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**ALOPECIA AREATA IN FEMALE PATIENT SUFFERING
FROM BORDERLINE PERSONALITY DISORDER (WITH
CO-OCCURRING MOOD DISORDER, PRESENT EPISODE
DEPRESSIVE)**

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Abstract:

Case report of a 44 years old female patient, highly educated, suffering from Borderline personality disorder with co-occurring mood disorder, present episode depressive who suffered from acute emotional stress for a few months. She was in a process of divorce and losing her children by order of the court. In a two months period she has lost over a 90% of her hair and started treatment for alopecia areata. Dermatologist and psychiatrist treated her simultaneously; she also went on group psychotherapy. The influence of psychological factors in the development, evolution and therapeutic management of alopecia areata is documented in this case. Life events and intrapsychically generated stress played an important role in triggering of the disease. The role of treatment on concomitant psychopathological disorders is a vital one in this case because it positively affected how the patient adapted to her alopecia areata and social setting and led to a better dermatological evolution of the alopecia areata.

Key words:

Borderline personality disorder with co-occurring mood disorder, acute emotional stress, alopecia areata

Introduction:

The influence of psychological factors in development, evolution and therapeutic management of alopecia areata is, in general, well documented. Life events and intrapsychically generated stress can play an important role in triggering of some episodes. The co morbidity of psychiatric disorders, mainly generalized anxiety disorder, depression, and phobic states, is high.(1)

Still, dermatologists correctly recognize 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 by the dermatological diagnosis. This suggests that patients who are not aware of a psychological influence in the aetiology of their disease could not be recognized by the dermatologist and could thus not be treated optimally. (2)

Case report:

Case report of a 44 years old female patient, highly educated, employed as a customs clerk, mother of three sons (19, 15 and 11 years old). On DSM-IV diagnostic criteria the patient is suffering from Borderline personality disorder with co-occurring mood disorder, present episode depressive. She is in a psychiatric treatment since the year 2000. She has been hospitalised four times in our hospital, previous diagnosis were bipolar disorder (recurrent major depressive episodes -severe with psychotic features for manic episodes). She was and still is treated with risperidon, Na-valproat and alprazolam or diazepam in different dosages, depending on clinical picture. She was on different anti depressants over the years but remained unsatisfied because she didn't take the medicine properly, constantly complaining on her "chronic felling of emptiness and loneliness". Since the November 2003 the patient takes sertralin. She is mostly regular on her psychiatric controls and was attending a psychotherapy group for two years. In the group she was at first making monologs but later, gradually, she could hear other members also. Somatically, she is under internist controls from the year 1998 because her tachycardia and palpitation, regularly taking sotalol, once hospitalised. In the year 2003 she did neurological examination because of the pain in the neck and headaches. She lost her first child in the fifth month of pregnancy in the year 1982, when she got ill from Hepatitis B. The patient was in the past three years going through a divorce, the situation escalated before six months, when the patient deserted her husband and children and moved to a

rented apartment in the same town. Since her previous psychiatric diagnosis and treatment, the children were supposed to fall to fathers share. Over the years, the patient's complaints to this court decision were rejected on court and now, when she resigned from the children; divorce procedure was over in a short time period. Her husband was forbidding their children to visit mother. In a few months period the patient felt that she "lost her children, family and home". The situation increased her constant calm belief that her surroundings are withholding, uncaring and she experienced intense abandonment fear and inappropriate anger when she was faced with a realistic time-limited separation from her children. The feelings that have followed the anger were shame and guilt for her children and contributed her feeling that she is "evil" or "bad". She started spending time writing to the various organisations and social services, trying to get help and support on gaining her children back, but her trying were hopeless. She was displaying extreme sarcasm, enduring bitterness and verbal outbursts. She quit at free will her psychotherapy group; despite the suggestions made by the therapist that this is the time she actually needed it most. At that time she had no close friends to confide and she has complicated relatively cold relationship with her mother, who was "rigid and very authoritative". So she felt "alone on the world". During these times of stress she developed psychotic-like symptoms, her illness exacerbated to the extent of transient stress-related paranoid ideation and severe dissociative symptoms and an extreme increase in activity and impairment in judgment as well as psychomotor agitation. The basic dysphoric mood of those 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. She was under this acute emotional stress for a few months when she started to lose her hair. She lost over a 90 % of her hair in a two months period. The dermatological diagnosis, stated on clinical picture, trihogram and histology was alopecia areata multilocularis, a dermatological disease that, we assume, occurred after stress and it is a psychosomatic disease. Everything else was checked. No bed teeth, no chronic inflammation stimulus (focuses), no cats, no allergies and no fungus, normal blood results, as well as ASTO, ALTO, LPT ++++. Her family anamnesis was negative. The loss of hair was instant, painless, and in forms of circular skin areas without hair, some of them in size of a small palm. The hair was falling down on the easy pull, especially from the corners of the inflected areas. The patient lost her hair only on her head. There were no changes on nails. Dermatologically, the patient was treated with Fluacet gel and Pifud. The new hair started to grow in the short period of time and up to now, a three months later, there seems to be no new localisations and the hair losses. Basic psychotherapeutic support recommended in recent studies, proved to be in use in our case. During the recovery of alopecia areata, our patient went to psychiatric controls and support and now she started again and her psychotherapy group as well. The patient gains her hair completely. No relaps was noted in a period of past six months.

