

Very Early Onset Trichotillomania Associated with Family Stress: Two Case Reports

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Abstract

Trichotillomania (TTM) is a disorder characterized with recurrent pulling out of one's hair from any part of his/her body and significant distress or functional impairment. Case reports and case series are the majority of the scientific literature on TTM in childhood and the true prevalence is not known; however it is well known that TTM frequently occurs in younger childhood. In the literature, it is reported that trichotillomania can be a manifestation of conflicting situations such as disturbed mother-child relationship, inadequate communication with family members or constant stress in school, sibling rivalry, raised inner psychic aggression against parents, overindulgence by parents, or inadequate emotional satisfaction. Studies show that symptoms of depression and anxiety may be pervasive among youth with TTM and likely impact functional impairment. The aim of this article is to present two very early onset trichotillomania cases which are thought to be associated with anxiety and family stress, especially with maternal stress and impaired affective interpersonal communication between mother and child.

INTRODUCTION

Trichotillomania (TTM) is a disorder characterized with recurrent pulling out of one's hair from any part of his/her body and significant distress or functional impairment. The scalp is the most common site of pulling and TTM is an important cause of childhood alopecia (Tay et al., 2004). The other common regions are eye lashes, eyebrows, pubic area, face and less frequently arms, legs, chest and abdominal hair (Keuthen et al., 2001). TTM was classified as an impulse control disorder in DSM-IV, whereas with DSM-5, it's classified under the category of "Obsessive Compulsive and Related Disorders".

The lifetime prevalence rate of TTM has been reported to be 0.6-3.4% in adults (Christenson, MacKenzie & Mitchell 1991). Case reports and case series are the majority of the scientific literature on TTM in childhood and the true prevalence is not known (Tay et al., 2004, Bruce et al., 2005). The mean age of onset for adult hair pullers is about 13 years of age; however it is well known that TTM frequently occurs in earlier childhood (Swedo et al., 1992, Wright & Holmes 2003). A survey of 123 adults found that the onset of the disorder was predominantly during the childhood, most frequently in the middle childhood and least frequently before age 6 (Cohen et al., 1995).

Swedo et al. (1992) argued that, TTM in children younger than 5 years is benign, has an episodic course, and frequently resolves without intervention. Several factors have been implicated in the etiology like family dynamics, modeling, genetics and neurobiology (Wright & Holmes 2003). In the literature it is reported that trichotillomania can be a manifestation of conflicting situations such as disturbed mother-child relationship, inadequate communication with family members or constant stress in school, sibling rivalry, raised inner psychic aggression against parents, overindulgence by parents, or inadequate emotional satisfaction (Aqarawal et al., 1988). Wright and Holmes (2003) also suggested that TTM may be more of an anxiety disorder in very young children.

The aim of this article is to present two very early onset trichotillomania cases which are thought to be associated with anxiety and family stress, especially with maternal stress and impaired affective interpersonal communication between the mother and child.

CASE 1

A 3.5 year old girl was brought to a private psychiatry clinic by her parents with the complaint of hair pulling (eye lashes) for two months. A month before her symptoms began her

mother had an operation and she reported that she was very nervous, stressed, and had difficulty to control her anger and anxiety since then. The patient was nurtured by her mother since birth and she was attending kinder garden for about a year. The mother was lately feeling intolerant, tired, and unwilling to spend time with her child.

In clinical observations, the patient was shy, anxious, and dependent to her mother. Her mother was also contributing her dependency with behaviors like having difficulty to leave the patient in the playroom alone and trying to do the things asked from the patient. In clinical interviews, the mother was diagnosed with mild depression and drug therapy was started. She was over protective and very rigid about the rules of daily life like sleeping and eating times. She told that she was frequently interfering with her husband and they were having arguments near the child because of her perfectionistic expectations.

Decreased care and attention of her mother and incompatible relationship between the parents were thought to be the precipitating factors of the patient's hair-pulling. Because most children below the age of 11 lack a fully developed capacity for a meaningful verbal expression and understanding of complex issues, motives, and feelings (Piaget, 1962), play therapy was chosen as the treatment option in order to create a safe therapeutic environment where the patient could express her feelings through playing. Play allows children to bridge the chasm between their experiences and understanding, thereby providing the means for insight, learning, problem solving, coping and mastery (Bratton et al., 2005). The parents were included in therapy sessions and supportive discussions with the parents were held in order to explain the importance of their attitudes and family relations. Although the hair-pulling behavior stopped after just 2 sessions, the patient's mother terminated the treatment asserting that it was too exhausting for her daughter to come to the therapy sessions.

CASE 2

A 4 year old girl was pulling hair from her eyebrows for 2 months when she was brought to the clinic. Her behavior started 6 months after her sister was born. Her mother had a tough pregnancy period and she was in bed rest for the last two months of her pregnancy. After birth, the mother and the baby had to spend a long time in the hospital for medical reasons, therefore, although they were close before, the mother's care and attention was decreased for the patient at the same time period when her symptoms occurred. Besides

hair pulling, she was having adaptation problems in new environments and became too dependent on her mother.

