

A Case of Late-Onset Trichotillomania with Coexisting Dysthymia and Substance Use

Geç Başlangıçlı Trikotilomani ve Eşlik Eden Distimi ve Madde Kullanımı Olgusu

Shruthi Vasishta¹, Aswath Manju¹, Haradanahalli Giriprakash Kshama¹

¹Kempegowda Institute of Medical Sciences, Bangalore, Department of Psychiatry, Karnataka, India

ABSTRACT

Trichotillomania is a compulsive disorder characterized by recurrent hair-pulling, typically beginning in adolescence and showing a marked female predominance. Late-onset cases are rare and frequently associated with psychiatric comorbidity. We report a 62-year-old woman referred from dermatology with a two-year history of scalp itching and repetitive hair-pulling that began shortly after she realized she had used expired hair dye. Despite multiple dermatological consultations, no organic pathology was identified. Psychiatric evaluation revealed a three-year history of persistent low mood, worsening over the preceding two months, along with relapse of alcohol use 20 days prior to presentation after 25 years of abstinence. Psychosocial stressors were significant, and biological and social functioning were impaired. Examination showed patchy alopecia, while dermatoscopy demonstrated broken hairs and perifollicular hemorrhage. Mental status examination revealed agitation, preoccupation with scalp discomfort, and depressive cognitions. She was diagnosed with dysthymia, a current moderate depressive episode with somatic syndrome, and trichotillomania; alcohol use did not meet criteria for dependence. Laboratory investigations and brain MRI were normal. Treatment with escitalopram, short-term anxiolytics, and behavioral interventions resulted in an approximately 25% reduction in symptom severity at six-week follow-up. This case underscores the importance of recognizing psychiatric morbidity underlying persistent dermatological complaints and highlights the need for a multidisciplinary approach in late-onset trichotillomania.

Keywords: Trichotillomania, late-onset trichotillomania, psychiatric morbidity in trichotillomania, bodily focused repetitive behaviours

ÖZET

Trikotilomani, yineleyici saç yolma davranışı ile karakterize, genellikle ergenlik döneminde başlayan ve kadınlarda belirgin olarak daha sık görülen kompulsif bir bozukluktur. Geç başlangıçlı olgular nadir olup sıklıkla psikiyatrik eş tanılarla ilişkilidir. Bu yazıda, süresi geçmiş saç boyası kullandığını fark etmesinden kısa süre sonra başlayan ve iki yıldır devam eden saçlı deride kaşıntı ve tekrarlayıcı saç yolma yakınmaları nedeniyle dermatoloji kliniğinden yönlendirilen 62 yaşındaki bir kadın olgu sunulmaktadır. Çok sayıda dermatolojik değerlendirmeye rağmen organik bir patoloji saptanmamıştır. Psikiyatrik değerlendirmede üç yıldır süregelen düşük duyu durumu, son iki ayda belirgin kötüleşme ve 25 yıllık yoksunluk sonrası başvurudan 20 gün önce yeniden başlayan alkol kullanımı saptanmıştır. Belirgin psikososyal stresörler mevcut olup biyolojik ve sosyal işlevsellik etkilenmiştir. Muayenede yamalı alopesi alanları izlenmiş, dermatoskopide kırık saç telleri ve perifoliküler hemoraji görülmüştür. Ruhsal durum muayenesinde ajitasyon, saçlı deriye yönelik yoğun uğraş ve depresif bilişler dikkati çekmiştir. Hastaya distimi zemininde mevcut somatik sendromlu orta şiddette depresif epizod ve trikotilomani tanısı kondu; alkol kullanımı bağımlılık ölçütlerini karşılamamaktaydı. Laboratuvar incelemeleri ve beyin MRG normal bulunmuştur. Escitalopram, kısa süreli anksiyolitik tedavi ve davranışçı müdahaleler sonrası altıncı haftada semptom şiddetinde yaklaşık %25 azalma izlenmiştir. Bu olgu, dirençli dermatolojik yakınmaların altta yatan psikiyatrik morbiditeyi maskeleyebileceğini ve geç başlangıçlı trikotilomanide multidisipliner yaklaşımın önemini vurgulamaktadır.

Anahtar Kelimeler: Trikotilomani, geç başlangıçlı trikotilomani, trikotilomanide psikiyatrik morbidite, vücut odaklı tekrarlayıcı davranışlar

Received: 8 December 2025 **Accepted:** 19 February 2026 **Published Online:** 18 March 2026

INTRODUCTION

Trichotillomania, derived from the Greek terms trich (hair) and till (to pull), is a psychiatric condition where there are repetitive, irresistible compulsions to pull out one's own hair. This leads to overt hair loss, distress and impairment in functioning. Lifetime prevalence is approximated to be 1–3% of the general population. There is a marked female predominance (approximately 10:1).