Discussion:

Alopecia areata is a dermatological disease, characterized by the loss of hair and it appears to be a psychosomatic disease. It often occurs after stress. Psychiatric disorders are more frequent in patients with alopecia than in healthy subjects. Hair follicle cells possess receptors for neurotransmitters, which are synthesized by neural endings, sensitive for stress-induced hormones. Destruction of hair follicles by lymphocytes induces alopecia areata. All functions in the skin (and the scalp), are narrowly controlled by nerve fibres. Among these functions are hair growth and immunity. Immune cells and hair follicle cells possess receptors for neurotransmitters, which are synthesized by neuronal endings. When activated, these receptors are able to modulate cell properties. The same phenomena are described with stress-induced hormones. In alopecia areata, like in numerous other diseases, psychosomatics and immunology are not opposed because immune cells are controlled by the nervous system through neurotransmitters. (3). The comorbidity of psychiatric disorders, mainly generalized anxiety disorder, depression and phobic states are high (1). The incidence of thyroid disease in alopecia areata is higher than in general population so the screening on endocrinological disorders is necessary (4). Accordant to the higher incidence of thyroid disease in alopecia areata our patient screening on the endocrinological diseases showed slightly lower T3 hormone. Acute emotional stress may precipitate alopecia areata by activation of over expressed type 2 beta CRH receptors around the hair follicles leads to intense local inflammation (5). Similar

to our case the recent investigations suggest that personality characteristics might modulate individual susceptibility to alopecia areata (6). Alexithymic individuals, who fail to cope with stress and also fail to communicate their feelings, might be more prone to develop alopecia areata (7). Also, alopecia areata tends to be associated with high avoidance in attachment relationships, and poor social support (6). But, recent studies emphasizes high alexithymic characteristics in patients with alopecia areata, and our patient, on contrary, can verbally express herself very well. Similar like in already made studies, in our case also life events played an important role in triggering of disease together with trait-anxiety and stress perception (8,9). Fortunately, our patient was aware of a psychological influence in the aetiology of her disease so she was recognized by the dermatologist as such and treated optimally. Our patient's psychological test made at present time shows borderline personality disorder with depressive episode. Therefore the question of self-mutilating behaviour always remains opened but we assume that this was not a case in our patient's alopecia areata.

Furthermore, it is known that alopecia areata is a chronic skin disease so we could expect recidivism, especially according to the patient's psychiatric illness, her constant regret for children, remorse, her affective instability that is due to a marked reactivity of mood (intense episodic dysphoria, irritability or anxiety) and her sensitiveness to environmental circumstances, her not yet resolved financial status. Her recent wish for reconciliation with her husband "for the children's sake", which he withholds, were consistent with her previous attempts of undermining herself at the "moment a goal is about to be realized". Mixed with a

present life situation were the ex housebound and the youngest son relocated 600 miles away, trait-anxiety and stress perception constitutes risk factors that may influence the exacerbation of the disease.

Conclusion:

The role of treatment of concomitant psychopathological disorders is a vital one. Combined type of therapy, both by psychiatrist and dermatologist is necessary in the case of our patient, because of her identity disturbance, characterized by markedly and persistently unstable self-image or sense of self. It positively affected how the patient adapted to her alopecia areata and social setting as well as the quality of our patients life.

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