Inadequate emotional satisfaction and the arrival of a new sibling were thought to trigger the hair pulling behavior. In clinical interviews, the parents were frequently warning the patient about her attitudes with expressions like "don't do that", "ask for permission" or "say, you are sorry" etc. Especially the mother was a perfectionistic, controlling, and anxious person. She was also anxious about her daughter's appearance because the hair loss was significant.

At the initial play therapy sessions, the patient's relationship with the therapist was competitive which was interpreted as the prospect of sibling rivalry. After a couple of months with play therapy and supportive sessions with her mother, her symptoms decreased but have not ceased completely and her manner was more collaborative.

DISCUSSION

Although TTM has predominantly been reported in female adult patients, among children it is thought to occur about equally by gender (Tay et al., 2004, Duke et al., 2010). Penzel (2003) suggested that males and females may be equally prone to pull hair in adulthood and childhood, but at younger ages it is the parent who determines the course of action. As mentioned in our second case, deterioration of outer appearance may be a source of concern and a reason for treatment pressure for parents. The scalp is the most frequent site of pulling, but eyelashes and eye brows are common sites in very early onset trichotillomania (Flessner et al., 2010, Tay et al., 2004), as seen in our cases.

Azrin and Nunn (1973) proposed that TTM occurs through a learning process, similar to the formation of habits. Hamdan-Allen (1991) explained trichotillomania in young children as either a habit, like thumb sucking, or a symptom of anxiety, often provoked by actual or threatened separation from an attachment figure. Further analysis shows that this symptom often develops in a climate of psychosocial stress in the family, e.g. parent-child relationship disturbances, hospitalizations of child or mother, developmental problems such as sibling rivalry, inability to focus on activities and play, or school problems (Oranje et al., 1986, Wright and Holmes 2003, Keren et al., 2006). Both cases presented here provide good examples for mother-child relational pattern and psychosocial stress in the family in trichotillomania. Children with TTM tend to have a need for tactile stimulation via the fingertips, which may serve as a self-quieting, calming function, especially in infants and younger

children (Tay et al., 2004). Because children have been noted to pull when emotionally distressed it has been postulated that perhaps pulling produces counter irritation that competes with dysphoria for central nervous system recognition (Christenson, Pyle and Mitchell 1991).

Research suggests that TTM may be related to body-focused related behavior such as nail biting and skin picking (Stein et al., 2008, Snorrason et al., 2012). Studies also show that symptoms of depression and anxiety may be pervasive among youth with TTM and likely impact functional impairment (Lewin et al., 2009). Wright and Holmes (2003) examined 10 toddlers with TTM and found that 50% had a comorbid DSM-IV diagnosis of anxiety, 40% presented with a developmental problem, and family/stress problems were found in all cases. Consistent with the literature both cases presented in this article had anxiety as a prominent feature for both patients and their mothers.

Non-pharmacologic treatments in the form of behavioral and/or supportive family and professional counselling should be considered first-line therapy for children with TTM (Tay et al., 2004). Although the selective serotonin reuptake inhibitors are the most commonly used pharmacocuticals for TTM, the efficacy of SSRI's in the treatment of childhood TTM remains doubtful. Targeting the primary symptoms of TTM with SSRIs is unadvisable; they may be useful in the treatment of comorbid symptoms of anxiety or depression (Bloch, 2009). Play therapy and counseling were preferred in both cases presented here because both cases had a very early onset and hair pulling behavior was thought to be associated with family stress and the mothers' excessive anxious, controlling, and protective attitudes. Play therapy is widely used to treat children's emotional and behavioral problems and a meta-analysis of 93 controlled outcome studies revealed that it is a statistically viable intervention (Bratton et al., 2005). In therapy, play is viewed as the vehicle for communication between the child and the therapist on the assumption that children will use play to express their feelings and problems (Axline, 1974).

Finally, studies suggest that very early onset trichotillomania occurs more frequent than it was thought before. Both cases presented here presented to our psychiatry clinic with similar precipitating factors at nearly the same time. Although there is not enough longitudinal research and the hair-pulling behavior seems to serve as a benign, anxiety soothing behavior, a mild to moderate social and interpersonal impairment has been reported during childhood (Franklin et

al., 2008). Given that distress and impairment associated with TTM is largely social in nature, children may begin to report higher levels of impairment and distress as children get older and develop an increased awareness of social consequences, (Walther et al., 2014). The patients suffering from trichotillomania report low self-esteem, shame, feelings of unattractiveness, depressed affect, and avoidance behavior from common activities (Stemberger-Townsley et al., 2000). In another study, a significant association between earlier age of onset of TTM symptoms and longer duration of hair pulling was reported which may be an indicator of the chronic nature of the disorder (Flessner et al., 2010). These results highlight the importance of identifying and treating these patients to alleviate the impairment caused by TTM.

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