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Trichotillomania and Incest

ASHOK N. SINGH and JAMES MAGUIRE

Trichotillomania is reported in a 33-year-old female victim of incest, with a possible causal connection.

The French dermatologist Hallopeau (1889) first coined the term 'trichotillomania' to describe compulsive hair pulling, mainly from the scalp area, but which can also involve other areas, such as eyebrows, eyelashes, pubic hair, and beard. It usually presents in adolescence, although occasionally children may also be affected. Female hair pullers are predominent. It appears to be related to stress, varying in duration from weeks to years, and in isolated cases the hair, which may be pulled singly or in tufts, is collected, and may even be swallowed, with subsequent intestinal complications.

Tricotillomania has been reported in the context of many psychopathological processes, and has been described as an obsessive–compulsive disorder (Philippopoulos, 1961), a neurotic trait (Seitz, 1950; Sperling, 1954; Gerard, 1953), a tension-reducing habit (Gelder *et al*, 1983), fetishism (Buxbaum, 1960), masochistic behaviour (Oguchi & Miura, 1977), denial of femininity, masturbatory equivalent, and castration equivalent. It has been reported in a variety of psychiatric disorders, notably schizophrenia, borderline state, and depression (Greenberg & Sarner, 1965). Bartsch (1956) suggested a possible organic aetiology resulting from motor discharges originating in subcortical regions. It is also known to occur in the mentally retarded (Gelder *et al*, 1984).

The prognosis is always guarded, as reports suggest (Mannino & Delgado, 1969) that no one treatment modality has been successful. Many approaches have been attempted, for example, treatment with chlorpromazine (Childers, 1958), psychotherapy (Stockmann, 1962), psychoanalysis (Monroe & Abse, 1963), and behavioural methods, among others (Deluca & Holborne, 1984). Here we present what we believe to be the first report of a case of trichotillomania in an incest victim.

Case report

A 33-year-old woman presented for the first time to our services in May 1983 for assessment of compulsive hair pulling from her scalp. She was noted to have significant depressive features, mainly reactive in nature, with vague suicidal ruminations. She commenced amitriptyline (75 mg *nocte*), but defaulted from follow-up almost immediately. She was referred two years later, three weeks after the birth of her first child, a son by Caesarean section, with a post-partum depressive state, and she responded well to small doses of amitriptyline.

She had been continuously hair pulling since the age of 15 years. It had a marked compulsive quality to it. She described self-punitive impulses in association with the trichotillomania, and rationalised these on the basis that if she failed to continue hair pulling there might be ominous consequences for those around her. In her own words: "If I don't do it something terrible will happen to everybody, but not to me. That will be my punishment – left alone."

She was born fourth in a family of nine children. Her three older siblings, one brother and two sisters, were aged five years, four years and three years, respectively, at the time of her birth, which was by Caesarean section. Her mother, aged 27 years at that time, suffered perinatal brain damage. This rendered her unable to look after the child, and the patient was placed in institutional care until the age of 15 years. It is noteworthy that the other siblings and subsequent siblings, four girls and one boy born 2, 4, 11, 12, and 16 years later, were cared for at home.

Her father was aged 31 years at the time of her birth, a small farmer with little income. At that time he was already a well-established alcoholic, and despite his wife's ill-health continued to drink, making minimal efforts to maintain cohesion within the family. On further enquiries we discovered that our patient had been cared for by her grandmother for the first year of her life, but when she was seen to be developing rickets, she was placed in care, where she received neither letters nor gifts from her family, and was visited on only two occasions. She recalls her stay in care as being a happy one, with good adjustment and no obvious neurotic traits. This placement was unusual, in that she was the only child in the institution, was cared for by a religious order, and her only contacts were with lay and religious nursing staff and geriatric patients. She recalled a visit from her father when she was aged 15 years, and his insistence on taking her home "because he knew I was 15". Her father told her that he wanted to take her on a fortnight's holiday; according to our patient he raped her in a field, and refused to allow her to return to the institution. She received no further schooling, and was required almost exclusively to cater for the upkeep and management of the home and family. Her father continued to abuse her sexually over the ensuing seven years. Her older brother also indulged in regular sexual abuse shortly after her return home. It seems despite the fact that she had five sisters, she was the only victim of incest. She felt the reason that she was singled out was that she was never viewed

as a member of the nuclear family, because of her long absence from home.

