

Trichotillomania in Children

SAVITA MALHOTRA, SANDEEP GROVER, RAMAN BAWEJA AND GAURAV BHATEJA

From the Department of Psychiatry, Post Graduate Institute of Medical Education and Research, Chandigarh 160 012, India.

Correspondence to: Prof. Savita Malhotra, Department of Psychiatry, Post Graduate Institute of Medical Education and Research, Chandigarh 160 012, India. E-mail: dr.savita.malhotra@gmail.com

Manuscript received: October 11, 2007; Initial review completed: August 14, 2007;

Revision accepted: December 13, 2007.

ABSTRACT

In this paper, we describe the sociodemographic profile, clinical characteristics and treatment outcome of 20 children with trichotillomania. These children presented to the Child Adolescent Psychiatry Clinic over a period of 6 years, with a prevalence of 1.24%. Most subjects were females (85%), hindu by religion (65%), and belonged to urban nuclear family (70%). The mean age at first presentation was 10.1 yr (SD = 4.4). Comorbid psychiatric illness and family history of psychiatric disorders was present in 40% and 20% cases, respectively. Nearly two-third of these had associated impulse; 75% denied resistance to pluck. Children who continued treatment, showed improvement.

Key words: *India, Trichotillomania.*

INTRODUCTION

Trichotillomania is classified as an impulse control disorder, in which the individual has an overwhelming urge to pluck out hair, which leads to momentary relief from associated anxiety(1). It is reported to be more common in females with prevalence rates of 0.6%(2). Trichotillomania is described to have substantial comorbid psychopathology, and a parental history of tics, habits, or obsessive-compulsive symptoms(3,4). It frequently runs a chronic course with frequent remissions and relapses and the main stay of treatment is behavior therapy, although pharmacotherapy has also been used for the treatment(5).

There is limited data from India regarding this entity, mainly in form of case reports or series of 2-3 cases(6-9). We conducted this clinic based retrospective study with the aim to study the clinic prevalence, sociodemographic profile, clinical profile, comorbidity and treatment outcome of trichotillomania in children.

METHODS

Records of all patients diagnosed as trichotillomania as per ICD-10(10) who attended the Child Adolescent Psychiatry Clinic at the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh between 2000-2005 were assessed for information on the socio-demographic, clinical and treatment variables. Case work-up of each patient is done on a semistructured history sheet with thorough and complete details from patient and family including a mental status examination. Each case is discussed and reviewed by a consultant psychiatrist who makes the diagnosis as per ICD-10. Patient is followed by the same team for treatment.

A total of 1610 cases were registered during the study period, of which 20 cases were diagnosed as trichotillomania. The case files were retrieved and information on the sociodemographic profile, age of onset, duration of symptoms, age at first presentation, source of referral, type of onset, precipitating factor, course of symptoms,

phenomenology, family history of mental illness, family functioning, comorbid physical and psychiatric illnesses, management done and outcome was extracted. The response to treatment was operationally defined and divided into 'partially improved' (reduction of symptoms from 25% to 50%) and 'improved' (>50% reduction of symptoms).

RESULTS

The clinic prevalence rate of trichotillomania was 1.24%. The mean age at first presentation was 10.1 years (SD=4.4; range 2-14). Detailed sociodemographic and clinical profile is presented in **Table I**.

One child developed cervical abscess due to repeated plucking of hairs, 2 cases had additional seborrheic dermatitis and 1 case had morphea. Only one child developed trichobezoar.

All affected children plucked hair from the scalp; which was diffuse in 14 (70%) cases; from fronto-temporal region in 4 (20%) cases and from parieto-temporal area in 2 (10%) children. In addition, 20% ($n=4$) subjects also plucked hairs from eyelashes and eyebrows. All patients plucked hairs with hands only and did not report use of other tools such as tweezers, brushes, or combs.

Besides the supportive management (psycho-education, parental counselling, environmental manipulation, liaison with other specialties), 45% ($n=9$) children were treated with a combination of behavior therapy and antidepressant; 25% ($n=5$) with antidepressants alone and 15% ($n=3$) with behavior therapy alone. The most commonly used antidepressant was fluoxetine (50%) in the dose of 10-20 mg per day, followed by sertraline (15%) in the dose of 25-200 mg per day and clomipramine (5%) in the dose of 75 mg per day. Habit reversal was used as the behavioral treatment modality. Half of the patients dropped out after 2-3 visits, within 2 months of presentation, before treatment could be considered as complete. Dropout was less in cases in which behavior therapy was considered.

