Co-Occurrence of Trichotillomania and Nocturnal Enuresis: A Case Report

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Abstract:

Introduction: Trichotillomania is obsessive compulsive related disorder which causes significant distress or impairment. It can be precipitated by various stress factors in children.

A 12-year-old girl presented with the complaints of pulling off hair from one half of scalp, headache, aches and pains in leg with un-refreshed sleep. History revealed she had been suffering from nocturnal enuresis which was untreated and resulted in maltreatment and caused her emotional anguish. Her trichotillomania was a done in a habitual way along with rumination later turned compulsive and irresistible. She was treated with integrated approach of pharmacotherapy and behavioral treatment which resulted complete diminution of her symptoms.

Key words: 'Trichotillomania', 'nocturnal enuresis', 'habit reversal', 'motivational therapy', psychoeducation', 'social stigma', 'integrative approach'.

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Introduction:

Trichotillomania is obsessive compulsive related disorder characterized by recurrent hair pulling with attempt to decrease or stop such behavior with significant distress or impairment[1]. Its prevalence varies with prevalence bring 1.7%, with lifetime prevalence of 2.5% and sex ratio being close to 1[2]. Trichotillomania in children usually runs a benign course which is precipitated by stressors such as sibling rivalry, lack of parental affection and nocturnal enuresis[3]. Nocturnal enuresis which is thought to be a distinct phenomenon can cause significant distress specially when it interferes with children's ability to socialize with peers. Due to cultural barrier and pre conceived stigma, patient or their parent may be reluctant to provide proper history as well. So, identifying cases and proper treatment can pose significant challenge. Although both the conditions are distinct in nature with treatment approaches, this case report aims to shed light into a rare combination of this two with a holistic treatment approach considering their intertwined nature.

Case Scenario:

A 12-year-old girl was referred from Skin Outdoor with the complaints of pulling off hair from one half of scalp, headache, aches and pains in leg with unrefreshed sleep. Patient was accompanied by her mother; was well oriented, conscious, attention concentration was normal. No delusion or hallucination was present, but her mood and affect were anxious. On query although initially hesitant, the patient disclosed being suffering from nocturnal enuresis. As a cultural belief of it being a shameful thing to disclose, her parents did not tell it to any one and was even reluctant initially to disclose during the interview. They even at times shouted at her, beat her up thinking it a mischief on her behalf and even took help of religious faith healers thinking it a bad omen. Although patient was already distressed but thing turned for the worst when a cousin of her who is also from her same school came to visit their home. Due to shortage of space in their home, both the patient and her cousin slept in the same bed. On mid night, her cousin was shocked and furious at her for wetting the bed. She also threatened to tell this to all other

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kids, if she does not get her affairs sorted soon enough. Her cousin stayed for two more days and to not repeat previous days event, the patient slept on the floor. Thought of being humiliated Infront of her peer kept her up most of the night. While awake, she felt an urge to pluck off her hair and ruminating what may happen in coming days. Although her cousin left soon, her anxiety increased even more. She started having pain in leg, headache and developed poor appetite. Pain in leg and head would increase during school time and in afternoon when she usually plays with other children. So, she started skipping school and started avoiding peers. Keeping by herself, ruminating anxious thought while plucking off her hair became increasingly frequent. She tried to stop even at times but failed to do so. She would sleep little with periods of nightmares and would get up unrefreshed. After few days, when one of their neighbors suggested her hair loss maybe due to some dermatological issue, they visited local hospital from where they were referred to the tertiary care center. The patient and her mother both were explained about the nature and cause of the disease. A urine profile was advised and according to DSM-5-TR a diagnosis of Enuresis (nocturnal only) and trichotillomania were made. Supportive psychotherapy was provided to the patient. Moreover, habit reversal, wearing a head scarf temporarily and breathing exercise to relieve anxiety was also taught. Patients mother was taught to maintain a star chart; which was customized to incorporate both compliance with behavioral techniques and non-hair pulling days. Limited drink after evening hours and urinating before going to bed along with a scheduled toileting was suggested. 25 mg of clomipramine was administered at night. Patient was scheduled for biweekly follow-up. Initially after 4week her anxiety lessened, sleep improved and headache decreased. Her symptoms of both enuresis and trichotillomania were although present but intensity was reduced. After 3 months, her enuretic symptom totally resolved and soon after her hair pulling also stopped. Clomipramine was discontinued gradually and during later follow-up, she was going to school, doing house hold chores and was cured of both trichotillomania and enuresis.

Discussion:

Trichotillomania is a complex disorder having various hypothesized etiologies including genetic [4] and neuroanatomical [5,6] being most prominent. It has also been described as a maladaptive way of coping and emotion regulation[7,8] . Nocturnal enuresis although is relatively common, affecting about 10% of children of 7 years old[9] ; can be a major concern both patient and their parents. Moreover, co-morbid both the conditions may become difficult to treat due to lack of communication from patients part owing to stigma and also due to lack of updated knowledge on part of clinicians[10]. There have been few case reports with both these symptoms[11,12] indicating co-occurrence is not that common. Behavioral therapy with habit reversal training components (BT HRT), Clomipramine , N acetylcysteine, and olanzapine demonstrated significant benefits compared to placebo in RCT trials[13]. Habit reversal and TCA showed greater benefit; habit reversal being superior to TCA alone and combination of both bearing best outcome[13–15].Various other methods such as behavioral therapy, psychoeducation, motivational therapy which are commonly used to treat nocturnal enuresis[16]can also be incorporated treating both the conditions simultaneously. Moreover TCA has been proven effective in the treatment of both the diseases [13,15–17] which further emphasizes the fact that both can be treated successfully via integrative approach.

