Journal of Child & Adolescent Behavior

Case Report Open Access

A Case of Very Early Onset Trichotillomania

Vishwa Thakkar*, Richa Saxena, Manish Thakre, Sudhir Mahajan, Pranjalee Bhagat, Prashant Tiple

Department of Psychiatry, Government Medical College, Nagpur, India

Background

Hair pulling disorder. (Trichotillomania) is a disabling condition characterized by essential criteria of recurrent hair pulling resulting in noticeable hair loss. It is now classified under obsessive compulsive and related disorders in Diagnostic and statistical Manual of Mental disorders-5. Individuals who have symptoms before 6 years of age are uncommon and classified as very early onset "trichotillomania" [1]. The literature on very early onset Trichotillomania is sparse contributing to poor understanding of this variant [2].

Aim

To present the case of a 4-year-old female child with very early onset Trichotillomania, who improved with pharmacological as well as behavioural intervention.

Case Details

A 4-year-old female child was referred from Dermatology OPD after detailed dermoscopic assessment in view of plucking of hair since 1 year which resulted in a bald patch in the right scalp that measured about 5 cm ×5cm. Patient was admitted to the Psychiatry ward for detailed evaluation and treatment.

Plucking of hair started 1 year back while watching Television or while lying on bed. Patient used to stroke her hair with right thumb and index finger curl and pluck them. This increased over a period of 2 months. When asked about her hair plucking, patient would either deny about it or keep mum. No history of mouthing/eating hair, plucking hair from roots or other sites/itching or oozing. After about 2 months, the mother noticed thinning of hair over right side of scalp. She tried various oils for her hair growth but did not see any results. Patient still continued plucking of hair despite getting several warnings from her mother. Gradually it resulted in a bald patch (Figure 1).

Hence, the mother brought her to Dermatology OPD from where she was referred to Psychiatry OPD. A detailed history of patient was taken. Patient was born of full-term normal delivery with no h/o of antenatal or perinatal complications in mother. Patient cried immediately after birth and there was no h/o any fever/seizures/jaundice or NICU stay. Also, on asking about developmental history, there was no delay in any gross motor, fine motor, social or language milestones. No h/s/o hyperactivity, inattention, conduct disorder, decreased interaction, irritability, sleep difficulty, crying spells, other obsessive compulsive related symptoms. Patient lived in a joint family with father as the breadwinner who worked as a farmer. Family atmosphere as per mother was warm. There was no history of psychiatric illness in family. Patient was an easy and flexible child as per mother. Patient was later admitted in Psychiatry ward.

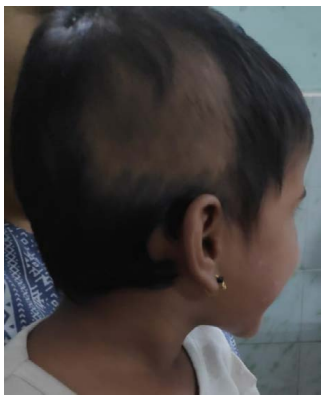

Figure 1: On Admission.

Course in Ward

On admission, a detailed mental status assessment and child observation was done. The child appeared active and playful during the interview. On asking about her hair plucking, she nodded her head showing no. After the interview a picture of her bald patch was shown to her. Routine blood work up was done which was within normal limits. Patient was started on oral suspension Fluoxetine 3.5ml (20 mg/5ml) in the morning time. Also, the mother was asked to cover her hands with hand gloves throughout the day. Patient was given an apple at the end of the day as a token if she kept the gloves. She was discharged after a week when mother and the staff corroborated that no hair plucking was seen. She was discharged with the same medications and mother was educated about the continuation of hand gloves and token economy.

Patient followed up after 15 days in the OPD when mother denied hair plucking behaviour. Objectively, new hair growth was seen which was confirmed on dermoscopy (Figure 2).

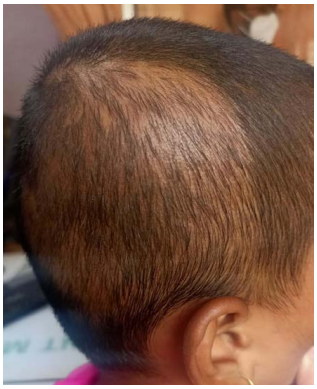

Figure 2: After 22 days.

