CASE REPORT

Trichotillomania Comorbid with Schizophrenia

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ABSTRACT

Introduction: **Trichotillomania (TTM) is now part of DSM-5 classification of obsessive-compulsive and related disorders. A quarter of schizophrenia patients suffer from obsessive-compulsive symptoms (OCS) and the use of atypical antipsychotics may worsen or even induce new onset OCS.**

Objective: **A 25-year old man who presented with TTM comorbid with schizophrenia was studied. The symptomatology and treatment will be discussed.**

Results: **The patient had prominent anxiety and mild OCS during the prodromal phase of schizophrenia. While on atypical antipsychotics treatments, he developed TTM which was partially reduced with addition of selective serotonin reuptake inhibitor (SSRI).**

Conclusion: **Schizophrenia patient with prodromal OCS is probably at increased risk of developing TTM while on atypical antipsychotics treatment. Atypical antipsychotics and SSRI combination therapy is a useful strategy in such patient.**

KEY WORDS

trichotillomania, obsessive-compulsive, schizophrenia, aypical antipsycotics, selective serotonin reuptake inhibitor

INTRODUCTION

Trichotillomania (TTM) has been mostly a comorbid with other obsessive-compulsive related disorders (OCRD), notably skin-picking disorder. Until recently there have been only few reports of TTM in schizophrenia[1]. Here, we present a case of TTM in a young man with schizophrenia to add to the scarce literature available on this comorbidity and discuss the possible etiology.

CASE

A 25-year-old single Malay man with 2 years history of schizophrenia presented to our clinic with a new complaint. Shyly, he took off his

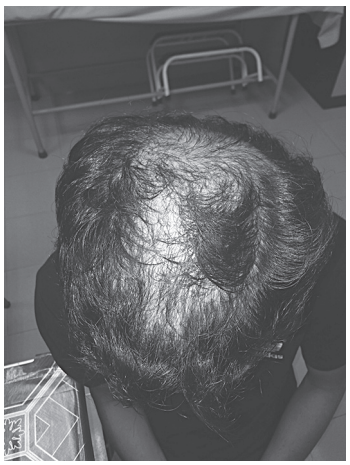

Figure 1. Initial presentation of trichotillomania. The patient was on quetiapine 500 mg ON.

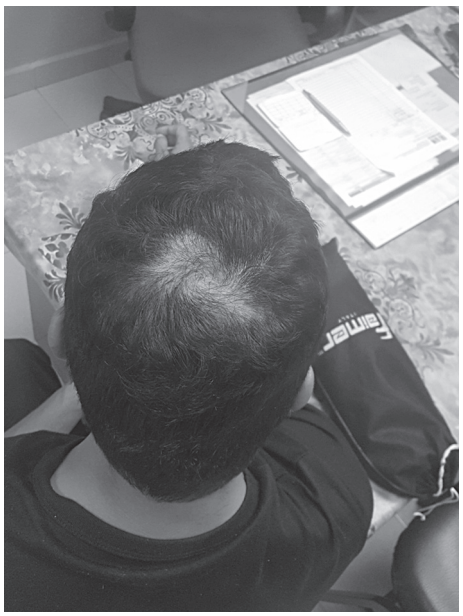

Figure 2. One year after escitalopram 10 mg ON was added to quetiapine 500 mg ON.

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cap which that he wore to avoid embarrassment showing bald patches on his scalp. For the past 1 year, he developed hair pulling which was preceded by mounting anxiety and was relieved afterward. He minimized the hair loss by claiming that most of the time he just twirled and pulled it lightly until it gave out popping sounds. There was no history of eating the hair.

Past psychiatric history revealed that his initial presentation was 4 years prior when he presented with severe unremitting panic attacks for which he was treated with escitalopram 15 mg nocte and alprazolam 0.5 mg tds. He also had mild and transient doubts over the cleanliness of his undergarment whether it was acceptable during prayers. One and a half year later, he developed auditory hallucinations for the first time. Soon he became depressed with suicidal thoughts as the voices became more prominent commanding him to kill himself. He was discharged well after 2 weeks of admission with quetiapine 500 mg nocte. During the follow-ups, he had tactile hallucinations described as being touched and sexually aroused by invisible *Jin*. His father and brother were diagnosed with schizophrenia obsessive-compulsive disorder, respectively.

Escitalopram 10 mg nocte was added to existing queatiapine 500mg nocte. Having seen the long-term effect of schizophrenia on his father and being unemployed caused him to constantly worry about his future. He was referred for psychosocial rehabilitation. He sought solace in religion through activities such as prayer and *dhikr*. About a year after later, the bald patches on his scalp had become smaller in size but not completely disappear. As he was busy working in a nearby hypermarket, he was able to distract his mind from the worrying thoughts and thus had greater control over his hair pulling behavior.

DISCUSSION

DSM-5 brings TTM more in line with repetitive and ritualized behavior and impulses in obsessive-compulsive and related disorders (OCRD) and distinguishes it from its previous roots with impulse control disorders[2]. Both TTM and OCD have underlying problems with inhibitory control but perhaps stemming from different motivating factors driving the behaviors[3].

This case illustrates a number of complex and interrelated psychopathology such as anxiety, depression, psychosis, obsession and compulsion. The initial presentation of this patient was panic attacks and obsessive-compulsive symptoms. Later on, he developed a psychotic episode accompanied by severe depression with suicidal ideations even though he was already on adequate dose of antidepressant and benzodiazepine. As all these symptoms stabilized during the follow-up, he presented with yet another symptom which was TTM.

In this case, the TTM is most likely a comorbid with schizophrenia due to the fact that the hair pulling behavior remains when all the other symptoms including panic attacks, depression and psychosis were minimal or absent. In contrast, if TTM was in response to commanding hallucinations or delusions, we would expect improvement in tandem with psychotic symptoms resolution with antipsychotics treatment[4].

In second generation antipsychotics (SGA)-induced obsessive-compulsive symptoms (OCS), a patient without a previous history of OCS develops these phenomena during antipsychotic treatment[5]. A clear association and possible causal interaction between SGA, in particular clozapine, and the de novo occurrence of OCS has been reported[6,7] In this patient, the onset of OCS preceded the psychotic symptoms and initiation of SGA. The onset of TTM however, was during the antipsychotic treatment. Therefore, the role of SGA in this case is to aggravate existing OCS rather than inducing *de novo* OCS.

Selective serotonin reuptake inhibitors (SSRI) and antipsychotics are the most commonly use pharmacological treatments for TTM[8]. Olanzapine[9] and quetiapine[10] for instance, have been reported as a useful treatment for TTM. As this patient was already on quetiapine, an SSRI was added which can also treat the concomitant anxiety symptoms.

CONCLUSION

Schizophrenia patient with prodromal OCS is probably at increased risk of developing TTM while on atypical antipsychotics treatment. Atypical antipsychotics and SSRI combination therapy is a useful strategy in such patient. In addition, psychosocial intervention will be helpful to alleviate the ongoing stressor and reduce the hair pulling behavior.

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