

DEPRESSIVE DISORDER AND ALOPECIA

Tanja Grahovac¹, Klementina Ružić¹, Dubravka Šepić-Grahovac²,
Elizabeta Dadić-Hero^{3,4} & Aristeja Pavešić Radonja¹

¹University Psychiatric Clinic Rijeka, Clinical Hospital Centre Rijeka, Croatia

²Department of neurology, Clinical Hospital Centre Rijeka, Croatia

³Community Primary Health Centre, Primorsko-goranska county, Croatia

⁴Department of Social Medicine and Epidemiology, School of Medicine, Rijeka, Croatia

SUMMARY

Psychophysical dermatitis is frequently manifested in patients that suffer from psychiatric illnesses and disorders as well as in patients that suffer from depressive disorders. These diseases occur or worsen after acute stress that may trigger them. Difficulties in expressing feelings or impossibility to verbalise them are connected to somatic diseases. In order to emphasize their importance, we will present a case of a 58 years old woman who has been suffering from alopecia areata that developed after her husband's death.

The patient doesn't function well since then - she is socially isolated, she has lost self confidence and self esteem. As she has realised it was impossible to live like that, she decided to seek psychiatric help.

The patient should be examined through the prism of the interdisciplinary treatment and as an integral structure of the mind and body.

Key words: alopecia – depression - integrative psychiatry

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INTRODUCTION

According to current classifications depressive disorders belong to mood disorders (American Psychiatric Association 2000, World Health Organization 1999). The etiology of depressive disorders is multifactorial. Depressed person complains of sluggishness, loss of strength (power), a sense of worthlessness and guilt, he or she manifests eating/appetite, sleeping and concentration disorders, psychomotor changes and has suicidal ideation. Moreover the patient often suffers from somatic disorders that may be the first symptoms of depressive disorder.

Alopecia occupies an important place in psychiatric comorbidity and is most often associated with anxiety and depression (Poot 2004). Psychiatric illnesses are more frequent in patients with alopecia than in mentally healthy persons (Misery 2001).

Alopecia areata is a psychophysical dermatitis characterized by circular, round or oval spots without hair. These spots/points are usually the size of a coin and occur in the scalp or other parts of the body.

The areas without hair can gather and cause complete baldness (alopecia totalis) and hair loss on other body parts (alopecia universalis) (Harrison 1997, Yazici 2006). The illness appears suddenly, sometimes the hair grows back spontaneously and suddenly in the same way as it fell. Alopecia occurs equally in both sexes, it doesn't depend on age or race. The cause of alopecia is not fully resolved, but the etiopathogenesis of the disease includes genetic factors, various infections, psychological factors and autoimmune diseases.

Psychophysical dermatitis is related to skin diseases, which regularly worsen or are manifested for the first time after acute stress. Stressful events can trigger alopecia. It is usually a stressful event that happened immediately before the illness or a chronic exposure to stress that causes it (Manolache 2007, Pott 2004) . These people encounter difficulties in expressing their feelings, i.e. alexithymia. According to the literature, the researches show that alexithymia can trigger many somatic and psychiatric diseases (Willemsen et al. 2008). These persons can't verbalise their emotional state, therefore the abreactions are channelled somatically.

CASE REPORT

Woman aged 58, with secondary qualifications; widow; mother of two children. She is the younger child who grew up in a "family full of understanding". Early psychomotor development and growing up were normal. She describes herself as a social child, as "a real fighter for herself and for others". She was more attached to her father – he understood her better, even if he periodically consumed alcohol. Her education took a regular course.

After a brief emotional relationship, she married at the age of 18. She became a mother at the age of 24. After 17 years of relatively harmonious marriage she got divorced at the age of 34 on her own initiative. She said her husband had worked all the time and had never spent time at home so they had become distant. She had problems in coping with divorce, she felt guilty because she didn't provide a normal and complete family to her daughter. She let the apartment in which they lived to

her husband. Her daughter still objects her that decision. Only after the divorce she found out that her husband had had an affair for years. She claims it made her “explode”, she felt deceived and tricked, and she couldn’t verbalize the anger she felt.

She soon got bronchial asthma and since then she has been treated by a pulmonologist.

At the age of 38 she married again and a year later she gave birth to a son with whom she still lives. With her second husband she established a stable relationship. In the 90ies they both lost their jobs and were in a difficult financial situation. They decided to start a private business. The business started to run well but they had to close it eventually. They were again in a difficult financial situation. She claimed her husband couldn’t cope with the situation. At the time (2004) her father died, eight months later her mother died too and in 2005 her husband died suddenly.

