Psychiatric Diagnosis

Ashford University

Psychopathology PSY 645

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**Suzanne’s presentation, symptoms, and behaviors**

Suzanne is nervous, anxious to get help, and under an enormous amount of stress due to an extreme confusion as to why she cannot stop pulling her hair out. She is aware that her behavior is due to the heightened amount of stress and anxiety that she is continuously under but does not understand why she can’t just stop. Suzanne has always been nervous about everything, either her schoolwork, her overconcerned parents, her boyfriend, and even about being sociable around others. Suzanne developed a nervous habitual behavior when she was in seventh grade of picking out her eyelashes. It has been proposed that hair pulling creates “counterirritation” to reduce the perception of stress by the brain (França et al., 2018). This continued until it became noticeable by her parents during dinner one evening. She was able to self-correct this impulsive behavior, however, years later when she started college and was overwhelmed by all the responsibilities and starting dating around the same time, she began pulling her hair from her head. This time was different, she pulled her hair until she had a bald spot. She tried and was unsuccessful at stopping this time. She thought that a new hairstyle would hide the bald spot but when she returned home for a visit her parents noticed. She then promised her parents that she would seek therapy for her impulsive behavior. From a cognitive behavioral perspective Suzanne is aware that she is pulling her hair and the behavior provides such a relief to her nervousness and anxiety it is too difficult to practice habit reversal or stimulus control. According to Slikboer et al. (2017), impaired cognitive flexibility is consistent with repetitive habitual motor patterns in TTM. Suzanne is aware that her heightened anxiety is causing her to become impulsive and repetitively pull her hair and then go to the length to hide the results from it. It is an unending repetitive cycle that Suzanne feels she needs professional help with to overcome the behavior.

**Identified symptoms of TTM in the DSM-5**

The DSM-5 contains a section in Chapter 5, obsessive-compulsive and related disorders, that reads “repeated pulling out of the patient’s own hair results in bald patches and attempts to control the behavior” as an essential feature of trichotillomania (Morrison, 2014). She also experiences heightened anxiety and stress when feeling pressured by her parents, interacting socially with friends and school assignments, and everyday decisions.

**Diagnosis based on the Suzanne’s symptoms and the criteria listed for the disorder(s) in the DSM-5**

Establishing the exact condition that pertains to the patient is key to the diagnosis. In this case, a probable condition that can be attributed to the patient is Trichotillomania (TTM), defined as pulling hair from various parts of the body that is often accompanied by feelings of “tension and release” (Morrison, 2014). The symptoms that Suzanne mentions in her case are archetypical to those who have TTM. From the interview, the patient reports to have started the act of hair pulling at around 13 years of age, which is approximately the same age that patients who develop compulsive disorder. Also, she exhibits other symptoms that are typical of TTM, such as shame and embarrassment as a result of the disorder.

**How Suzanne meets criteria for TTM according to her symptoms and the criteria outlined in the DSM-5**

Suzanne meets the criteria for Trichotillomania due to her excessive hair pulling, at times to the point of a bald spot on her head. She also shows behavior consistent with trying to hide the results of her pulling. She has heightened anxiety and stress that causes her to pull her hair in order to relieve that stress. There is behavior also associated with embarrassment and trying to hide her behavior of pulling her hair.

**Justify the use of the chosen diagnostic manual**

It is imperative that an assessment is conducted based on the patient’s behavior in order to validate the concerns of a medical disorder (Robbins, 2014). The DSM-5 is used in order to effectively and accurately ascertain that this case study is a valid cause of a mental disorder that needs treatment, several diagnostic procedures entailed objective questioning of the patient to establish key elements that would be key to the case in hand. The Diagnostic Statistical Manual 5th edition (DSM-5) offers a wealth of guidelines for criteria, diagnosis, and treatment for all mental disorders. The manual offers extensive and specific information to healthcare providers when he/she is faced with a patient’s symptoms and a diagnosis and treatment plan is needed. The DSM-5 provides separate chapters with each disorder in an organized fashion. The author, Dr. James Morrison is a professor of psychiatry and has guided hundreds of thousands of mental health professionals and students through the complexities of clinical evaluation and diagnosis through his publications of the DSM (Morrison, 2014). Each new edition of the manual is updated with a language that is easy to understand between professionals and contains new findings that are relevant to the disorders and places them in specific categories that make it easier to diagnose and treat the patient. It is important that the DSM be seen in its proper context, as a socially constructed document that has far reaching implications for our clients and our profession (Robbins, 2014). The DSM-5 is the most widely used and accepted manual when researching mental health disorders.

