Letters to the Editor

Trichotillomania and Bipolar Disorder

TO THE EDITOR: We read with interest the article by Grant and Chamberlain (1), published in the September 2016 issue of the *Journal*, on the assessment and treatment of trichotillomania. As the authors point out, psychiatric comorbidity is the rule rather than the exception in patients with trichotillomania. In one study (2), approximately 55% of patients with trichotillomania met DSM-III-R criteria for a lifetime diagnosis of a mood disorder, including bipolar disorder in a small number of patients. While major depressive disorder is the most common mood disorder, the relationship between trichotillomania and bipolar disorder remains unclear (3).

Over the past few years, we have successfully treated several women at our perinatal psychiatric clinic who were comorbid for bipolar II disorder and trichotillomania (4). Interestingly, all of our patients (N=5) had experienced exacerbation of symptoms of trichotillomania immediately after giving birth. All patients failed to respond to trials of selective serotonin reuptake inhibitors (SSRIs), and two patients failed to respond to olanzapine. However, there was a robust and sustained response to lithium (in three patients) or lamotrigine (in two patients) monotherapy.

Studies have shown a correlation between changes in reproductive physiology and the onset or exacerbation of symptoms of trichotillomania in humans and hair plucking behavior (barbering) in mice (S. Husk, 2010 master's thesis). Childbirth is also a well-recognized trigger of onset or exacerbation of bipolar disorder.

As the authors point out, SSRIs are not generally effective in trichotillomania. Moreover, the use of these drugs in patients with bipolar disorder may lead to further mood instability. Available literature, although limited to anecdotal reports, suggests that antidepressants should be avoided in favor of mood stabilizers for management of trichotillomania and bipolar disorder comorbidity.

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Dr. Sharma has received grant support from, participated on scientific advisory boards for, or served on speakers bureaus of Assurex, Genome Canada, Neurocrine Biosciences, Stanley Medical Research Institute, and Sunovion Pharmaceuticals. Ms. Baczynski reports no financial relationships with commercial interests.

This letter was accepted for publication in November 2016.

Am J Psychiatry 2017; 174:186; doi: 10.1176/appi.ajp.2016.16091095

Refining Treatment Approaches in Comorbid Trichotillomania and Bipolar Disorder: Response to Sharma and Baczynski

TO THE EDITOR: Sharma and Baczynski present five cases of co-occurring trichotillomania and bipolar disorder with worsening of trichotillomania symptoms following childbirth. The individuals in question responded to either lithium or lamotrigine. This case series of the comorbidity of trichotillomania and bipolar disorder, as well as the exacerbation of hair pulling postchildbirth, raises important clinical and research issues: the role of sex hormones in the pathophysiology of trichotillomania, and appropriate pharmacological management of these disorders when they co-occur. The authors mention a correlation between changes in reproductive physiology and hair plucking behavior in mice. In furtherance of the possible role of sex hormones in trichotillomania, a recent study showed that 94% of a large sample of patients who sought treatment for trichotillomania (N=462) were female and that the majority reported an age of onset coincident with puberty (12 years of age) (1). Taken together, these findings seemingly beg for an examination of sex hormones in trichotillomania. In terms of pharmacological treatment of this comorbidity, this case series supports the possible use of lithium and lamotrigine. Both lithium and anticonvulsants have been reported as potentially beneficial for trichotillomania, even in the absence of bipolar disorder, in case reports or open-label studies (2–4). Despite promising research, there is no clear first-line pharmacological agent for trichotillomania. Previous research has suggested that understanding the heterogeneity of the disorder (i.e., using clinical, neurocognitive, and neuroimaging findings to subtype people with the disorder) may improve treatment approaches (5). This case series importantly adds to this approach by suggesting that comorbidity and timing of symptom exacerbation may further refine treatment approaches.

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