




LETTER TO THE EDITOR

Cognitive behavioral therapy in an adolescent with trichotillomania partially responding to medical treatment

Medikal tedaviye kısmi yanıt veren trikotilomani tanılı ergen hastada bilişsel davranışçı terapi

Çağla Çelikkol Sadıç¹ 

¹Afyonkarahisar Health Sciences University, Afyonkarahisar, Türkiye

To the Editor;

Some treatment methods such as cognitive behavioral therapy and pharmacological treatment for the treatment of trichotillomania have been investigated¹. However, there is not enough evidence for the first choice treatment in trichotillomania, since randomized controlled studies in pediatric cases are very few².

A 13-year-old girl, who had been experiencing anxiety symptoms due to recurring hair, eyebrow and eyelash loss and hair, eyebrow and eyelash pulling for about two years, was brought for examination accompanied by her mother. It was learned that she was one of three siblings and there was no psychiatric history in the family. It was learned that she had previously used fluoxetine due to trichotillomania and used the drug regularly, but the treatment was not effective. The treatment of the patient, who had symptoms of separation anxiety and pulling her hair, eyebrows and eyelashes, was planned for CBT, which includes habit reversal interventions and initiation of sertraline 50mg. The patient and her parents were given detailed information about CBT and medical treatment process, and the importance of regular follow-up was explained. Before starting drug treatment, written consent was obtained from the family and verbal consent was obtained from the child. The patient, who did not attend the treatment follow-ups regularly and therefore CBT process could not be started, but continued to use medical treatment regularly, was admitted to the outpatient

clinic two months later. During the follow-up examination of the patient, it was determined that anxiety symptoms had decreased significantly. Since the patient's hair, eyebrow, and eyelash-pulling behaviors continued in the same way, the patient described side effects such as loss of appetite and nausea with antidepressant treatment, aripiprazole 5 mg was added to the patient's treatment as adjuvant therapy. The patient, whose hair pulling behavior decreased slightly after the treatment, did not decrease in eyebrow and eyelash pulling behavior and whose complaints largely continued, was re-evaluated in our outpatient clinic. The patient's routine biochemical examination was evaluated as normal. It was planned to continue the current medical treatment of the patient, who had no additional complaints other than hair, eyebrow and eyelash pulling. The Massachusetts General Hospital Scale for Hair Plucking was applied to the patient who continued to complain of trichotillomania and the scale score was found to be 24. The patient and her parent were informed again about the CBT treatment option. After receiving approval that they would comply with the treatment process, the patient's treatment continued with the addition of CBT.

The patient's treatment sessions were determined to be once a week. In the treatment of the patient, methods such as habit reversal training, stimulus control, awareness training and relaxation were emphasized. In the patient's first session, information was given about the structure of the therapy, the

Address for Correspondence: Çağla Çelikkol Sadıç, Afyonkarahisar Health Sciences University Faculty of Medicine, Department of Child and Adolescent Psychiatry, Afyonkarahisar, Türkiye E-mail: dr.cagla90@gmail.com
Received: 17.01.2024 Accepted: 07.04.2024

cognitive model, habit reversal training, and the disease; the problems experienced by the patient were determined; and the goals of the treatment were emphasized. In the following sessions, it was focused on when the patient's pulling behavior occurs, in which areas it occurs, what are the factors that reduce and increase the severity of the pulling behavior, and what are emotional and thoughts that occur during, before, and after the pulling behavior. An additional interview was conducted with the parent, which included topics such as the factors that increase and decrease her daughter's pulling behaviors and information about the disease and treatment process. At the end of the patient's fifth session, it was learned that the patient did not pull out hair, eyebrows and eyelashes, and could effectively apply the skills she had acquired for the urge to pull hair. The Massachusetts General Hospital Hair Pulling Scale was applied to the patient and her score was determined to be 8. The patient, who did not come for control for two months, reported that she had not used her medication for two months. It was learned that she did not want to leave her mother during this period, she was worried that something bad would happen to her when she left her mother, and her anxious thoughts were accompanied by abdominal pain. It was learned that despite the increasing anxiety of the patient, there was no increase in the hair, eyebrow and eyelash pulling behavior, and she was able to control her desire for this behavior. The Childhood Anxiety Disorders Screening Scale was applied to the patient and her score was 43. The Screen for Child Anxiety Related Disorders (SCARED) was applied to the patient and her score was 43. Sertraline 50 mg was added to the patient's treatment. After one month, the patient's anxiety symptoms decreased considerably, and the SCARED score was noted as 10 and The Massachusetts General Hospital Hair Pulling Scale score was noted as 8. In the follow-ups of the patient for the next 6 months, it was learned that there was no hair, eyebrow and eyelash pulling behavior, and the well-being achieved with CBT continued. Informed consent was received from the case and her parents for the study.