At the age of 22 years she became pregnant by her father, and following his attempts using traditional potions to induce abortion, she suffered a miscarriage. From this point onwards she rejected any further advances from her father and her brother. However, she stayed in the house, continuing to look after the family. Her father developed possessive, jealous feelings towards her, and refused to allow her to socialise or have any boyfriends. She tolerated this until she left the household at the age of 31 years. At this stage her trichotillomania was established for 16 years. In the year before she left home she was admitted on three occasions to a general hospital following overdoses. She said she intended to kill herself, as her role within the family was now becoming redundant – her younger brothers and sisters were becoming independent. She was seen by social workers during her admissions and arrangements were made for her to live in a flat of her own. She was very content with this arrangement and her new-found freedom, although she remained unemployed. She became pregnant by her first boyfriend, who left her when she told him. It was following the birth of this baby that she presented for the second time to our services.

As previously noted, her depression responded to amitriptyline, but her trichotillomania persisted. We initiated a treatment strategy of psychotherapy, with competing response training. She had had a short, brunette, male-type hairstyle at all stages of contact up to this point, and at the start of therapy she had multiple bald patches, averaging three inches in diameter, evenly distributed over her scalp. The initial objective was to re-enforce the positive aspects of her self-image and self-esteem. She was encouraged to pay particular heed to her grooming and make-up. She found this to have a positive effect on her sense of well-being, and after one month she spontaneously purchased a mid-length blonde wig, which enhanced her appearance dramatically. In the initial stages she had appeared motivated in using competitive response techniques, and her hair-pulling decreased considerably. She attended for regular psychotherapy, but it became clear after a number of weeks that she lacked consistent motivation, and she began to default before finally being lost to follow-up after a further two months.

Discussion

Hair has been traditionally viewed as a symbol of beauty and strength, and has played a major role in the myths and customs of many cultures (Barahal, 1940; Leach, 1958). Hair pulling by women can be viewed as displaced aggression, and an attempt to deprive themselves of their femininity (Oguchi & Miura, 1977). Several authors refer to sexual conflicts as being the basic psychopathological mechanism of trichotillomania; Berg (1936, 1951) suggested it to be a manifestation of an underlying conflict between sexual impulses at the genital level and the repressing forces of the superego or the ego; Barahal (1940) hypothesised that hair is a phallic symbol and disorders relating to it could thus be interpreted as indicative of poor sexual adjustment. Monroe & Abse (1963) again stressed sexual conflict as being an aetiologial feature of trichotillomania, and viewed it as a manifestation of self-castration or masturbatory impulses. Sperling (1954) suggested that in certain cases it symbolised unconscious bisexual conflicts; Zaidens (1951) viewed hair pulling in the scalp region as being more serious, and distinct from that in other areas; it represented in his case studies an attempt on the part of the patient to escape from intolerable sexual situations presented by marriage. This distinction was also made by Ilan & Alexander (1965), who took the view that trichotilloma of the scalp indicated pre-genital disturbances, involving deep regression. Irwin (1953) felt that hair pulling could be interpreted as an aggressive response to coping with grief and rage.

In our patient there would appear to be a relationship between her hair pulling and incest. Faced with the loss of her fantasised and idealised father figure and the reality of the return of a sexually aggressive father, with subsequent grief and rage, she introjected her aggression, and hence developed depressive ideation with parasuicidal behaviour. Her hair pulling could be viewed as a privatised magico-protective rite, or a maladaptive, masochistic attempt to deal with the conflict by denial of her femininity. Alternatively it could be interpreted as symbolising castratory impulses. Zaidens' (1951) view of trichotillomania of the scalp would account for this patient's attempts to escape from incest.

With the increasing number of reported cases of child sexual abuse, it is likely that more unusual presentations will emerge, and more vigilance is required. Sexual conflicts must always be considered when assessing trichotillomania.

References

BARAHAL, H. S. (1940) The psychopathology of hair plucking. *Psychoanalytic Review*, **27**, 291–310.

BARTSCH, E. (1956) Contribution towards the aetiology of trichotillomania in infancy. *Psychiatry, Neurology and Medical Psychology*, **8**, 173–182.

BERG, C. (1936) The unconscious significance of hair. *International Journal of Psychoanalysis*, **17**, 73–88.

—— (1951) *The Unconscious Significance of Hair*. London: George Allen & Unwin.

BUXBAUM, E. (1960) Hair pulling and fetishism. *Psychoanalytic Study of the Child*, **15**, 243–260.

CHILDERS, R. T., JR (1958) Report of two cases of trichotillomania of long standing duration and their response to chlorpromazine. *Journal of Clinical and Experimental Psychopathology*, **19**, 141–144.