**Theoretical orientations, historical perspectives, and comorbidity.**

One theoretical approach that would prove inappropriate in the case of Susan is the existential theory, based on the assumption that all individuals are inherently good and are inclined into positive acts. Thus, the theorem intonates that a person is responsible for their actions and the repercussions that come. Suzanne does not understand why she can’t just stop pulling her hair on her own, without the help of a professional. This approach would explain how Suzanne believes that everyone is good and has good intentions and when she is presented with evidence that this is not always true, she develops heightened stress and anxiety.

A second theoretical approach is an eclectic approach, which entails the therapist using more than one method in the assessment of a case. The psychotherapist combines multiple techniques in the diagnosis and treatment of TTM. These techniques may include interviews, questionnaires, direct observation, pharmacology, and multiple types of therapy. This approach explains how the therapist does extensive research and goes to extreme cautious measures to ensure that a patient is not misdiagnosed.

**Historical perspective**

The psychodynamic theory would explain how Suzanne developed TTM disorder at a young age due to her parents always being so overconcerned. This presented behavior that entailed stress, anxiety, and insecurity. According to Erik Erikson’s seven stages of psychosocial development, Suzanne began as at infancy developing an unconscious response to her parents overconcerned treatment toward her. During the early childhood and middle childhood stage Suzanne continued to develop these unconscious responses to her parents. During Suzanne’s adolescent stage her unconscious began submerging and she began having symptoms of stress and anxiety as a response to her overconcerned parents. At this stage Suzanne also presented with TTM, pulling her eyelashes out. At the current stage of Suzanne’s development, early adulthood, she has reached a level of consciousness where her way of responding has grown exponentially stronger, causing her to pull her hair out to the point of creating a bald spot.

A historical perspective that would not be appropriate for conceptualizing Suzanne’s case is the cognitive perspective. The cognitive perspective is based on mental processing involving memory, perception, and attention, and how knowledge is gained from those processes. This perspective suggests that the human brain is much like a computer, containing data processing, data storage, data input, and data output. This perspective would not prove to be beneficial in conceptualizing Suzanne’s case of a TTM diagnosis.

**Validity of diagnosis and who is most likely to have the diagnosis with regard to age, gender, socioeconomic status, sexual orientation, and ethnicity.**

A more comprehensive assessment of the disorder in relation to Suzanne shows a pattern of susceptibility from a social-cultural perspective. One key element of commonality is gender. Studies of patients who exhibit TTM show a consistent pattern where the condition is more prevalent in women than men. The studies show that women, in general, are four times likely to develop TTM as opposed to their male counterparts. The implication carried in this assessment would serve to validate this condition as a probable cause for the patient’s behavior.

Studies on the condition show a 50% prevalence in childhood. The condition is considered serious if the patient continues to exhibit the symptoms of the condition into adulthood (Sani et al., 2019). In the case of Suzanne, the continued hair-pulling that is characterized by the existence of a bald spot shows a recurrent issue that needs treatment.

Another socio-cultural factor that is notable with regards to TTM is family roots. An investigation into the condition shows a commonality among individuals who have a family history of anxiety, depression, and stress. Suzanne’s responses allude to the presence of consistent stress and anxiety caused by frequent exposure to tense situations.

McDonald, K. (2012). Trichotillomania: Identification and treatment. Journal of Counseling & Development, 90(4), 421–426. <https://doi.org/10.1002/j.1556-6676.2012.00053.x>

Racial/ethnic minorities are less likely than Caucasians to pull lashes and eyebrows, with the number of places being pulled from increasing as age increases. Early onset may be self-corrected, requiring no intervention. Hair may be pulled one strand at a time (most common) or in clumps and is most often pulled with fingers, tweezers, combs, or brushes (McDonald, 2012, p. 421). The patient may pull hair automatically in an unconscious pattern while focusing on reading, watching television, or another activity, or the patient could be aware of the hair pulling and this is considered an act of OCD (obsessive compulsive disorder), whereas there is an active urge or tension that is causing the hair pulling.

