Case Report

Behavioral Treatment Strategy for Early Onset of Trichotillomania with Simultaneous Thumb Sucking

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Abstract

An early onset (before age 6) of trichotillomania (hair-pulling disorder) tends to remit more readily and responds to suggestions, support, and behavioral strategies. We present a case of a five-year-old girl, with a three-year history of trichotillomania associated with simultaneous thumb sucking, who responded well with behavior treatment.

Keywords: Trichotillomania, Thumb sucking, Behavioral treatment

Introduction

The DSM-IV diagnosis of trichotillomania (TTM) is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV[1] classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.[2] Hair-pulling disorder is a chronic disorder characterized by repetitive hair pulling, leading to variable hair loss and resulting in distress or impairment in important areas of functioning.[3]

There is no general agreement as to the exact incidence and prevalence of TTM – some believing that it is underdiagnosed. The diagnosis encompasses at least two categories of hair pulling that differ in incidence, severity, age of presentation and gender ratio. The most serious, chronic form of the disorder usually begins in early to mid-adolescence, with a lifetime prevalence ranging from 0.6 percent to as high as 3.4 percent in general population and with female to male ratio as high as 10 to 1. Another type, which is said to be more common and far less serious than the adolescent or young adult syndrome, is childhood type of hair-pulling disorder that occurs equally in girls and boys.[3]

There are a few case reports[4-6] on hair pulling, associated with simultaneous thumb sucking, where elimination of hair pulling was obtained with successful treatment of thumb sucking through behavioral methods.

Case Report

A five-year-old girl was brought to the Child Guidance Clinic (CGC) by her father with complaints of hair pulling from scalp (especially from left side), left eyebrow, and eyelashes of left eye from left hand with simultaneous sucking of the right hand thumb for three years. The patient had a visible elongated patch of hair loss on left side of scalp especially on fronto-parietal area (Fig.1).

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(Photograph with Permission)

Figure 1.Elongated Patch of Hair Loss on Fronto-parietal Region (Left Side)

She had sparse eyelashes and lighter eyebrow on left side as compared to the right side. Her father reported hair pulling occurred while watching television, at bedtime or while sitting idle. Patient used to pull her hair from left hand with simultaneous thumb sucking of right hand; her father reported that she rarely pulled hair without a thumb in her mouth. The girl was right handed. There was no history of eating the pulled hair, itching or scarring over the scalp. In fact the patient was seen by a dermatologist in her hometown in Rajasthan where she was living with her mother and paternal grandparents; her father was working in Delhi. Associated findings included occasional nail-biting, pulling of buttons and threads of clothes. Development of all major mile stones was normal for the age; she was studying in upper kindergarten and was good in studies. There was no history of any psychiatric illness in the family. Patient's routine blood investigations were within the normal limits. Patient's father was psycho-educated about the problem and was explained about the plan of treatment and methods for its execution. He was asked to prevent the child from thumb sucking by applying aversive (bitter) taste solution (grinded neem or very little amount of quinine solution) at least twice in the morning and at bed time, and in addition whenever required, that means whenever the child was found sucking her thumb. Patient's father was asked to explain about the treatment to his wife as the child was living with her mother in Rajasthan and he was working in Delhi. Patient reported only once for follow up after two months along with her parents. They reported significant improvement in child's habit of thumb sucking with indirect reduction in hair pulling as she never pulled her hair without thumb sucking.

Discussion

In our case, significant reduction in hair pulling was obtained by treating thumb sucking with aversive-taste treatment method with application of a bitter-taste solution on the thumb.

Various case-studies from western countries[4-6,9] concluded that successful treatment of thumb sucking led to elimination of hair pulling based on the

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principle of "direct covariation between the two behaviors could lead to the elimination of one through successful treatment of the other."

The etiology of TTM is largely unknown, with hypotheses ranging from neurotic conflict, depression, anxiety, or learned behavior to biologically determined "pathological grooming behaviors" related to OCD.[7]

Behavioral theories of etiology view TTM as an anxiety-reducing habit; for children, it seems to be a learned behavior that present as a relatively isolated symptom, comparable to other habits such as thumb sucking or nail biting.[8]

Hair pulling was eliminated by preventing (taping the fingers) or punishing (putting a bad-tasting substance on the thumb) the finger-sucking response.[4,5,10] Knell and Moore[10] pointed out that although the temporal order of thumb sucking varied (it began before, simultaneously with, and after hair pulling) in these three studies, treatment of the thumb sucking eliminated hair pulling in all cases.

Conclusion

These results suggest that when trichotillomania is a benign habit disorder, the treatment of a co-varying habit such as thumb-sucking can be an effective treatment alternative for trichotillomania.

Conflict of Interest: None

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