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BEHAVIOUR THERAPY IN A CASE OF TRICHOTILLOMANIA

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Trichotillomania is an irresistible urge to pull out one's hair and this indulgence into actual pulling leading to baldness frequently. It is not yet established as a disease entity separately and usually considered as a manifestation of emotional disturbance (Monroe and Abse 1963) and disturbed interpersonal relationships (Tiling 1975). Some investigators have also observed that this morbid urge to pull out one's hair is sometimes associated with psychiatric episodes (Tiling 1975, Sethi et al 1982).

These cases are usually resistant to treatment and recently there have appeared several reports in the literature indicating more encouraging results with symptom centered behaviour therapy combined with psychotherapy (Tiling 1975), behaviour therapy alone (Mac Laughlin and Nay 1975) and multi-component behavioural intervention strategy (Bornstein and Rychtarik 1978).

Case Report

A 34 year old married male educated upto class X, unemployed, belonging to a Joint Hindu Family of lower socio-economic status sought himself the therapeutic help for his illness of 3 years duration characterised by sensation of itching and formication all over the body, a compulsive urge to pull out hair to get rid of the itching pervading all those body parts having hairs (head, eye brows, armpits and genitals). He appeared quite anxious and depressed and at times also expressed suicidal ideas as his illness seemed to be increasing day by day to the extent that the concerned body parts developed swelling and rashes giving a very ugly facial appearance. The situation was so acute at the time of his first consultation that the concerned body parts were totally devoid of hair (either he pulled them or got shaved as soon as they reappeared.)

Personal history revealed a chain of unpleasant events since childhood, such as death of mother and brother during early adolescence, failure in studies, job dissatisfaction, loss of job leading to unemployment, poor financial condition, disharmony among the family members and finally rejection by his wife as well as other family members. Introverted behaviour and aggressiveness were the salient features of his premorbid personality.

Management

The patient was first given anti-depressants and anxiolytics so as to make the patient more amenable to psychotherapeutic management. Then with a plan to explore the patient's conflict areas, psychotherapeutic sessions were started twice a week. During these psychotherapeutic sessions patient was gradually made aware of the psychopathology of his illness and emotional support was provided.

To a certain extent the patient could be helped to develop an insight into his condition which also contributed in lessening his depression and anxiety but the urge to pull out hair could not be controlled or even modified and after 15 sessions what ever improvement had occurred appeared quite transient except the depressive mood. As such, a second approach of treatment was planned out after a gap of 7-8 days during which he was kept almost drug free. Subse-

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quently the case was taken up for behaviour therapy.

The target symptom of hair plucking was chosen for implementation of response prevention technique. All his fingers including thumbs of both the hands were wrapped with leucoplast and bandage projecting beyond the nails so that the patient was totally unable to pluck the hair. Every day the bandages were removed for only short duration to attend to the essential things (e.g. toilet needs, taking food and breakfast) and a close watch was kept by the nursing staff to observe if he at all tried to pull his hair. As soon as he was observed repeating his behaviour during the bandage free short interval an immediate instruction was given in his presence to reduce the quantity of his breakfast and other food items for a day or two depending upon the severity of the situation.

Attempt was also made to keep the patient busy in music therapy, reading religious books or other literature of his liking. With the help of these techniques a sufficient control could be obtained over his habit of plucking hair within a fortnight. It may be mentioned here that during the phase of treatment, patient was not allowed to shave his beard or any other hairy part of the body and as such after a fortnight, the growth of hair became quite prominent and it was observed that at times patient tried to pluck hair with the help of his two thumbs. To counteract this problem another contingency of reward and punishment was designed. Whatever money patient had with him was taken away from him and kept with the treating physician with due account in the knowledge of the former. During his stay in the hospital it became quite evident that the patient is much fond of smoking bidies and as such the financial restrictions upon him enabled us to use his own resources to eliminate this maladaptive behaviour of plucking hair. Everyday he was given the desired money to purchase a fixed number of bidies and other articles of daily use and it was ensured that the money given was just sufficient to meet the 24 hours requirements and the daily amount was spent under the supervision of the nurse so that he was not able to withhold any extra money for the subsequent time. Besides, all the patients and hospital staff as well as the visitors were specially requested not to interfere out of courtesy or generousity in the implementation of this therapeutic programme. Incidentally he had no relatives or friends to visit him. A schedule was prepared to maintain this therapeutic programme based upon the compliance of the instructions and the supply of bidies and other essential items. The schedule was strictly followed inspite of patients' initial resistance or tantrums. At this juncture some amount of supportive psychotherapy had to be done to reassure him of the recovery. Soon the patient started co-operating in a more sincere manner and within 3 weeks of this schedule his abnormal behaviour could be adequately controlled. After 4 weeks he did not feel any itching over the hairy part and it was observed that he was not making any effort to pluck the hair during the bandage-free period even when he was totally unaware of being watched. In the next phase, gradually we started increasing the duration of bandage free period and after being convinced that this habit has become almost extinct, the bandages were removed during the whole day. At this juncture patient was also advised to get himself more deeply involved in music therapy or reading the literature of his liking in occupational therapy unit. This further helped in diverting his attention and establishing response prevention. After 3 months of the start of therapy patient was kept totally free from any restraints of physical or financial nature and by this time his beard and hair over scalp had sufficient

growth. He was persuaded to develop a liking for these hair with proper maintenance. At the time of discharge, patient had full control over his behaviour and appeared to have no obvious psychiatric symptoms. Symptoms of anxiety and depression remarkably disappeared as soon as he regained the confidence to have full control over his compulsive urge to pull hair and a positive self concept characterised with masculinity in the form of beard and moustaches. Nearly three months after discharge from the hospital, patient reported to the therapists and was found to be 100 per cent symptom-free, the family members mainly his wife having established harmonious relationship and the patient taking due interest in work as well as leisure. The overall improvement in his personality brought forth substantial social approval and enriched his social relationships.

Discussion

Taylor (1963) argues that obsessive behaviour including compulsive phenomena fails to extinguish as a result of social criticism because the punishment (criticism) comes too late, that is, the performance of the obsession produces immediate re-inforcement whereas the non-re-inforcing social disapproval only comes later. Taylor's method of treatment is heavily dependent upon response prevention by instructing or preventing the patient to inhibit the first movement in the chain of events leading to the plucking of hair. Heavy bandages in both thumbs, his constant engagement in certain tasks of his liking, strict application of positive and negative re-inforcement as well as supportive psychotherapy during critical phases of the treatment seemed to have greatly contributed in the full recovery of this acute case of trichotillomania. It may however be added that a longer follow-up is still needed because a risk of relapse is substantial in view of the patient's economic and psychosocial stresses. Had the family been involved in the treatment programme, a better prognosis could be predicted.

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