Few months after her husband died she started to lose hair. It was the first time she went to see the psychiatrist. She was clinically examined several times, she took antidepressants (mirtazapin), but on her own initiative she stopped the treatment.

She lost all her hair in next few months and she has not functioned normally since then. The dermatologist discovered allergies to several medicines, but she has never taken them. The etiology of alopecia has never been discovered. She was advised to remain under psychiatric treatment and she accepted it unwillingly.

Last December she realised that she could not function anymore so she decided to visit a psychiatrist. Due to the pronounced depressive symptoms, a hospitalisation was advised and the patient agreed to it. She claimed that since her husband died she had not had a normal life. She had been apathetic, she had had no interests and strength and she had felt anxious. She had felt anxious in social contacts and had not allowed closer relationships. She stated not to have a close friend; she pushed everyone away from her. She rarely went out, she had a feeling of being marked and that people looked strangely at her. She claimed she felt discomfort and tremendous fear among people. She had lost self-confidence and self-esteem. She was sensitive to critic and she easily felt guilty. Because of debts and mortgage on the apartment, she felt being a time bomb all the time. She did not sleep well, she got up at nights and ate but she did not gain weight. She said she was fed up with everything and she did not see a way out. She did her everyday activities with increased effort and she had concentration problems. She expressed a great number of problems –chest pressure, heart beating, numb legs, she saw sparks in front of her eyes.

At the examination the patient looked good, and the wig was hard to notice. Her consciousness and sense of orientation were preserved. In shorter contact she was not spontaneous, but during a longer examination while crying she managed to verbalize her main problem – alopecia. She was extremely anxious and intra-

psychologically tense and affectively depressed. Her stream of thoughts was slower, she had depressive ideas, ideas of hopelessness and guilt, all associated with existential problems. She showed a lot of somatisations and projections. She manifested hypovigil and hypertentional attention. She denied deception of feelings. She was hypobulic and had suicidal thoughts that she criticized, her vital dynamism was low.

During hospitalisation she was treated with a combination of psychopharmacological medicines – antidepressants, anxiolytics and hypnotics. She took part in several diagnostic evaluations: psychiatric and psychotherapeutic interviews, psychological testing, EEG and was examined by an ophthalmologist. We cut off the organic substrate which led to diagnosis of mood disorder.

DISCUSSION

Sudden loss of hair has an enormous impact on the quality of life of an individual, as in the case of our patient. It has been noticed that during the exacerbations of the disease, the patient manifested deterioration of psychological condition and social withdrawal, had less self-confidence, developed sense of frustration, anxiousness and depression (Gupta 1996, Koo 1992). Dermatological workup suggests important implications for the treatment of specific dermatological diseases. Alexithymia is associated with psychophysiological dermatosis. (Willemsen et al. 2008). People with alopecia areata, especially women, indicate a problem within the family, and are less associated with financial problems (Manolache 2007).

Alopecia areata is often associated with the avoiding of interpersonal relationships, with alexithymic characteristics in a patient and bad social support. (Cordan et al 2006). Some authors suggest that individual characteristics of a patient can trigger the alopecia. A study has showed that 65 percent of patients with alopecia areata had a comorbid psychiatric illness, adjustment disorder, depressive and general anxious disorder. Numerous studies have showed controversial thoughts about the stress origin of alopecia. Emotional traumas have an impact on everyone’s psychophysical state, but the question is if that is enough to start alopecia (Ruiz-Doblado 2003).

CONCLUSION

Skin condition reveals the emotional state of people, reflects the tension, fear and discomfort. Many patients have daily feelings of shame, guilt, and fear of skin changes. These patients need multidisciplinary approach. The psychological aspect of the disease must be taken in consideration as the primary psychological disorder and its reaction on the skin disease. It has been known since the time of Socrates and Hypocrite that the body can not be completely healed without the

contemporary treatment of the mind. A successful treatment requires the knowledge of the entire system.

Anxiousness and depression are often in comorbidity with alopecia areata. They have an important role in its development, while the stress events during one's life can be a trigger of development and exacerbations of the disease. For the treatment of skin diseases besides psychopharmacotherapy a patient needs strong psychotherapeutic support (Koo 1992).

The patient has to be seen and observed as an unique structure of mind and body. The psychic and somatic are connected and should be considered in continuous interaction. It is therefore extremely important interdisciplinary and personalized approach to patient.

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Correspondence:

Tanja Grahovac, MD, PhD

University Psychiatric Clinic Rijeka, Clinical Hospital Centre Rijeka

Krešimirova 42, 51000 Rijeka, Croatia

E-mail: tanja.grahovac@ri.t-com.hr