

ALOPECIA AREATA IN A FEMALE PATIENT SUFFERING FROM BORDERLINE PERSONALITY DISORDER WITH COMORBID MOOD DISORDER – DEPRESSIVE EPISODE

Ema N. Gruber¹, Danijel Crnković² and Mirjana Bjedov¹

¹Dr. Ivan Barbot Neuropsychiatric Hospital, Popovača; ²University Department of Psychiatry, Sestre milosrdnice University Hospital, Zagreb, Croatia

SUMMARY – A case is presented of a 44-year-old female patient, highly educated, suffering from borderline personality disorder with comorbid mood disorder, manifested as a depressive episode, who had been suffering from acute emotional stress for a few months. She was through the procedure of divorce, losing her children by the court decision. Over a two-month period she had lost over 90% of her hair and started treatment for alopecia areata. She was simultaneously treated by a dermatologist and a psychiatrist, and attended group psychotherapy. The impact of psychological factors in the development, evolution and therapeutic management of alopecia areata was documented in this case. Life events and intrapsychically generated stress played an important role in triggering the disease. The treatment for the concomitant psychiatric disorder had a crucial role in this case because it had a favorable effect on the patient's adaptation to her alopecia areata and social setting, and led to better dermatologic evolution of the disease.

Key words: *Alopecia areata – diagnosis; Alopecia areata – psychology; Life change events; Mental disorders – therapy*

Introduction

The rate of comorbidity of psychiatric disorders, mainly generalized anxiety disorder, depression, and phobic states, is high¹. Yet, dermatologists recognize correctly only about 35% of patients with difficulties in family relationships and 48% of patients with depression. It seems to be influenced by the patients' assumptions and dermatologic diagnosis, suggesting that patients who are not aware of the psychological impact in the etiology of their disease may not be recognized by the dermatologist and therefore cannot be treated optimally².

In this case report, the impact of psychological factors in the development, evolution and therapeutic management of alopecia areata was documented, and so were life events and intrapsychically generated stress that played an important role in triggering alopecia areata.

This case report is interesting because it shows how combined therapy of alopecia areata by both a psychiatrist and a dermatologist was necessary and effective.

Case Report

This is a case report of a 44-year-old female patient, highly educated, employed as a customs officer, mother to three sons (aged 19, 15 and 11 years). According to DSM-IV diagnostic criteria, the patient suffered from borderline personality disorder with comorbid mood disorder, manifested as a depressive episode. She had been under psychiatric treatment from 2000 and hospitalized four times at our hospital. Her previous diagnosis was bipolar disorder (recurrent major depressive episodes, severe with psychotic features of manic episodes). She was and still is treated with risperidone, Na-valproate, and alprazolam or diazepam in different dosages, depending on clinical picture. She was also treated with many different antidepressants over years, however, with poor therapeutic effect, probably because she did not take her medication regularly. Since November 2003,

Correspondence to: *Ema N. Gruber, MD*, Mate Ujevića 10, HR-10000 Zagreb, Croatia

Received February 24, 2005, accepted in revised form May 9, 2005

E-mail: emagruber2000@yahoo.com

the patient has been taking sertraline. She mostly presented regularly for psychiatric controls and participated in a psychotherapy group for two years. In the group, at first she used to monologize, however, later she gradually began to listen to other group members too. Somatically, she has been under internist control since 1998 for tachycardia and palpitation, has been taking sotalol regularly, and was hospitalized once. In 2003 she underwent neurologic examination for headaches and pain in the neck. In 1982, she lost her first child in the fifth month of pregnancy, when she acquired hepatitis B. Over the past three years, the patient was going through a divorce. The situation escalated six months before when she left her husband and children, and moved to a rented apartment in the same town. Since her previous psychiatric diagnosis and treatment, the father was supposed to get custody of the children. Over years, the patient's appeals were rejected, and she resigned from the children; divorce procedure was over in a short period of time. Her husband was forbidding the children to visit their mother. In a few months, the patient felt that she "had lost her children, her family and her home". The situation aggravated her constant belief that her environment was withholding and uncaring, she experienced intense abandonment, fear and inappropriate anger when she found herself faced with the real time-limited separation from her children. Her anger turned to the feeling of shame and guilt for her children, and contributed to her perception of herself as being "evil" or "bad". She started spending time writing to various organizations and social services, trying to get help and support to get her children back, however, all her attempts proved hopeless. She was displaying extreme sarcasm, bitterness and verbal outbursts. She abandoned her psychotherapy group on her own, in face of the therapist's advice that this time she needed it most. At that time she had no close friends to unbother herself to, and she had complicated the relatively cold relationship with her mother, who was "rigid and very authoritative". So, she felt "all alone in the world". During that stressful time, she developed psychotic-like symptoms, her illness exacerbated to the extent of transient stress-related paranoid ideation and severe dissociative symptoms, with extremely intensified activity, impaired judgment and psychomotor agitation. The patient had been under this acute emotional stress for a few months when she started to lose her hair. She lost over 90% of her hair over two months. Dermatologic diagnosis, based on clinical picture, trichogram and histology, was alopecia areata multilocularis, a dermatologic disease which, we believe, occurred after stress as a psychosomatic disease. The patient underwent all other relevant examinations, which revealed no bad teeth,

chronic inflammation stimuli (focuses), close contact with cats, allergies or fungi; blood tests, ASTO, ALTO and LPT + + + showed normal results. Her family history was negative. The loss of hair was instant, painless, and in the form of circular skin areas without hair, some of them of the small palm size. The hair was falling off on light pull, especially from the edges of the affected areas. The patient lost her hair only on her head. There were no nail changes. Dermatologically, the patient was treated with Fluocet gel and Pifud. New hair started to grow in a short period of time and up to now, three months later, there seems to be no new localizations or hair loss. During recovery of alopecia areata, the patient presented for psychiatric controls and support, and has started attending her psychotherapy group again. The patient has regained her hair completely. No relapse was noted over the past six months.