Sani, G., Gualtieri, I., Paolini, M., Bonanni, L., Spinazzola, E., Maggiora, M., Pinzone, V., Brugnoli, R., Angeletti, G., Girardi, P., Rapinesi, C., & Kotzalidis, G. D. (2019). Drug treatment of trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, and nail-biting (onychophagia). Current Neuropharmacology, 17(8), 775–786. <https://doi.org/10.2174/1570159x17666190320164223>

The prevalence of TTM ranges from .5 to 2%, affecting more women than men, with relevance of 50% in childhood and less than half of that persisting in adulthood, later onset is due to increased severity, resistance to treatment, and is often accompanied by comorbid psychopathology. Three features of TTM are: continuous repetition of a specific behavior, repeated attempts to reduce or eliminate the behavior, and clinically significant impairment on the psychological, social, and occupational levels (Sani et al., 2019).

**Summarize the risk factors (biological, psychological, and/or social) for the diagnosis**

Trichotillomania can run in family members that have a history of depression, heightened anxiety, and/or stress. The disorder begins most commonly between the ages of six and thirteen and is four times more likely to affect women than men (Montvilo, 2019). Risk factors for trichotillomania include depression, stress, and anxiety. Suzanne does not have biological risk factors from family members, and she has not suffered from a head trauma that could have caused her TTM. Suzanne has suffered psychologically during her upbringing by her parents. She was never able to satisfy them with her accomplishments and they would constantly use negative comments to push her to do more. She has not been prescribed any medications, does not use any substances, and is doing well physically. Socially, Suzanne is uncomfortable and nervous when presenting assignments in front of the class. She is also not comfortable socializing and interacting with her friends.

**Evidence vs non-evidence-based treatment**

Cognitive-behavioral therapy is an evidence-based treatment that is most commonly used and effective when treating patients with TTM. Evidence based treatment has been studied and proven effective which makes it a better treatment option. Evidence has shown that during cognitive-behavioral therapy negative thoughts are replaced by repetitive positive thoughts until the positive thoughts become a habit, therefore increasing self-confidence and creating better decision-making ability. The patient begins to replace the hair-pulling with an alternative behavior. The patient is also able to think positively about themselves, eliminating and disregarding any negative comments from others.

Medication is a non-evidence-based treatment that is not always best to use when treating patients with TTM as it affects each individual differently and could cause more harm than benefit to the patient. Medications such as SSRI’s are sometimes effective in balancing neurotransmitters in the brain so that the patient is able to process information correctly and make better decisions. Side effects from the SSRI’s are sometimes unbearable and therefore are not a good choice for treatment.

**Well-established treatments**

The most effective psychological treatment is Cognitive-Behavioral treatment. Another effective form of treatment is pharmacological treatment named Effexor. Effexor blocks dopamine and serotonin reuptake in the brain. These treatments can reverse habitual behavior allowing the patient to engage in an alternate behavior while preventing hair pulling. There is ample evidence to suggest that an effective way of treatment of the disorder would be the induction of cognitive-behavioral therapy. The inclusion of a therapeutic approach could entail the inclusion of family members (McDonald, 2012). In the case of Suzanne, it may be imperative to include her parents in the treatment by creating an awareness of the condition. There is sufficient evidence to suggest that behavior therapy yields the most results in the treatment of TTM. On the other hand, there is a need to investigate further the use of serotonin reuptake inhibitors (SRI) in the treatment of TTM. Based on the inclusion of Sensitivity response analysis for TTM patients, there is a need to establish whether selective SRIs can have an adverse effect on the patient. Habit Reversal Training is also a well-established and successful treatment for TTM that redirects negative behaviors into positive and equally satisfying behaviors. For example, when a hair-pulling tendency arises, an alternative behavior can be developed, such as exercising, writing, talking, and many other positive things. This will decrease the hair-pulling behavior as well as anxiety and stress by reversing those habits and creating new and positive habits that will increase quality of life and eliminate TTM.