***Corresponding author:** Vishwa Thakkar, Department of Psychiatry, Government Medical College, Nagpur, India; E-mail: vishwathakkar95@gmail.com

Received: 02-Aug-2022, Manuscript No: jcalb-22-71076; **Editor assigned:** 04-Aug-2022, Pre-QC No: jcalb-22-71076 (PQ); **Reviewed:** 18-Aug-2022, QC No: jcalb-22-71076; **Revised:** 20-Aug-2022, Manuscript No: jcalb-22-71076 (R); **Published:** 27-Aug-2022, DOI: 10.4172/2375-4494.1000461

Citation: Thakkar V, Saxena R, Thakre M, Mahajan S, Bhagat P, et al. (2022) A Case of Very Early Onset Trichotillomania. J Child Adolesc Behav 10: 461.

Copyright: © 2022 Thakkar V, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Discussion

As per ICD-10, Trichotillomania (TTM) is characterized by loss of hair due to recurrent failure to resist impulses to pull out hair. The hair pulling is usually preceded by mounting tension and is followed by sense of relief or gratification [3]. However, in very young children this phenomenon is not ellicitable. They do not have the psychological sophistication to describe feelings of gratitude or guilt. Only the behaviour in the form of hair –pulling is evident.

TTM in children aged ≤6 years has not been extensively studied. A growing number of authors are recognizing that hair pulling in this age may be higher than previously thought. The early-onset condition is reported to have different characteristics, co-morbidities duration, and treatment than hair pulling in older children and adolescents [4].

Two case reports were documented by G Altin et al in 2016 that presented two very early onset trichotillomania cases thought to be associated with maternal stress and impaired affective interpersonal communication between mother and child [5].

There is no consensus for treatment of trichotillomania in children and adolescents. Over the past several years few behavioural treatment studies that have been conducted with children have utilized token systems in conjunction with punishment procedures. In the article published by Ronald Blount and A.J. Finch JR, a treatment program was instituted to reduce trichotillomania in a 3 year old girl. It included hugs and praise for periods of not pulling, a loud "NO" for movements towards hair. Immediate reduction in hair pulling was obtained. Similar intervention was adapted for the girl in the present case with the modification of token system for keeping the gloves throughout the day [6].

In a paper published by Savita Malhotra et al, which described sociodemographic profile, clinical characteristics and treatment outcome in 20 children with trichotillomania who presented to Child and adolescent clinic over a period of 6 years, 45 % children were successfully treated with a combination of behaviour therapy and antidepressant and the most commonly used antidepressant was Fluoxetine in dose range 10-20 mg/day [7].

Similarly in the case described, we see an improvement with a mix of behavioral intervention using token system and pharmacological management using Fluoxetine.

Conclusion

It is not uncommon in Psychiatric OPDs to get children with hair pulling disorder. There has been literature suggesting other comorbid psychiatric illnesses, behavioural disturbances stress in family associated with Trichotillomania presenting to clinics. But patients like the one discussed here, without any comorbid conditions have presented very less. Also, there is need for modification of diagnostic criteria when very young children are taken into consideration

References

1. Flessner CA, Lochner C, Stein DJ, Woods DW, Franklin ME, et al. (2010) Age of onset of trichotillomania symptoms: Investigating clinical correlates. J Nerv Ment Dis 198:896-900.
2. Menon V, Shaik S, Mohan P (2015) Very early onset trichotillomania presenting with recurrent trichobezoar:Conventional wisdom questioned. Int J Trichol 7:36-37.
3. ICD-10 (1970) International Statistical Classification of Diseases and Related Health Problems: Tenth revision. World Health Organization.
4. Bruce TO, Barwick LW, Wright HH (2005) Diagnosis and management of trichotillomania in children and adolescents. Paediatric drugs 7: 365-376.
5. Altin G, Sanli I (2016) Very early onset trichotillomania associated with family stress : two case reports. The Internet Journal of Psychiatry.
6. Blount RL, Finch AJ (1988) Reducing trichotillomania in a three-year-old girl. Child Fam Behav Ther 9: 65-72.
7. Malhotra S, Grover S, Baweja R, Bhateja G (2008) Trichotillomania in children. Indian Pediatr 45: 403-405.