



Childhood Onset Trichotillomania – A Chart Review

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ABSTRACT **Background:** Trichotillomania is a not so common disorder seen in children and adolescents. Studies on childhood onset trichotillomania in India are rare and there is scarcity of literature on the subject. This study is aimed at describing the sociodemographic profile, clinical characteristics and treatment outcome of children with trichotillomania that presented to the child psychiatry outpatient department of a tertiary general hospital.

Methodology: The subjects of the study were 59 children and adolescents with trichotillomania (TTM) that presented to the child psychiatry clinic of our hospital over the past 10 years. The out-patient case records of these children were reviewed and data was tabulated. Descriptive statistics using frequency and percentages were used to present the data.

Results: A total of 59 children presented with childhood onset trichotillomania. Majority were Hindu by religion. The youngest age at presentation was 4 years and 6 months and the mean age of the sample was 8.9 years. Greater number of children were girls and belonged to urban nuclear families. Comorbid psychiatric illness was common in the cohort and scalp was the common site of hair pulling.

Conclusion: Childhood onset trichotillomania is under studied in India and data needs to be analyzed from various samples to reach distinct conclusions about variables that affect the course and outcome of the illness.

KEYWORDS : childhood onset, trichotillomania, hair pulling.

INTRODUCTION

Childhood onset trichotillomania (COTTM) or Hair Pulling Disorder is classified as an impulse control disorder as per the DSM-5 classification of psychiatric disorders wherein the individual has an overwhelming urge to pluck out hair, which leads to momentary relief from associated anxiety [1]. In children the condition is said to be more common in girls and small epidemiological studies report prevalence rates between 0.6 – 1.2% [2]. There is a large variation in the comorbid psychopathology, family history, obsessive-compulsive symptoms and symptom profile seen in COTTM [3]. The disorder usually runs a chronic course with multiple remissions and relapses, with the main stay of treatment being a combination of behavior therapy and pharmacotherapy [4]. There is scarce data from India on COTTM with most of the data being in the form of anecdotal case reports or case series of less than 5 cases [5-7]. The aim of the chart review was to study the sociodemographic profile, clinical profile, comorbidity and treatment outcome of children with COTTM presenting to our hospital.

METHODOLOGY

Case records of all child and adolescent patients diagnosed as trichotillomania as per the DSM-IV TR [8], ICD-10 [9] and/or DSM-5 [10] diagnostic criteria who attended the child guidance clinic at the Department of Psychiatry, Lokmanya Tilak Municipal Medical College, Mumbai between 1st April 2009 and 1st April 2019 were assessed for information on the socio-demographic, clinical and treatment variables. The data of each patient was collected on a semi-structured history taking proforma sheet with complete details from case records on the mental status examination and family history as well as symptom profile. Each case was diagnosed by a senior consultant psychiatrist in the department and follow up was with the same clinician. A total of 59 case record files of patients were diagnosed as trichotillomania were assessed for information on sociodemographic profiles, age of onset, duration of symptoms, age at first presentation, source of referral, type of onset, precipitating factors, course of symptoms, phenomenology, family history of mental illness, family functioning, comorbid medical and psychiatric illnesses, management and outcome where possible. The response to treatment was defined and divided into 'partially improved' (reduction of symptoms from 25% to 50%) and 'improved' (>50% reduction of symptoms). The data was tabulated and described using simple descriptive statistics like frequency and percentages.

RESULTS

The mean age of the sample was at first presentation was 8.9 years (SD = 5.1; range 4-13). The detailed sociodemographic and clinical profile of the sample is presented in Table 1. Of the 59 children, majority were Hindus and belonged to urban nuclear families. They were all school going and many reported the behavior increasing during stress and prior to exams.

All the cases reported plucking and pulling hair from the scalp. Some children had developed boils and abscesses on the scalp due to plucking of hair while 8 (13.55%) developed seborrheic dermatitis needing dermatological interventions. None of the children developed trichobezoar as a long-term complication. On the scalp based on the clinical data the hair pulling and plucking was diffuse in 36 (64.46%) cases, from frontotemporal region in 12 (20.33%) cases and from the temporal areas in 7 (12.73%) children. In addition, 11 (18.65%) children also plucked hairs from their eyelashes and eyebrows. All children plucked hairs with hands only and did not report use of other tools such as tweezers and brushes. Along with routine psychological management (psychoeducation for parents, counselling for parents and environmental manipulations), 46 (77.97%) children were treated with a combination of behavior therapy and pharmacotherapy, 6 (10.16%) with medications alone and 7 (12.73%) with behavior therapy alone. The most commonly used antidepressant was Fluoxetine followed by Escitalopram. Clomipramine, Paroxetine, Naltrexone and Amitryptiline were used in some cases. Habit reversal was used as the behavioral treatment modality in all cases. 28 (47.46%) patients dropped out after 2-4 visits, within 3 months of presentation and before treatment completion. 33 (55.93%) patients were rated as improved (more than 50% reduction of symptoms) and 26 (44.07%) were rated as having partial improvement at the last follow up. For the drop outs the improvement at last follow up was taken into the analysis.

DISCUSSION

COTTM is infrequently seen in child and adolescent psychiatric clinics. The cardinal findings include the presence of an urge prior to hair pulling, lack of resistance or distress for plucking the hair. These urges respond well to habit reversal therapy [11]. These features suggest that trichotillomania is different from obsessive compulsive disorder and is more on the lines of an impulse control disorder [12]. Many children had comorbid ADHD, depression and conduct

problems. Clinical comorbidity is high and has been reported in studies on COTTM [13]. The findings favor the use of medication in COTMM as an impulse control disorder as being close to the impulsive rather than the compulsive behavioral viewpoint. The study was circumscribed and limited to our center. Being a chart review, data had to be collated from the recorded facts and histories. The sample size was small and many of the parameters were not assessed that would have been had we screened the patient and even rating scale use was not possible. The treatment was not provided by any standardized methodology; hence, it could have influenced the final outcome of the cases. The treatment was more clinician based and on a case to case basis. There were many clinicians treating the various children and even this may have affected treatment outcomes. Further studies designed in a longitudinal domain in larger samples across multiple centers in India are warranted.

Acknowledgements – Nil

Conflict of Interest – Nil

Funding – Nil

Table 1 – Sociodemographic and clinical variables of the sample

Variable	N(%)
Sex	
Male	21 (35.59)
Female	38 (64.41)
Religion	
Hindu	50 (84.75)
Non-Hindu	9 (15.25)
Locality	
Rural	7 (11.86)
Urban	52 (88.14)
Family type	
Nuclear	50 (84.75)
Joint	9 (15.25)
Family Income	
< 15,000 / month	48 (81.35)
> 15,000 / month	11 (18.65)
Referred By	
Dermatologist	30 (50.85)
Family Physician / Pediatrician	19 (32.20)
Relative	10 (16.95)
Comorbid Disorders*	
ADHD	21 (35.59)
Conduct Disorder	14 (23.73)
Depression	19 (32.30)
Anxiety Disorders	12 (20.34)
Phenomenology	
Impulse for plucking hair	22 (37.29)
Chewing hair	5 (8.47)
Resistance to pluck hair	9 (15.25)
Anxiety before plucking hair	25 (42.37)
Hair collecting behavior	6 (10.17)

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