

CASE REPORTS

Baby trich: the role of psychosocial stressors in pediatric trichotillomania

Tricotilomania infantil: o papel dos fatores psicossociais

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ABSTRACT

Pediatric trichotillomania is characterized by the persistent pulling of one's own hair, resulting in areas of hair loss and affecting the child and family's daily functioning. Studies investigating the etiology, evolution, and treatment of pediatric trichotillomania are scarce. Scientific data suggests that pediatric trichotillomania can persist into adulthood and indicate the role of external stressors in its etiology. This article describes five clinical cases of children aged between 21 months and four years diagnosed with pediatric trichotillomania, with several external stressors as possible etiology. Psychoeducation and caregiver-child psychotherapy or child-centered play therapy were proposed as treatments. The authors highlight the importance of external stressors in the etiology of pediatric trichotillomania and suggest the beneficial effect of psychoeducation and psychotherapy in its course. Further research is critical to improve the screening and treatment of pediatric trichotillomania.

Keywords: pediatric; psychoeducation; psychosocial stressor; psychotherapy; trichotillomania

RESUMO

A tricotilomania infantil caracteriza-se pela necessidade recorrente de arrancar o cabelo/pêlo, resultando em áreas de rarefação capilar/pilosa e com impacto funcional na vida da criança e família. Os estudos acerca da etiologia, evolução e tratamento da condição são escassos. A evidência científica sugere que pode persistir até à idade adulta e ressalva a importância dos fatores psicossociais na sua etiologia. Neste artigo, são apresentados cinco casos clínicos de crianças com idades compreendidas entre 21 meses e quatro anos com diagnóstico de tricotilomania infantil com vários stressores como possível etiologia. O tratamento proposto consistiu em psicoeducação e psicoterapia cuidador-criança ou terapia de jogo centrada na criança. O presente estudo reforça a importância dos fatores psicossociais no desenvolvimento desta perturbação e o benefício da psicoeducação e da psicoterapia. São necessários mais estudos para otimizar o diagnóstico e tratamento da tricotilomania infantil.

Palavras-chave: fator psicossocial; infância; psicoeducação; psicoterapia; tricotilomania

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INTRODUCTION

Pediatric trichotillomania (PTTM) is characterized by the persistent pulling of one's own hair, resulting in areas of hair loss and with impact on the child and family's daily functioning. Hair pulling or loss cannot be attributed to another medical condition. According to current international classifications, PTTM is considered part of the spectrum of obsessive-compulsive disorders (OCD).^(1,2) Pulling one's own hair during childhood is often considered a benign behavior with little functional impact, potentially leading to underdiagnosis and non-treatment of PTTM.⁽³⁾ In fact, scientific evidence shows that PTTM can persist into adulthood and evolve into more serious hair-pulling behavior and anxiety disorders.⁽⁴⁾ Despite the scarcity of studies about PTTM etiology, available data suggest that psychosocial stressors may have a relevant role.⁽⁵⁻⁷⁾ Regarding treatment, there are no randomized controlled trials investigating pharmacological strategies. Cognitive-behavioral therapy has shown some evidence.⁽⁸⁻¹⁰⁾ Child-caregiver psychotherapy (CCP), including caregiver-oriented guidance and psychoeducation, take environmental factors into account and seem to be effective in erasing the stressful event, or at least in providing healthy tools to deal with it and reduce its impact.^(11,12) Child-centered play therapy is an empirically supported method of play therapy that has been successfully used in a wide range of pediatric problems, including anxiety and OCD.⁽¹³⁾

CLINICAL REPORTS

The first case refers to a four-year-old girl who was referred to psychiatric evaluation by her general clinician due to hair-pulling behavior since the age of two. The mother stated that nothing was wrong with the child and classified this behavior as a tic (*"She is just like her father, who also used to pull his hair"*). In addition, she was unable to identify stressors that could have triggered the behavior and was not worried about it. The girl used to touch her parents' hair since she was a baby as a self-regulating mechanism, and at the age of one year, she started twirling her own hair. Until the age of two, the father was the main caregiver. At this time, the mother had two different jobs and did not spend much time at home. At the age of two, parents got divorced, the father moved to another house, and the girl was sent to nursery school. Around the same time, she began pulling her own hair. Psychoeducation was provided, and child-caregiver psychotherapy (CCP) was suggested.