**Trichotillomania: Annotated Bibliography**

França, K., Kumar, A., Castillo, D., Jafferany, M., Hyczy da Costa Neto, M., Damevska, K., Wollina, U., & Lotti, T. (2018). Trichotillomania (hair pulling disorder): Clinical characteristics, psychosocial aspects, treatment approaches, and ethical considerations. Dermatologic Therapy, 32(4), 1–9. <https://doi.org/10.1111/dth.12622>

This article reveals the common characteristics of TTM, causes and associations, complications resulting from the disorder, decline of quality of life and social interaction, and treatment plans. Treatment plans that are reviewed are tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), Opioid antagonists, N-acetyl cysteine, Silymarin, among other successful drug treatments. Ethical responsibilities that are required when diagnosing and treating patients with TTM are discussed, as well as non-FDA approved treatment options. Cognitive behavioral therapy (habit reversal and stimulus control) is an approved method of treatment compared to psychotherapy or psychoanalytic psychotherapy.

McDonald, K. (2012). Trichotillomania: Identification and treatment. Journal of Counseling & Development, 90(4), 421–426. <https://doi.org/10.1002/j.1556-6676.2012.00053.x>

This article provides an extensive overview of TTM, identifies all criteria based on multicultural ethnicities, impairment, comorbidity, and differential treatments available. TTM is comorbid in patients with mood, depression, anxiety, eating, and substance abuse disorders with useful medications that are successful at treating TTM such as dopamine blocker (pimozide), carbohydrate inositol, and the tricyclic antidepressants, clomipramine, due to the increased effect on norepinephrine.

Nelson, S. O., Rogers, K., Rusch, N., McDonough, L., Malloy, E. J., Falkenstein, M. J., Banis, M., & Haaga, D. F. (2014). Validating indicators of treatment response: Application to trichotillomania. Psychological Assessment, 26(3), 857–864. <https://doi.org/10.1037/a0036333>

This article focuses on individual behavior therapy treatment for a broad spectrum of TTM symptoms. This article contains results from a web-based self-help treatment that measures significant clinical improvement in symptoms, severity and recovery rate within a three-month duration.

Sani, G., Gualtieri, I., Paolini, M., Bonanni, L., Spinazzola, E., Maggiora, M., Pinzone, V., Brugnoli, R., Angeletti, G., Girardi, P., Rapinesi, C., & Kotzalidis, G. D. (2019). Drug treatment of trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, and nail-biting (onychophagia). Current Neuropharmacology, 17(8), 775–786. <https://doi.org/10.2174/1570159x17666190320164223>

This article reviews efficacy of drugs that are commonly used in treating TTM, such as noradrenaline, serotonin reuptake, and dopamine. The reviews focused on interaction with transmitters that are involved in impulse control behavior.

Slikboer, R., Reser, M. P., Nedeljkovic, M., Castle, D. J., & Rossell, S. L. (2017). Systematic review of published primary studies of neuropsychology and neuroimaging in trichotillomania. Journal of the International Neuropsychological Society, 24(2), 188–205. <https://doi.org/10.1017/s1355617717000819>

This article focuses on neuropsychological studies of TTM behavioral addiction and cognitive control for habitual and impulsive behavior. Brain regions associated with TTM show an impairment in the visuo-spatial learning and response. Criteria for TTM do not consist of a deficit in memory, verbal ability, executive or motor function. The neuropsychological studies revealed activity within the nucleus accumbens, dorsal striatum, hippocampus, amygdala, cingulate, occipital regions, temporal lobe, parietal regions, motor areas, prefrontal cortex, and frontal lobe.

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França, K., Kumar, A., Castillo, D., Jafferany, M., Hyczy da Costa Neto, M., Damevska, K., Wollina, U., & Lotti, T. (2018). Trichotillomania (hair pulling disorder): Clinical characteristics, psychosocial aspects, treatment approaches, and ethical considerations. Dermatologic Therapy, 32(4), 1–9. <https://doi.org/10.1111/dth.12622>

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