Of the patients who continued the treatment (50% of the whole sample), 80% (8 out of 10) were rated as improved (more than 50% reduction of

TABLE I SOCIODEMOGRAPHIC AND CLINICAL PROFILE OF TRICHOTILLOMANIA ($N=20$)

Variable	<i>n</i> (%)
<i>Sex</i>	
Male	17 (85)
Females	3 (15)
<i>Religion</i>	
Hindu	7 (35)
Non-Hindu	13 (65)
<i>Locality</i>	
Rural	6 (30)
Urban	14 (70)
<i>Family type</i>	
Nuclear	6 (30)
Non-nuclear	14 (70)
<i>Family income</i>	
≤4000 rupees	7 (35)
≥4000 rupees	13 (65)
<i>Age of onset</i>	
0 to ≤5 years	8 (40)
5 to ≤10 years	3 (15)
10 to ≤14 years	9 (45)
<i>Referral</i>	
Relative	5 (25)
Dermatologist	9 (45)
Physician	6 (30)
<i>Temperamental adversity</i>	
Easy	18 (90)
Difficult	2 (10)
<i>Family history present (as per ICD-10)</i>	
Habit and impulse disorders (trichotillomania)	2 (10)
Obsessive compulsive disorder (mixed thoughts and acts)	1 (5)
Psychosis	1 (5)
<i>Comorbid psychiatric disorders present</i>	
Mental retardation	2 (10)
Thumb sucking	2 (10)
Enuresis	1 (5)
Depression	1 (5)
Eating disorder	1 (5)
depression + eating disorder	1 (5)
<i>Comorbid physical illnesses</i>	
Dermatological diagnosis	3 (15)
Bacterial abscess	1 (5)
<i>Phenomenology</i>	
Impulse for plucking	13 (65)
Chewing of hair	4 (20)
Hair hoarding behavior	1 (5)
Resistance to pluck hair	5 (25)

WHAT THIS STUDY ADDS?

- Phenomenologically, trichotillomania does not resemble OCD, and is more akin to other impulse control disorders. Patients who comply with treatment usually improve.

symptoms) and 20% were rated as having partial improvement at the last follow up. These patients had made 5-18 visits and the duration of contact was more than 3 months. Those patients who showed improvement were those treated with behavior therapy alone (30%), pharmacotherapy alone (30%) or combination of treatments (40%).

DISCUSSION

Trichotillomania is infrequently seen in psychiatric clinics. Most salient findings include presence of an urge (rather than any cognition) prior to hair pulling, lack of resistance or distress for plucking the hair. These children responded to habit reversal, a type behavior therapy, which is quite different from exposure and response prevention (which is often used in OCD). These features suggest that trichotillomania is different from obsessive compulsive disorder and is more akin to anxiety or other impulse control disorders. Some of our patients had comorbid depression and showed response to antidepressants. The findings favour categorizing of trichotillomania on the spectrum of OCD or impulse control disorder as being close to the impulsive end than the compulsive end.

Our study has some limitations. Because of the retrospective design, data had to be inferred from the recorded facts/narratives. The sample size was small and many of the parameters were not assessed by using screening and rating scales. The treatment was not provided by any standardized methodology; hence, it could have influenced the final outcome of the cases.

Contributors: SM and SG were involved in conceptualizing and designing the study, interpretation of data, revising the manuscript critically for important intellectual content. RB and GB were involved in the acquisition of data, analysis and interpretation of data and drafting the manuscript.

Funding: None.

Competing interests: None stated.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edition text revision. Washington (DC): American Psychiatric Association; 2000.
2. Christenson GA, Pyle RL, Mitchell JE. Estimated lifetime prevalence of trichotillomania in college students. *J Clin Psych* 1991; 52: 415-417.
3. King RA, Scahill L, Vitulano LA, Schwab-Stone M, Tercyak KP Jr, Riddle MA. Childhood trichotillomania: clinical phenomenology, comorbidity, and family genetics. *J Am Acad Child Adolesc Psychiatr* 1995; 34: 1451-1459.
4. Christenson GA, Mansueto CS. Trichotillomania: descriptive characteristics and phenomenology. In: Stein DJ, Christenson GA, Hollander E, editors. *Trichotillomania*. Washington (DC): American Psychiatric Press, Inc.; 1999. p. 1-42.
5. O'Sullivan RL, Mansueto CS, Lerner EA, Miguel EC. Characterization of trichotillomania. *Psychiatr Clin North Am* 2000; 23: 587-604.
6. Kumar D, Singh H, Trivedi JK. Trichotillomania—a brief review and case report. *Indian J Psychiatr* 1982; 24: 95-98.
7. Rangaswami K. Management of a case of trichotillomania by cognitive behaviour therapy. *Indian J Clin Psychol* 1997; 24: 89-92.
8. Aggarwal SM, Divakara PG, Pramanik KB. Trichotillomania in depression—a case report. *Indian J Psychiatr* 1988; 30: 423-425.
9. Kaur H, Chavan BS, Raj L. Management of trichotillomania. *Indian J Psychiatr* 2005; 47: 235-237.
10. World Health Organisation. *International Classification of Diseases—10th Ed, Clinical Description and Diagnostic guidelines*. Geneva: WHO; 1992.