Original Research

Study to Assess Phenomenological Comparison Between Obsessive Compulsive Disorder and Trichotillomania

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ABSTRACT

Background: Obsessive–compulsive disorder (OCD) and trichotillomania (repetitive hair-pulling; TTM) are debilitating conditions. The present study was conducted to phenomenologically compare obsessive compulsive disorder and trichotillomania.

Material &Methods: In the present study 50 OCD patients and 50 TTM patients of age group 18 to 75 years were included. Demographic data was collected. Participants completed the self-report Young Schema Questionnaire to assess the current profile of fundamental maladaptive beliefs in OCD and TTM. Data was analyzed using SPSS version 21. p value ≤0.01 considered statistically significant.

Results:TTM patients had an earlier age of onset of illness compared to patients with OCD. YBOCS score for OCD patients was 20.4 and MGHHPS score for TTM patients was 16.3. The severity of depressive symptoms BDI score was more in OCD patients than TTM patients. Pair-wise comparison indicated that OCD and TTM patients differed significantly on 5 schemas, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition. More specifically, OCD patients had significantly higher scores on each of these schemas compared to TTM patients.

Conclusion: The study concluded that there was significant difference between 5 schemas, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition and more specifically, OCD patients had significantly higher scores on each of these schemas compared to TTM patients. These findings support differences in underlying psychobiology and may necessitate contrasting treatment approaches.

Keywords: Trichotillomania, hair-pulling disorder, obsessive-compulsive disorder

INTRODUCTION

Trichotillomania (hair-pulling disorder) is an often debilitating psychiatric condition characterized by recurrent pulling out of one's own hair, leading to hair loss, and marked functional impairment.[1] According to the DSM-IV, other features include an increased sense of tension preceding hair pulling and feelings of pleasure, gratification, or relief following hair pulling.[2] Phenomenological observations have suggested that symptoms of repetitive hair-pulling are reminiscent of the compulsions seen in obsessive-compulsive disorder (OCD).[2,3] The onset age is reported to be the period during childhood or adolescence, which ranges the ages between four and 17. It has been revealed that the female/male incidence ratio in adolescence and adulthood is approximately four to one.[4] The legs and arms, eyebrows, eyelashes, and pubic regions, and specifically the region with the hair, are the locations

that are typically affected by the pulling-out behavior.[5] OCD and trichotillomania share overlapping co-morbidity, familial transmission, and possibly treatment response. Phenomenologically, both are characterised by difficulties suppressing inappropriate repetitive behaviours, suggesting underlying dysregulation in inhibitory control processes.[6] Therefore, the present study was conducted to phenomenologically compare obsessive compulsive disorder and trichotillomania.

MATERIALS & METHODS

Present Study was conducted in Department of Dermatology, Subdivisional Hospital, Benipur, Darbhanga, Bihar, India. In the present study 50 OCD patients and 50 TTM patients of age group 18 to 75 years were included. Before the commencement of the study ethical approval was taken from the Ethical committee of the institute and informed consent was taken from the participants after explaining the study. Participants who met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria[7] for either a primary diagnosis of OCD or TTM on the Structured Clinical Interview for Axis I Disorders (SCID-I)[8] were included. Patients were included irrespective of whether they were at baseline (i.e. not receiving any form of treatment for their primary psychiatric disorder), or were receiving treatment for OCD / TTM. Patients with comorbid OCD and TTM, a history of psychosis were excluded from the study. Demographic data was collected. In addition to the SCID-I, and selected parts of the SCID-II (obsessive-compulsive, avoidant, schizotypal, borderline personality disorders) for adult patients (aged 18 or older)[8], the interview also included the Structured Clinical Interview for Obsessive-Compulsive Spectrum Disorders (SCID-OCSD) to determine the presence of other obsessive-compulsive related conditions.[9]The Yale-Brown Obsessive-Compulsive Severity Scale (Y-BOCS)[10] was implemented to assess the severity of OCD symptoms. Severity of hair-pulling symptoms was assessed with the Massachusetts General Hospital Hair-pulling Scale.[11] The Trichotillomania Behaviour Profile was administered to TTM patients to assess hair-pulling phenomenology.Participants completed the self-report Young Schema Questionnaire (YSQ)[12] to assess the current profile of fundamental maladaptive beliefs (cognitive schemas) in OCD and TTM. For each item of the 75-item "short form" of the YSQ (which includes 15 schemas), the answer is required to be placed on a 6-point Likert-type scale (1= 'completely untrue of me', 2 = 'mostly untrue of me', 3 = 'slightly more true than untrue', 4 = 'moderately true of me', 5 = 'mostly true of me', 6 = 'describes me perfectly'). Data was analyzed using SPSS version 21. p value ≤ 0.01 considered statistically significant.