Despite the evidence that habit reversal training is effective in the treatment of adult patients, few studies appear to have been published on children and adolescents for trichotillomania³. Some studies indicate that CBT, which includes habit reversal training, can be effective in children and adolescents⁴. In a study conducted with children and adolescents

diagnosed with trichotillomania, it was found that habit reversal treatment was 76% effective and there were findings supporting the treatment in 1-3 months follow-up³.

Although there is no FDA-approved medical treatment option in the treatment of trichotillomania, research is being conducted on this. However, these studies mostly include the adult population¹. Although the most commonly used agents in trichotillomania include clomipramine, fluoxetine, and paroxetine, some results show that antidepressants such as sertraline and antipsychotic agents such as aripiprazole may also be effective in the treatment of trichotillomania^{5,6,7}. Here, we present a case of trichotillomania whose symptoms improved significantly with CBT, which included components of habit reversal training, and which continued despite the patient suddenly discontinuing the medications she was using during the treatment process. It is thought that studies with large samples and controlled studies are needed to understand the effectiveness of psychopharmacological and CBT applications in the treatment process of trichotillomania in children and adolescents.

Author Contributions: Concept/Design: ÇÇS; Data acquisition: ÇÇS; Data analysis and interpretation: ÇÇS; Drafting manuscript: ÇÇS; Critical revision of manuscript: ÇÇS; Final approval and accountability: ÇÇS; Technical or material support: ÇÇS; Supervision: ÇÇS; Securing funding (if available): n/a.

Ethical Approval: An ethics committee approval certificate is not required for the case report we have made.

Peer-review: Editorial review.

Conflict of Interest: Authors declared no conflict of interest.

Financial Disclosure: Authors declared no financial support

Acknowledgments: I thank the family for allowing me to publish this case report.

REFERENCES

1. Henkel ED, Jaquez SD, Diaz LZ. Pediatric trichotillomania: Review of management. *Pediatr Dermatol.* 2019;36:803-7.
2. Farhat LC, Olfson E, Levine JLS, Li F, Franklin ME, Lee HJ et al. Measuring treatment response in pediatric trichotillomania: a meta-analysis of clinical trials. *J Child Adolesc Psychopharmacol.* 2020;30:306-15.
3. Rahman O, McGuire J, Storch EA, Lewin AB. Preliminary randomized controlled trial of habit reversal training for treatment of hair pulling in youth. *J Child Adolesc Psychopharmacol.* 2017;27:132-9.
4. Tolin DF, Franklin ME, Diefenbach GJ, Anderson E, Meunier SA. Pediatric trichotillomania: Descriptive psychopathology and an open trial of cognitive behavioral therapy. *Cogn Behav Ther.* 2007;36:129-44.

5. Dougherty DD, Rebecca L, Michael AJ, Nancy JK. Single modality versus dual modality treatment for trichotillomania: sertraline, behavioral therapy, or both? *J Clin Psychiatry*. 2006;67:1086-92..
6. Yasui-Furukori N, Sunao K. The efficacy of low-dose aripiprazole treatment for trichotillomania. *Clin Neuropharmacol*. 2011;34:258-59.
7. Bruce TO, Barwick LW, Wright HH. Diagnosis and management of trichotillomania in children and adolescents. *Paediatr Drugs*. 2005;7:365-76.