Case Report

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Auditory Hallucinations with an Unusual Content

Psychiatry Section

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ABSTRACT

Recurrent hair pulling resulting in hair loss, in the absence of a medical or another mental disorder is a diagnostic feature of trichotillomania. It is commonly seen in depression and many other psychiatric disorders. Trichotillomania rarely occurs as a co morbid condition in patients with schizophrenia. Even rarer is recurrent hair pulling in response to psychotic symptoms in schizophrenia. We present the case of a young adult male who presented with recurrent hair pulling due to command auditory hallucinations and discuss the salient differentiating features of hair pulling seen in our patient and hair pulling in patients with trichotillomania.

Keywords: Command auditory hallucinations, Hair pulling, Schizophrenia, Trichotillomania

CASE REPORT

A 28-year-old male, educated up to ninth standard, unemployed, from a Tamil speaking middle socio economic status rural background, was brought with four years history of a continuous psychotic syndrome characterised by firm, false beliefs that his relatives were plotting to kill him and that neighbours were talking about him. He was found to talk and smile to himself and would become irritable, verbally and physically abusive towards family members without provocation. His self-care was poor and his sleep was decreased. There was significant impairment in his social and occupational functioning. There was also history of recurrent pulling out of hair from the front of scalp, eye brows, eye lashes, forearms and legs, beard and the pubic region for three years. There was no history of a pervasive mood syndrome or anxiety disorder. There were no features to suggest any organic cause for the illness or substance dependence. There was family history of psychosis suggestive of schizophrenia in two cousins on the paternal side.

Patient's father reported that when they told him not to pull out his hair, patient would say that he would feel better only if he did so. He discarded the hair without manipulating it. There was no mouthing of hair (trichophagy). His family has had his head tonsured several times both for religious purposes as well as to prevent him from pulling out his hair. Two years after the onset of illness, patient received treatment with antipsychotics and electro convulsive therapy and he discontinued medications six months ago. Father reported that hair pulling had significantly reduced while he was on medications and increased during the current period of non- compliance of around six months.

On mental status examination, the patient was poorly kempt, conscious and oriented with intact memory. Thought form was characterised by shifting of ideas from one subject to another in a completely unrelated way suggesting loosening of association, though content revealed delusions of persecution and reference. He had command auditory hallucinations of a male or female voice asking him to pull out his hair. The voices also told him that he would develop headache if he didn't do so. He also reported hearing voices telling him that he would be killed. He reported fearfulness secondary to the auditory hallucinations. He also said he would feel fearful unless his nails are clipped and kept clean but refused to elaborate further. There were no perceptual abnormalities in any other modality. Abstraction was impaired and insight was absent. On Positive and Negative Syndrome Scale (PANSS) he scored 17 on the positive symptom scale, 31 on the negative symptom scale and 36 on general psychopathology. Routine investigations including haemoglobin, total count, differential count, blood urea, serum creatinine, blood sugars, lipid profile and ECG were done in view of treatment with antipsychotics and found to be normal.

Dermatologists opined that there were multiple broken hairs of varying length seen over the frontal scalp adjacent to the hair margin and also over the dorsum of fingers and peri-umbilical area. Skin biopsy was not planned because the patient admitted to hair pulling. There was also diffuse scaling over the scalp and a diagnosis of seborrheic dermatitis was also given. He was advised ketoconazole shampoo for the same.

Patient was admitted and treated with tablet Risperidone upto 4 mg. His auditory hallucinations reduced during his in patient stay of 9 days and he did not pull out his hair during the stay. The patient came for follow up visits in the next two months when the dose of tablet Risperidone was increased to 6 mg. He continued to have delusions and hallucinations but he did not have command auditory hallucinations and its consequent hair pulling.

DISCUSSION

Recurrent hair pulling is an essential feature of trichotillomania which has been classified under obsessive-compulsive and related disorders in DSM 5 [1]. The diagnostic criteria require that recurrent hair pulling results in hair loss and the individual makes repeated attempts to decrease and stop hair pulling. Trichotillomania should not be diagnosed if hair pulling is the result of a medical condition or another mental disorder. Hair pulling has rarely been described in patients with schizophrenia as a co morbid condition and these patients' hair pulling decreased only when specific serotonin reuptake inhibitors were added to the antipsychotics [2-5]. Even rarer is hair pulling which occurs as a response to somatic delusions or hallucinations in the tactile modality in patients with schizophrenia [6,7], which, according to DSM cannot be termed as trichotillomania [1].

Our patient presented with four years history of a continuous psychotic syndrome and three years history of hair pulling in response to command auditory hallucinations. There was correlation between response of psychosis to antipsychotics and reduction in hair pulling. We like to highlight the differences between hair pulling

of trichotillomania and that secondary to psychosis in our patient with regard to epidemiology, clinical features and response to treatment.

CONCLUSION

This report describes a rare case of hair pulling in response to auditory hallucinations in schizophrenia and the differentiation in its presentation from trichotillomania. These unusual features should raise an index of suspicion in the clinician when hair pulling is encountered in patients with schizophrenia, thereby avoiding a diagnosis of co-morbid trichotillomania and the resultant pharmacotherapy with additional agents to antipsychotics which may worsen the underlying psychosis and add to the burden of illness.

REFERENCES

[1] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington DC: *American Psychiatric Association*: 2013, pp. 251-54.
[2] Kahkonen S. Trichotillomania in a schizophrenia patient. *CNS Spectr*. 2002; 7(10):751-52.
[3] Chang CH, Lee MB, Chiang YC, Lu YC. Trichotillomania: a clinical study of 36 patients. *J Formos Med Assoc*. 1991;90(2):176-80.
[4] Shah R, Somaiya M, Grover S. Trichotillomania comorbid with schizophrenia. *German J Psychiatry.* 2010;13(3):154-56.
[5] Kumar PNS, Rajmohan V. Trichotillomania with trichorhizophagia in a schizophrenic patient: Case report and review of literature. *Indian J Psychiatry*. 2012;54(2):196-97.
[6] Tsai SI, Chang FR. Repetitive hair pulling associated with schizophrenia. *Br J Dermatol*. 1998;138(6):1095-96.
[7] Sethi BB, Chaturvedi PK, Gupta AK, Trivedi JK. Trichotillomania in association with psychosis- a case report. *Indian J Psychiatry*. 1982;24(4):396-98.

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