The disorder typically starts in early adolescence (1). Although paediatric and adolescent-onset trichotillomania is fairly well established, late-onset trichotillomania in geriatric patients is rare and only a few cases have been reported worldwide (2). Its appearance in the elderly population is thus clinically relevant because it could be easily missed or mistakenly attributed to dermatological and neurological disorders. Late-onset

Corresponding Author: Shruthi Vasishta, Kempegowda Institute of Medical Sciences, Bangalore, Department of Psychiatry, Karnataka, India
e-mail: shruthivasishta.1@gmail.com

Cite this article as: Vasishta S, Manju A, Kshama HG. A Case of Late-Onset Trichotillomania with Coexisting Dysthymia and Substance Use. Selcuk Med J 2026;42(1): 94-96

Disclosure: The author has no financial interest in any of the products, devices, or drugs mentioned in this article. The research was not sponsored by an outside organization. Author has agreed to allow full access to the primary data and to allow the journal to review the data if requested.

"This article is licensed under a [Creative Commons Attribution-NonCommercial 4.0 International License](https://creativecommons.org/licenses/by-nc/4.0/) (CC BY-NC 4.0)"



trichotillomania usually co-occurs with mood or anxiety disorders. Evaluation of trichotillomania in this age group is crucial, as it underscores the intricate interplay between psychiatric comorbidity, psychosocial stressors and unusual clinical presentations in later life.

CASE

A 62-year-old female patient was referred from the Department of Dermatology with the complaint of itching over her scalp and hair plucking since two years, 1 week after she became anxious on finding out that the hair dye that she had used had expired. Although she consulted dermatologists on multiple occasions, underwent repeated clinical evaluations and was reassured consistently that there was no dermatological pathology and no medical harm from the expired dye, she remained unconvinced and anxious. The worry gradually progressed to an extreme preoccupation with her scalp, followed by subjective feelings of itching and discomfort, ascribed to the previous application of the dye. She had a tendency of plucking and pulling her scalp hair every time the feeling became overwhelming. When family members attempted to stop her from the constant pulling, she described a feeling of unbearable restlessness, anger and anxiety, which forced her back into the act. Over a period of time, the hair-pulling led to large, patchy areas of baldness accompanied by broken hairs and overt scalp lesions (Figure 1). The family was worried about the unsightly appearance of these patches and, on two occasions, tonsured her head entirely. This however, did not bring the hair-pulling to an end. On comprehensive psychiatric assessment, it was seen that

she had been persistently feeling sad, was irritable, had crying spells and tiredness from almost three years, features consistent with dysthymia. There was worsening of the above symptoms in the last two months. Her son was physically abusive, actively involved in polysubstance abuse and legal issues. Her husband was emotionally distant and did not provide for the family. This led to frequent arguments at home. The exacerbation was temporally related to multiple psychosocial stressors. This was characterized by further worsening in her biological functioning, such as disrupted sleep and decreased appetite. She stopped doing the household chores and there was reduced self-care. Of particular concern was the resumption of alcohol use approximately 20 days prior to presentation after nearly 25 years of abstinence. Initially limited to small amounts (60 mL weekly), consumption escalated under interpersonal stress to 180–270 mL, 2–3 times per week. No withdrawal symptoms were observed, and criteria for dependence were not met. She had a history of hypothyroidism on stable replacement therapy. Premorbidly, she was described as dominant and the primary decision-maker in the family.

On mental status exam, patient was restless, agitated and was preoccupied with her scalp itch during the entire interview. She was speaking coherently. Her affect was anxious and was congruent with her self-report of low mood and worrying. She had depressive thoughts, hopelessness, ruminations concerning her dermatological issues, constant worry about the psychosocial stressors and preoccupation with the fear of long-term consequences of the use of expired hair dye. There were no psychotic symptoms. Her cognitive functions were normal with impaired personal, social judgement and preserved insight. Mini Mental Status Examination score was 27. Massachusetts General Hospital Hair Pulling scale (MGH-HPS) was administered – showed a score of 26. Dermatoscopy showed broken multiple hairs of different length, patchy hair loss, comma sign, black dot and perifollicular haemorrhage, features indicative of trichotillomania (Figure 2). Routine laboratory investigations and MRI brain were within normal



Figure 1. Large patchy areas of hair loss

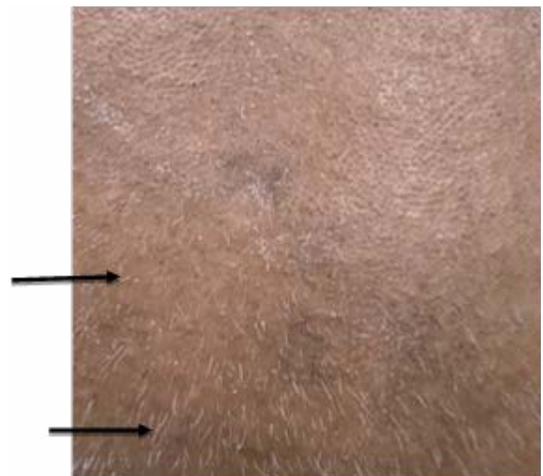


Figure 2. Broken hair, black-dot haemorrhages

limits. Given the egosyntonic nature of the symptoms and preserved insight, obsessive-compulsive disorder and delusional disorder were excluded. Based on ICD-10 criteria, she was diagnosed with dysthymia (F34.1), a current moderate depressive episode with somatic syndrome (F32.11), trichotillomania (F63.3), and alcohol use not meeting criteria for dependence.