The second case refers to a 31-month-old girl whose parents were concerned about her hair-pulling behavior and tantrums. These behaviors started after the birth of her baby sister. Before then, the girl used to sleep with her parents, but after the sister's birth, they said having *"to pay more attention to the baby"*. The girl used to twirl her hair even when sleeping. The parents decided to cut her hair and bought her a doll with long hair, so she could twirl the doll's hair instead of her own. Additionally, she started throwing tantrums,

hitting her head against the wall, and pulling her hair at the same time. At the nursery, none of these behaviors was present. Family medical history revealed that the mother was diagnosed with anxiety disorder and the father had a previous diagnosis of depressive disorder. The pregnancy had been unplanned, as the parents had decided not to have children for professional reasons. After the girl was born, the family moved house four times, and sometimes the father had to work in a different city and stayed out for several weeks. Both parents exhibited a permissive parenting style and showed divergent approaches regarding hair-pulling behavior. Brief CCP was suggested but refused due to the distance between home and the hospital. The importance of individual and positive time dedicated to the girl was highlighted.

The third case of this series refers to a four-year-old girl who pulled her own hair while throwing tantrums. She was institutionalized when she was only eight days old and subsequently moved to her grandparents' house at the age of one year. The mother had intellectual disability, and the father was unknown. Both grandparents reported that the girl had low tolerance to frustration and cried, yelled, hit them, and pulled her own hair. She used to sleep with her grandparents while watching videos on their cell phones. In the nursery, the girl's behavior was described as more appropriate. Several sessions were provided to help grandparents find strategies to deal with tantrums, promote self-regulation and autonomy and, most importantly, invest in positive playtime with the granddaughter. Child-centered play therapy was suggested, with clinical improvement after four sessions and both grandparents mentioning a reduction in the frequency of hair-pulling behavior and tantrums.

The fourth case refers to a three-year-old girl with a poor sleeping pattern, taking a lot of time to fall asleep and waking up several times during the night crying and yelling. The parents believed that she did it intentionally and that it seemed that *"she was doing it on purpose to wake up the neighbors, making us very anxious. She has both mother and father's flaws, all at the same time"*. The girl used to twirl her mother's hair as a self-regulation mechanism before falling asleep, and since the age of two, she started pulling her own hair. The parents began worrying because alopecia was getting worse every day. CCP was suggested. Although both parents were initially receptive, soon after the first sessions, they started disbelieving the approach and refused to participate in playing activities. Due to this refusal, parental guidance and psychoeducation with both parents were provided, and individual playing psychotherapy was provided to the girl. A transitional object was successfully introduced, with great improvement in caregiver-child interactions.

The last case refers to a 21-month-old girl with hair-pulling behavior since 11 months that aggravated after starting nursery school four months later. At that point, the girl was able to sit by herself, not moving much or exploring toys. The hair-pulling behavior occurred before falling asleep, and behavioral techniques – like putting tights in her head – were used. At home, the behavior occurred when the girl was *"left alone with nothing to do"* or when the mother arrived

home after work. According to the mother's description, "When I arrive home, she stops what she is doing and stares at me while pulling her hair". Both parents believed that the hair-pulling behavior improved when they cut the girl's hair. The mother described the first three months after birth as very stressful because the baby cried a lot. When the girl was four months old, the mother started a new job, and the family moved to a different city, with grandparents looking after the baby all day long and parents only seeing her when she woke up before leaving for the nursery. Six sessions of CCP were undertaken with the mother, encouraging positive, individualized time between the girl and the parents and promoting a better understanding of the child's behavior.

