

Letter to the Editors

Trichotillomania in a 7 year old girl

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Trichotillomania is considered a type of impulse control disorder in DSM-IV-TR where repetitive hair pulling results in hair loss, distress, and social and occupational dysfunction [1], with the peak age of onset to be 12-13 years [2]. Early-onset (eg. childhood) is thought to be a benign, self-limiting habit, while later onset (eg. adolescence and adults) is associated with increased psychopathology [3]. Lifetime prevalence is 0.6% using strict DSM-III-R criteria [2]. Depending upon the developmental maturity of the child, the number of hair pulling sites varies. The most common location is scalp, closely followed by eyebrows and eyelashes [2, 4, 5].

In our practice we encountered a case of 7-year-old girl who presented to our clinic with skin-picking and hair-pulling on her eyebrows, eyelashes, and the hairs on her arms and legs. There had been significant stressors in the child's life over the past few years. An adult sibling moved out of the home; grandmother died, and her mother was hospitalized for a suicide attempt, all within months of one another. Hair pulling resulted in petechial bleeding during stressful periods (eg. being redirected to complete homework or chores, playing video games, buying a gift for mother, or being asked a question). She would also engage in skin-picking. The child is described to pull hair from her eyebrows and eyelashes with her right thumb and index finger while flexing her head down and performs hair-pulling while looking at herself in the mirror.

Although risk factors for hair pulling are unknown, most theories are associated with a tran-

sitional object or separation response to an impaired mother-child relationship in young children [3]. Common comorbidities include depression, anxiety disorders, attention-deficit hyperactivity disorder (ADHD), tic disorders, and OCD [2]. Hair-pulling can occur in two distinct styles. Automatic, where the individual has little to no awareness, as in our case. This occurs most commonly in children. The second style is focused; they are fully aware of the behavior and able to identify a trigger.

While performing a wide search through pubmed for treatment, there was a dearth of studies showing treatment efficacy in children, adolescents, and adults. Medications, including antidepressants (eg. citalopram, fluoxetine, and clomipramine), have minimal role in treatment. The cornerstone treatment is habit reversal therapy (HRT), which is a form of cognitive behavioral therapy (CBT). Other forms of therapies including behavior therapy and simplified HRT appear promising. Due to limited statistical power involving populations below the age of 9 years, no definitive conclusions on effectiveness can be made [6]. Acceptance-enhanced behavior therapy is effective in adults. Dialectal Behavior Therapy-Enhanced HRT appears promising in adults and targets emotional regulation, which in turn decreases hair pulling severity. This may be promising in children also as many children have difficulty with emotional regulation. Much more research is needed in the treatment of trichotillomania in this young population.

Through this letter we would like to draw attention to the disorder and to encourage clinicians and researchers to extend studies and literature concerning the etiology, course and treatment of trichotillomania, especially in children.

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