RESULTS

TTM patients had an earlier age of onset of illness compared to patients with OCD. YBOCS score for OCD patients was 20.4 and MGHHPS score for TTM patients was 16.3. The severity of depressive symptoms BDI score was more in OCD patients than TTM patients.

Pair-wise comparison indicated that OCD and TTM patients differed significantly on 5 schemas, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition. More specifically, OCD patients had significantly higher scores on each of these schemas compared to TTM patients.

Table 1: Comparison of symptomatology: OCD vs TTM

Variables	OCD(N=50)	TTM(N=50)	p-value
Age of onset (SD)	24.6	31.4	<.001
Symptom severity (SD)	YBOCS score: 20.4	MGHHPS score: 16.3	
Severity of depressive symptoms (BDI score)	8.5	5.4	0.04

Table 2: OCD and TTM scores on the YSQ subscales

Schemas	OCD(N=50) MEAN	TTM(N=50) MEAN	p-value
Emotional deprivation	2.5	2.4	NS
Abandonment	2.9	2.3	NS
Mistrust / abuse	2.5	1.8	0.02
Social isolation	2.4	1.8	0.07
Shame / defectiveness	2.1	1.3	0.03
Incompetence	2	1.9	NS
Failure to achieve	2	1.9	NS
Vulnerability to harm	2.1	1.7	NS
Enmeshment	1.9	1.8	NS
Subjugation	2.2	1.7	0.05

Self-sacrifice	3.5	3.3	NS
Emotional inhibition	2.3	1.3	<0.01
Unrelenting standards	3.9	3.7	NS
Entitlement	2	2.6	NS
Self-discipline	3	2.9	NS

DISCUSSION

It has been proposed that OCD, trichotillomania, and other disorders may be conceptualized as part of a 'spectrum' or 'family' of obsessive–compulsive disorders associated with inhibitory control deficits manifesting as excessive motoric output.[13]

TTM patients had an earlier age of onset of illness compared to patients with OCD. YBOCS score for OCD patients was 20.4 and MGHHPS score for TTM patients was 16.3. The severity of depressive symptoms BDI score was more in OCD patients than TTM patients. Pair-wise comparison indicated that OCD and TTM patients differed significantly on 5 schemas, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition. More specifically, OCD patients had significantly higher scores on each of these schemas compared to TTM patients.

Stewart SE, et al determined the prevalence of hair pulling in an inpatient obsessive-compulsive disorder (OCD) population and compared clinical characteristics and treatment response between subgroups with and without comorbid hair pulling. Of the OCD subjects, 18.8% (N = 29) endorsed any hair pulling, 15.6% (N = 24) had moderate to severe hair pulling, and 7.8% (N = 12) had severe hair pulling comparable to that of a specialty trichotillomania clinic population. OCD patients with moderate to severe hair pulling were more likely to be women (p 1 comorbid tic (p < .05), and have earlier-onset OCD (p = .001). This cohort also had fewer contamination obsessions (p = .04) and checking compulsions (p = .04) and was more likely to be receiving stimulant (p = .006) or venlafaxine (p = .02) medication than those patients without hair pulling. Posttraumatic Diagnostic Scale scores were nearly significantly higher in the OCD + hair pulling group (p = .08). OCD treatment response was unaffected by the presence of comorbid hair pulling.[14]

Lochner C, et al found that OCD patients reported significantly more lifetime disability, but fewer TTM patients reported response to treatment. OCD patients reported higher comorbidity, more harm avoidance and less novelty seeking, more maladaptive beliefs, and more sexual abuse. OCD and TTM symptoms were equally likely to worsen during menstruation, but OCD onset or worsening was more likely associated with pregnancy/puerperium.[15]