Conclusion:

This is an uncommon case where an underlying stress of nocturnal enuresis with poor affect regulation culminated into trichotillomania. Moreover; social stigma, lack of proper knowledge of both nocturnal enuresis and trichotillomania added further complexity at presentation and management. Interesting similarities on management of both conditions can be utilized for a better outcome. Previous case reports along with this one is a testament that in cases like this, treatment outcome can rather be favorable with proper combination of pharmacotherapy, psychoeducation and behavioral techniques.

Conflict of interest:

We have no conflict of interest to declare

References:

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. American Psychiatric Association. 2022. 1924 p. https://doi.org/10.1176/appi.books.9780890425787
2. Zheng Y, Xiao L, Xie Y, Wang H, Wang G. Prevalence and Characteristics of Obsessive-Compulsive Disorder Among Urban Residents in Wuhan During the Stage of Regular Control of Coronavirus Disease-19 Epidemic. Front Psychiatry. 2020;11(12):1-7. https://doi.org/10.3389/fpsyt.2020.594167 PMid:33391055 PMCid:PMC7772465

3. Sah, D.E., Koo, J., Price VH. Trichotillomania.Dermatol Ther. 2008;21(1):13-21.
https://doi.org/10.1111/j.1529-8019.2008.00165.x
PMid:18318881

4. Bienvenu OJ, Wang Y, Shugart YY, Welch JM, Grados MA, Fyer AJ, et al. Sapap3 and pathological grooming in humans: Results from the OCD collaborative genetics study. Am J Med Genet Part B Neuropsychiatr Genet. 2009;150(5):710-20.
https://doi.org/10.1002/ajmg.b.30897
PMid:19051237 PMCid:PMC10885776

5. Chamberlain SR, Menzies LA, Fineberg NA, Del Campo N, Suckling J, Craig K, et al. Grey matter abnormalities in trichotillomania: Morphometric magnetic resonance imaging study. Br J Psychiatry. 2008;193(3):216-21.
https://doi.org/10.1192/bjp.bp.107.048314
PMid:18757980 PMCid:PMC2806575

6. Roos A, Fouche JP, Stein DJ, Lochner C. White matter integrity in hair-pulling disorder (trichotillomania). Psychiatry Res - Neuroimaging. 2013;211(3):246-50.
https://doi.org/10.1016/j.pscychresns.2012.08.005
PMid:23149033

7. Grant JE, Dougherty DD, Chamberlain SR. Prevalence , Gender Correlates , and Co-morbidity of Trichotillomania. Psychiatry Res.2020; 288: 112
https://doi.org/10.1016/j.psychres.2020.112948
PMid:32334275 PMCid:PMC7212053

8. Shusterman A, Feld L, Baer L, Keuthen N. Affective regulation in trichotillomania: Evidence from a large-scale internet survey. Behav Res Ther. 2009;47(8):637-44.
https://doi.org/10.1016/j.brat.2009.04.004
PMid:19467648

9. Von GA. The impact of DSM-5 and guidelines for assessment and treatment of elimination disorders. Eur Child Adolesc Psychiatry. 2013;22(SUPPL.1).
https://doi.org/10.1007/s00787-012-0363-9
PMid:23247389

10. Brook A. M ,Chad T, Douglas W. Investigating Healthcare Providers' Knowledge of Trichotillomania and its Treatment . Cogn Behav Ther. 2006;35(1):19-27.
https://doi.org/10.1080/16506070510010657a

11. Sahoo T, Gulla KM, Kumar N, Malhi P. Case of Extreme Trichotillomania in a Child with Comorbidities. J Clin Diagnostic Res. 2019; 2020:10-2.
https://doi.org/10.7860/JCDR/2019/41954.13026

12. Ubukata S, Mimura T, Watanabe E, Matsumoto K, Kawashima M, Kitsu K, et al. Bilateral Trichotillomania of Eyelashes Triggered by Anxiety due to Nocturnal Enuresis: A Case Report. Case Rep Ophthalmol Med. 2019;2019:1-4.
https://doi.org/10.1155/2019/4650217
PMid:31321109 PMCid:PMC6609362

13. Farhat LC, Olfson E, Nasir M, Levine JLS, Li F, Miguel EC, et al. Pharmacological and behavioral treatment for trichotillomania: An updated systematic review with meta-analysis. Depress Anxiety. 2020;37(8):715-27.
https://doi.org/10.1002/da.23028
PMid:32390221

14. Bloch MH, Landeros WA, Dombrowski P, Kelmendi B, Wegner R, Nudel J, et al. Systematic Review: Pharmacological and Behavioral Treatment for Trichotillomania. Biol Psychiatry. 2007;62(8):839-46.
https://doi.org/10.1016/j.biopsych.2007.05.019
PMid:17727824

15. Caldwell P, Sureshkumar P, Wong W. Tricyclic and related drugs for nocturnal enuresis in children. Cochrane Database Syst Rev. 2016;2016(1).
https://doi.org/10.1002/14651858.CD002117.pub2
PMid:26789925 PMCid:PMC8741207

16. Naiwen D,Laurence B. Nocturnal enuresis in children. Pharm J. 2023;294(7):21-31.

17. Franklin ME, Zagrabbe K, Benavides KL. Trichotillomania and its treatment: A review and recommendations. Expert Rev Neurother. 2011;11(8):1165-74.
https://doi.org/10.1586/ern.11.93
PMid:21797657 PMCid:PMC3190970