DELUCA, R. V. & HOLBORN, S. W. (1984) A comparison of relaxation training and competing response training to eliminate hair pulling and nail biting. *Journal of Behaviour Therapy and Experimental Psychiatry*, **15**, 67–70.

GELDER, M., GATH, D. & MAYOU, R. (1983) *Oxford Textbook of Psychiatry*. Oxford: Oxford University Press.

GERARD, M. W. (1953) Emotional disorders of childhood. In *Dynamic Psychiatry* (eds F. Alexander & H. Ross), pp. 165–211. Chicago: University of Chicago Press.

GREENBERG, H. R. & SARNER, C. A. (1965) Trichotillomania, symptom and syndrome. *Archives of General Psychiatry*, **12**, 482–489.

HALLOPEAU, X. (1889) Alopecia par grottage (trichomania ou trichotillomania). *Annals of Dermatology and Syphilis*, **10**, 440.

ILAN, E. & ALEXANDER, E. (1965) Eyelash and eyebrow pulling (trichotillomania): treatment of two adolescent girls. *Israel Annals of Psychiatry and Related Disciplines*, **3**, 267–281.

IRWIN, D. (1953) Alopecia. In *Emotional Factors in Skin Disease* (eds B. G. Russel & E. D. Wittkower), p. 179. New York: Paul Hoeber.

LEACH, E. R. (1958) Magical hair. *Journal of the Royal Anthropological Institute*, **88**, 147–164.

MANNINO, F. V. & DELGADO, R. A. (1969) Trichotillomania in children. A review. *American Journal of Psychiatry*, **126**, 505–511.

MONROE, J. T. JR & ABSE, D. W. (1963) The psychopathology of trichotillomania and trichophagy. *Psychiatry*, **26**, 95–103.

OGUCHI, T. & MIURA, S. (1977) Trichotillomania: its psychopathological aspect. *Comprehensive Psychiatry*, **18**, 177–182.

PHILIPPOPOULOS, G. S. (1961) A case of trichotillomania (hair pulling). *Acta Psychotherapeutica (Basel)*, **9**, 304–312.

SEITZ, P. F. (1950) Psychocutaneous conditioning during the first two weeks of life. *Psychosomatic Medicine*, **12**, 187–188.

SPERLING, M. (1954) The use of hair as a bisexual symbol. *Psychoanalytic Review*, **41**, 363–365.

STOCKMANN, F. (1962) Trichotillomania – a study in child psychiatry. *Praxis Kinderpsychology*, **11**, 281–290.

ZAIDENS, S. (1951) Self-inflicted dermatoses and their psychodynamics. *Journal of Nervous and Mental Disorders*, **113**, 400–402.

*Ashok N. Singh, DPM (RANCHI), *Registrar, St Brigid's Hospital*; James Maguire, MRCPsych, *Consultant Psychiatrist and Clinical Tutor, St Brigid's Hospital, Ardee, Co. Louth, Ireland*

*Correspondence: *St John's Hospital, Stone, Aylesbury, Buckinghamshire HP17 8PP*

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Transient Recurrence of Auditory Hallucinations During Acute Dystonia

LEO P. W. CHIU

Three schizophrenic patients who had transient recurrence of auditory hallucinations during acute dystonia precipitated by neuroleptic medication are reported. If it is accepted that psychotic symptoms result from dopaminergic overactivity, such phenomena suggest that acute dystonia might also have been caused by increased dopaminergic neurotransmission in these cases.

Acute dystonia occurs in 2–10% of patients receiving neuroleptic drugs (Swett, 1975). Its five commonest manifestations are oculogyric crisis, torticollis, contraction of the tongue, trismus, and opisthotonus (Mackay, 1982). Such drug-induced dystonia is seen more frequently in young males; it is rapidly relieved by anticholinergic medication (Roos & Buruma, 1984). However, the mechanism of drug-induced dystonia is still not well understood (Fahn & Marsden, 1987). There are two opposing hypotheses. One proposes that it is due to post-synaptic dopaminergic blockade by neuroleptics, resulting in imbalance between dopaminergic and cholinergic neurotransmission, similar to what happens in drug-induced Parkinsonism (Borison *et al*, 1982; Loudon, 1983; Hollister, 1983). The second hypothesis suggests that it results from initial pre-synaptic inhibitory dopaminergic receptor blockade by neuroleptics, leading to increased dopaminergic transmission (Silverstone & Turner, 1982; Hirsch, 1982; Grohmann *et al*, 1983; Roos & Bruyn, 1986). In the first hypothesis, anticholinergics are thought to act