Discussion

This case report shows that combined therapy for alopecia areata by both a psychiatrist and a dermatologist is necessary and effective, since comorbidity of psychiatric and dermatologic diseases was present¹. Our patient's diagnosis was alopecia areata, which is a dermatologic disease, however, it developed after stress. The possible explanation for this can be found in the literature. All functions in the skin including the scalp are closely regulated by nerve fibers. Among these functions are hair growth and immunity. Immune cells and hair follicle cells possess receptors for neurotransmitters, which are synthesized by neural endings that are sensitive to stress-induced hormones. Destruction of hair follicles by lymphocytes can induce alopecia areata³.

Furthermore, our patient's screening for endocrine diseases showed a slightly lower level of T3 hormone, which is associated with a higher incidence of thyroid disease in alopecia areata⁴. It is also known that acute emotional stress may precipitate alopecia areata by activation of overexpressed type 2 beta CRH receptors around the hair follicles, leading to severe local inflammation⁵.

Our patient's psychological tests showed borderline personality disorder with comorbid mood disorder, manifested as a depressive episode. Basic psychotherapeutic support and participation in group therapy proved useful, since the patient had not taken her medication regularly and had been under acute emotional stress for a few months before she lost her hair. The basic dysphoric mood in patients with borderline personality disorder is often disrupted by periods of anger, panic, or despair. These episodes may reflect the individual's extreme reactivity to interpersonal stress. Furthermore,

it is known that personality characteristics may modulate individual susceptibility to alopecia areata, a disease tending to be associated with high avoidance in attachment relationships and poor social support⁶. Recent studies also emphasize high alexithymic characteristics in patients with alopecia areata⁷.

In our patient, life events played an important role in triggering the disease, along with the trait-anxiety and stress perception, similar to that reported elsewhere^{8,9}. Fortunately, our patient was aware of the psychological influence in the etiology of her disease, and she was also appropriately recognized by the dermatologist and treated optimally².

Yet, recurrence might be expected in the patient because alopecia areata is known to be a chronic skin disease, especially in association with her psychiatric illness, her constant regret for children, remorse, affective instability due to marked mood reactivity (pronounced episodic dysphoria, irritability or anxiety), sensitivity to environmental circumstances, and her uncertain financial status. Her recent wish for reconciliation with her husband "for the children's sake", which he rejected, was consistent with her previous attempts of undermining herself at the "moment the goal was about to be realized". In addition to her current life situation, her ex-husband and youngest son moved 600 miles away, which along with her trait-anxiety and stress perception represent risk factors that may lead to exacerbation of the disease. Also, since our patient's diagnosis is borderline personality disorder, the question of self-mutilating behavior always remains open.

Conclusion

In alopecia areata, the role of treatment of a concomitant psychiatric disorder is of utmost importance. Basic psychotherapy support and participation in group psycho-

therapy had favorable effect on the patient's adaptation to her alopecia areata and social setting, and led to better dermatologic evolution of alopecia areata.

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Sažetak

ALOPECIA AREATA U BOLESNICE S GRANIČNIM POREMEĆAJEM OSOBNOSTI UZ ISTODOBNI POREMEĆAJ RASPOLOŽENJA U OBLIKU DEPRESIVNE EPIZODE

E.N. Gruber, D. Crnković i M. Bjedov

Prikazan je slučaj 44-godišnje visoko obrazovane bolesnice s graničnim poremećajem osobnosti uz istodobni poremećaj raspoloženja u obliku depresivne epizode, koja je nekoliko mjeseci proživljavala akutni emocionalni stres. Prošla je postupak razvoda braka, a sudskom joj odlukom djeca nisu dodijeljena. Kroz dva mjeseca izgubila je preko 90% kose i započela je liječenje zbog alopecie areate. Istodobno su ju liječili dermatolog i psihijatar, a pohađala je i grupnu terapiju. U ovom je slučaju dokumentiran utjecaj psiholoških čimbenika na razvoj, evoluciju i liječenje alopecie areate. Životni događaji i psihički stres imali su važnu ulogu u pokretanju bolesti. Uloga liječenja u istodobnom psihičkom poremećaju bila je presudna u ovom slučaju, jer je imala pozitivan učinak na način na koji se je bolesnica prilagodila nastalom opadanju kose i društvenom okruženju, što je dovelo do boljeg dermatološkog razvoja alopecie areate.

Ključne riječi: *Alopecia areata – dijagnostika; Alopecia areata – psihologija; Životne promjene; Psihički poremećaji – liječenje*