She was started on escitalopram 10 mg/day for her symptoms. A combination of etizolam 0.5 mg and propranolol 20 mg was given to treat acute anxiety which was tapered and stopped during follow-up visits. Quetiapine 25 mg was started in view of disturbed sleep. Patient and her family were psycho-educated regarding the nature of her condition, with special emphasis on the contribution of psycho-social factors, the vicious cycle of hair pulling and the significance of supportive management. Relaxation strategies, such as guided breathing and progressive muscle relaxation, were taught. Multiple sessions on habit reversal therapy sessions were conducted. Weekly supportive psychotherapy was initiated with an emphasis on rapport building, coping skill augmentation and reinforcement of adaptive behaviour. Family therapy sessions were conducted to decrease critical remarks, increase understanding of the disorder and reinforce supportive feedback.

At the six-week follow-up, the patient reported improvement, with an approximately 25% reduction in symptom severity. (Massachusetts General Hospital Hair Pulling Scale score dropped to 19 after 6 weeks) She reported less preoccupation with her scalp and a decrease in the frequency of hair-pulling episodes. There was improvement in her mood and sleep. She was better able to participate in daily activities. The family also decreased their hostile response. Informed consent was obtained from the patient.

DISCUSSION

Late-onset trichotillomania is uncommon. Adult cohort analyses suggest that only a small minority (around 4%) develop symptoms after adolescence (4). Reports of late-life onset are therefore considered clinically significant and are frequently associated with comorbid mood or anxiety disorders, psychosocial stressors, or medical vulnerability, highlighting the need for careful psychiatric evaluation when new-onset hair-pulling behavior emerges in older adults (2,3). The primary precipitating factor in our case was anxiety about the perceived harmful effects of using an expired hair dye in the background of low mood resulting in itching and compulsive hair-pulling. This in turn presented as non-response or minimal response to dermatological treatment. The presence of co-occurring mood disturbance and alcohol use also made the presentation more complex. Chronic dermatologic complaints often mask an underlying psychiatric disorder leading to underdiagnosis of the same.

Pharmacological treatments have shown variable efficacy. The FDA has not approved any medication for trichotillomania. A double-blind randomized trial of N-acetylcysteine (NAC) in adults reported significant symptom reduction, with

≈56% reporting improvement suggesting potential benefit through glutamatergic modulation. Clomipramine, NAC and olanzapine have some evidence in managing trichotillomania (6). However, SSRIs retain an important therapeutic role in the presence of comorbid depressive or anxiety disorders, where they effectively reduce affective distress, rumination, and anxiety, which may in turn decrease suggesting the urge to pull hair and improves overall functioning (6).

Randomized and controlled clinical trials have demonstrated that behavioural interventions, particularly habit reversal training (HRT)-based cognitive-behavioural therapy (≈64% responders) have superior efficacy over pharmacotherapy (≈9% responders) (5).

Our case highlights the complex presentation of late onset trichotillomania and the need for early screening for psychiatric morbidity in such patients.

DECLARATIONS

Conflict of Interest: *The authors declare that they have no conflict of interest.*

Financial Disclosure: *The authors declare that there is no financial conflict of interest related to this study.*

Acknowledgements: *Not applicable*

Funding: *No financial support was received for this study*

Author Contributions: *Concept: SV, MA; Design: SV, MA, KHG; Literature Search: SV, KHG; Writing: SV, MA, KHG*

Address correspondence to: *Shruthi Vasishta, Kempegowda Institute of Medical Sciences, Bangalore, Karnataka, India*
e-mail: *shruthivasishta.1@gmail.com*

REFERENCES

1. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry. 11th ed. Philadelphia: Wolters Kluwer; 2015. p. 432.
2. Abhijita B, Ganesh R. Very late onset hair-pulling disorder: A geriatric case report. *Psychogeriatrics*. 2023;23(6):1088-90. doi:10.1111/psyg.13032.
3. Sutar R, Rajan A, Siddiqui F. Rare presentation of trichotillomania in elderly with sensory impairments: A case report with diagnostic and therapeutic challenges. *Psychiatry Res Case Rep*. 2022;1(2):100051. doi: 10.1016/j.psycr.2022.100051.
4. Ricketts EJ, Snorrason I, Kircanski K, et al. A latent profile analysis of age of onset in trichotillomania. *Ann Clin Psychiatry*. 2019;31(3):169-78.
5. van Minnen A, Hoogduin KAL, Keijsers GPJ, et al. Treatment of trichotillomania with behavioral therapy or fluoxetine: A randomized, waiting-list controlled study. *Arch Gen Psychiatry*. 2003;60(5):517-22. doi:10.1001/archpsyc.60.5.517.
6. Hoffman J, Williams T, Rothbart R, et al. Pharmacotherapy for trichotillomania. *Cochrane Database Syst Rev*. 2021;9(9):CD007662. doi: 10.1002/14651858.CD007662.pub3.