DISCUSSION AND CONCLUSIONS

The authors described five clinical cases of female children aged between 21 months and four years diagnosed with PTTM, with several psychosocial stressors coinciding with the onset or worsening of hair-pulling behavior. Some were family-related, such as parental divorce, parental mental illness, divergent parental approaches, poor caregiver-child interaction, and the birth of a sibling, but others were family-unrelated, such as starting nursery school, institutionalization, and frequent changes in the place of residence.

Some studies indicate that PTTM etiology is complex and not yet fully understood. The literature on adult trichotillomania suggests that hair-pulling behavior may initially develop as a stress-coping behavior that is maintained through reinforcement.⁽⁶⁾ One study reported a higher prevalence of posttraumatic stress disorder and a history of traumatic events in adults with trichotillomania, suggesting that trichotillomania may serve as a form of self-soothing coping mechanism.⁽¹⁴⁾ Some authors highlight that stress plays a similar role in hair-pulling behavior in childhood.^(5,6) Nisha and colleagues reported that triggers were associated with the onset of trichotillomania in 48.5% of 33 children diagnosed with PTTM in their study cohort.⁽⁷⁾ In another study, family-related issues (such as the death of one parent, parental separation, Munchausen by proxy) accounted for most patient troubles, with other problems, such as starting a new school, poor performance, bullying, and strained teacher-student relationship, also reported.⁽⁵⁾ Other psychological studies indicate the role of inadequate mother-child relations in PTTM development.^(15,16)

The findings of the present study are in agreement with the literature and additionally suggest that psychosocial factors may play a role in the development of PTTM.

Several challenges and environmental stressors may arise during child development. An attentive and nurturing family atmosphere is crucial to help the child cope with these difficulties. Some family-related stressors, namely those that negatively impact the caregiver-child relationship, may contribute to the child's inability to deal with these adverse events.

When it comes to treatment, some studies suggest that it is

mandatory to clarify parents about PTTM diagnosis and provide psychoeducational measures.⁽⁷⁾ Behavioral therapy (with simple operant conditioning techniques) has shown efficacy in some cases.⁽⁸⁻¹⁰⁾ In the last decades, an improved understanding of the strong association between affective experiences in early years and biopsychosocial disorders led to an increased focus on caregiver-child interactions.⁽¹¹⁾ Until 24 months old, most psychopathological expressions are better understood in the context of caregiver-child interaction. CCP is one of the interventions that can foster healthier relationships and ultimately lead to decreased symptomatology.^(12,13) CCP with caregiver-orientated guidance has been proposed as sufficient to reduce PTTM symptomatology in the long term.^(17,18) Another possible psychotherapeutic approach is child-centered play therapy, an empirically supported method of play therapy that has been successfully used in a wide range of child problems, including anxiety and obsessive-compulsive disorder.⁽¹⁹⁾

In this study, CCP and child-centered play therapy were proposed to manage the presented cases. These interventions aim to promote healthier interaction and positive and individualized time spent between parents and children, besides allowing an accurate understanding of the child's behavior. However, most caregivers in the study were reluctant to engage in CCP. It can be hypothesized that caregivers who were less motivated to engage in this approach were those with less time to invest in positive playing activities with their children, leaving little space for them to express their feelings and thoughts. This may result in some kind of self-soothing coping mechanism, such as hair-pulling behavior. Parents' low adherence to CCP can also be a defense mechanism for dealing with parental feelings of guilt and insecurity. However, the small number of cases assessed in this study precludes generalizing these hypotheses to a larger population or drawing robust conclusions about the subject.

Overall, more studies (including regarding psychotherapeutic interventions) are required to explore the role of external factors in PTTM etiology and effective treatment strategies for the condition. Notwithstanding, there is no doubt about the importance of positive time spent between caregivers and children to guarantee their healthy development and happiness. Therefore, the authors subscribe to the importance of systematically encouraging healthy relationships and positive play time between caregivers and their children.

AUTHORSHIP

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Teresa Sá - Writing – review & editing

Mariana Liz - Writing – review & editing

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