some patients, however, describe a tension that seems to be relieved by pulling hair. The tension or urge keeps returning, resulting in repeated pulling.¹



sample size, lack of control groups, and lack of a standard symptom rating scale.

Most clinicians begin with SSRIs because they are generally well tolerated, even at high dosages. Monotherapy often is not adequate for trichotillomania, however. Medication augmentation is common, although little empiric data support this practice.

When clomipramine did not work initially, I explored serotonergic combination strategies.

continued

Table

Medications shown to benefit patients with trichotillomania

Drug	Evidence	Dosage range (mg/d)	Potential side effects
First-line			
<u>Tricyclic</u>			
Clomipramine	Swedo et al ¹⁰	50 to 300	Sedation, weight gain, cardiac arrhythmias
<u>SSRIs</u>			
Fluoxetine	van Minnen et al ¹¹	20 to 60	GI symptoms, insomnia
Fluvoxamine	Gabriel ¹²	50 to 250	Sexual dysfunction, weight gain
Paroxetine	Ravindran et al ¹³	20 to 60	Sexual dysfunction, weight gain
Sertraline	Bradford and Gratzer ¹⁴	50 to 200	Sexual dysfunction, GI symptoms, insomnia
Second-line			
<u>Antipsychotics</u>			
Haloperidol	Van Ameringen et al ¹⁵	0.25 to 2	Sedation, EPS
Olanzapine	Gupta and Gupta ¹⁶	2.5 to 10	Sedation, weight gain
Pimozide	Stein and Hollander ¹⁷	25 to 200	Restlessness, EPS
Quetiapine	Khouzam et al ⁸	25 to 200	Sedation
Risperidone	Gabriel ¹² Senturk and Tanriverdi ¹⁸	0.5 to 4.0	Sedation, hyperprolactinemia
<u>Mood stabilizer</u>			
Lithium	Christenson et al ¹⁹	900 to 1,500	Increased thirst, weight gain, tremor

EPS: extrapyramidal symptoms

FURTHER TREATMENT RELAPSE, RESECTION

Ms. D was lost to follow-up for 1 year. She returned in 1996, just after undergoing a laparotomy for removal of a trichobezoar large enough to fill two 2-inch-by-6-inch bags. She also had been treated for pneumonia and a pulmonary embolus.

Riddled with shame and embarrassment, Ms. D had stopped pulling for 10 months, during which time she was off medication. Her pulling behaviors re-emerged, however, and clomipramine was restarted and titrated to 250 mg nightly.

One year later, a second trichobezoar was resected. Her clomipramine/N-desmethylclomipramine level reached 1,535 ng/mL, although an ECG reading was normal. Subsequent clomipramine/N-desmethylclomipramine blood levels were within the therapeutic range. Fluvoxamine, 25 mg/d titrated across 6 weeks to 150 mg/d, was added.

Again, Ms. D stopped taking her medications and was lost to follow-up. Her gastroenterologist began managing her care and started sertraline, dosage unknown, to address her depressed mood. A third trichobezoar was removed.

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Trichotillomania: A heads-up on severe cases

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When Ms. D returned to my practice, I resumed CBT and increased sertraline over 1 month from 100 to 300 mg/d. Adding olanzapine, 2.5 mg/d, diminished her anxiety and markedly decreased her hair pulling.

Months later, her hair-pulling/eating behaviors again intensified, resulting in a small-bowel obstruction and a fourth trichobezoar removal. Olanzapine was increased to 5 mg nightly without significant benefit and with sedating effects.

Clomipramine, 125 mg/d, was reintroduced and her symptoms improved dramatically. On a regimen of sertraline, clomipramine and olanzapine, Ms. D remained stable for 2 years.

Last year, however, a fifth trichobezoar measuring 20 x 15 cm was removed. Subsequent trials of methylphenidate, titrated to 72 mg every morning, and tramadol, titrated to 100 mg/d, were unsuccessful.

After 10 years of medication and psychotherapy with three different providers, Ms. D's hair-pulling/eating behaviors persist. She is taking ziprasidone, 120 mg bid, and naltrexone, 100 mg bid, to help her impulse control, as well as sertraline, 300 mg/d, and clomipramine, 125 mg/d. Another trichobezoar removal—her sixth in 8 years—is scheduled.

What strategies exist for minimizing Ms. D's hair-pulling behavior and keeping her in therapy?



Dr. Lundt's observations

Trichotillomania's waxing and waning course—and its destructive effects on a patient's self-esteem—pose a clinical challenge. The disorder's severity can range from cosmetically annoying to life-threatening, as in Ms. D's case. Patients embarrassed by their behavior often prematurely leave treatment, desperate to cut off all social contact—including medical appointments.

It is crucial to maintain a nonjudgmental, inviting demeanor to alleviate the patient's fears and facilitate a return to treatment. Support groups, especially online, can help decrease patients' isolation and provide a reliable information network (see *Related resources*).

I have had excellent results with other trichotillomania patients—especially children and adolescents. Simply naming their condition and demystifying the problem can be therapeutic. Many patients have responded to SSRIs combined with CBT.

Not long ago, trichotillomania patients were met with ignorance and disbelief within the medical community as the disorder was poorly understood. We need to break this cycle of shame and continue investigating treatment strategies.

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Trichotillomania is stigmatizing, recurrent, and possibly life-threatening if the disorder progresses to trichophagia. A welcoming, nonjudgmental approach can encourage patients to discuss symptoms and stay in treatment. An SSRI/cognitive-behavioral therapy regimen may reduce pulling behaviors. If necessary, add or switch to another serotonergic agent.

BottomLine

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Related resources

- ▶ StopPulling.com, an interactive behavioral program for persons with trichotillomania. www.stoppulling.com.
- ▶ Penzel F. *The hair pulling problem: a complete guide to trichotillomania*. New York: Oxford University Press, 2003.
- ▶ Keuthen NJ, Stein DJ, Christenson GA. *Help for hair pullers: understanding and coping with trichotillomania*. Oakland, CA: New Harbinger Publications, 2001.

DRUG BRAND NAMES

Amitriptyline • Elavil	Olanzapine • Zyprexa
Buspirone • BuSpar	Paroxetine • Paxil
Clomipramine • Anafranil	Pimozide • Orap
Fluoxetine • Prozac	Quetiapine • Seroquel
Fluvoxamine • Luvox	Risperidone • Risperdal
Haloperidol • Haldol	Sertraline • Zoloft
Lithium • Eskalith, others	Tramadol • Ultram
Methylphenidate • Concerta, Ritalin	Ziprasidone • Geodon
Naltrexone • ReVia	

DISCLOSURE

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Have a case from which other psychiatrists can learn?

Check your patient files for a case that offers “lessons learned” and send it to pete.kelly@dowdenhealth.com. Keep it to 2,000 words, outlining history and treatment options, with interspersed commentary to reinforce the key points.

If you have questions before writing, contact Pete Kelly. Our editorial board and case history editor will review your article—and you’ll hear from us soon.