OCD patients had more maladaptive cognitive schemas than TTM, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition. The schemas that OCD and TTM patients differed on are included in 2 of the 4 higher order factors (i.e. "impaired autonomy" and "disconnection") described by Lee and colleagues' YSQ factor model.[16]

CONCLUSION

The study concluded that there was significant difference between5 schemas, i.e. mistrust / abuse, social isolation, shame / defectiveness, subjugation and emotional inhibition and more specifically, OCD patients had significantly higher scores on each of these schemas compared to TTM patients. These findings support differences in underlying psychobiology and may necessitate contrasting treatment approaches.

REFERENCES

1. Tung ES, Flessner CA, Grant JE, Keuthen NJ. Predictors of life disability in trichotillomania Compr Psychiatry. 2015;56:239–44
2. Tükel R, Keser V, Karalı NT, Olgun TÖ, Çalıkuşu C. Comparison of clinical characteristics in trichotillomania and obsessive–compulsive disorder. Journal of Anxiety Disorders. 2001 Sep 10;15(5):433-41.
3. Stein DJ, Simeon D, Cohen LJ, Hollander E. Trichotillomania and obsessive-compulsive disorder. J Clin Psychiatry. 1995;56:28–34.
4. Christenson GA, Mackenzie TB, Mitchell JE. 1991. Characteristics of 60 adult chronic hair pullers. Am J Psychiatry. 148(3):365–370.
5. Franklin ME, Flessner CA, Woods DW, Keuthen NJ, Piacentini JC, Moore P, Stein DJ, Cohen SB, Wilson MA; Trichotillomania Learning Center-Scientific Advisory Board 2008. The child and adolescent trichotillomania impact project: descriptive psychopathology, comorbidity, functional impairment, and treatment utilization. J Dev BehavPediatr. 29(6):493–500.
6. Chamberlain SR, Fineberg NA, Blackwell AD, Clark L, Robbins TW, Sahakian BJ. A neuropsychological comparison of obsessive–compulsive disorder and trichotillomania. Neuropsychologia. 2007 Jan 1;45(4):654-62.
7. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4. Washington DC: American Psychiatric Association; 1994.
8. First MB, Spitzer RL, Gobbon M, Williams JBW. Structured clinical interview for DSM-IV Axis I disorders – Patient edition (SCID-I/P, Version 20, 8/98 revision) New York: New York State Psychiatric Institute, Biometrics Research Department; 1998.
9. du Toit PL, van Kradenburg J, Niehaus D, Stein DJ. Comparison of obsessive-compulsive disorder patients with and without comorbid putative obsessive-compulsive spectrum disorders using a structured clinical

interview. Compr Psychiatry. 2001;42:291–300. doi: 10.1053/comp.2001.24586.
10. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Arch Gen Psychiatry. 1989;46:1006–1011.
11. Keuthen NJ, O'Sullivan RL, Sprich-Buckminster S. Trichotillomania: current issues in conceptualization and treatment. PsychotherPsychosom. 1998;67:202–213. doi: 10.1159/000012282.
12. Young JE. Cognitive Therapy for Personality Disorders. Florida: Professional Resource Press; 1994.
13. Chamberlain, S. R., & Sahakian, B. (2005). Neuropsychological assessment of mood disorder. Clinical Neuropsychiatry, 2(3), 137–148.
14. Stewart SE, Jenike MA, Keuthen NJ. Severe obsessive-compulsive disorder with and without comorbid hair pulling: comparisons and clinical implications. Journal of Clinical Psychiatry. 2005 Jul 1;66(7):864-9.
15. Lochner C, Seedat S, du Toit PL, Nel DG, Niehaus DJ, Sandler R, Stein DJ. Obsessive-compulsive disorder and trichotillomania: a phenomenological comparison. BMC Psychiatry. 2005 Jan 13;5:2. doi: 10.1186/1471-244X-5-2. PMID: 15649315; PMCID: PMC546013.
16. Lee C, Taylor G, Dunn J. Factor structure of the schema questionnaire in a large clinical sample. Cognitive Therapy and Research. 1999;23:441–451. doi: 10.1023/A:1018712202933.