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Psychiatric aspects of Alopecia : a brief update

Medical Science

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ABSTRACT

Alopecia areata accounts for about 2% of dermatological out patients. This literature review looks at the various psychiatric issues one may encounter when handling a patient with alopecia areata. Personality factors, family issues, stress, post traumatic patterns and childhood trauma may all play a role in the precipitation of alopecia. Proper psychological management at an early stage may prevent treatment resistant at later stages. A proper consultation liaison between dermatologists, trichologists and psychiatrists when needed will yield good results in many cases.

INTRODUCTION

Alopecia areata accounts for about 2% of new dermatological out patients in Britain and the United States.[1] The onset may be any time from infancy to old age with maximal incidence between 5 and 40 years and a gradual decline after that time.[2] Alopecia totalis involving the entire scalp is seen in 10% of cases while in other cases just part of the scalp is involved.[3]

PSYCHIATRIC ASPECTS OF ALOPECIA

Par excellence, diverse opinions about the cause of alopecia areata over the years have exemplified the polarization of our understanding of disease etiology in the terms of psyche and soma. The literature seems to stress a dichotomy between the two suggesting that alopecia may be physical in nature or psychological in origin but in some cases rather an interaction between the two as is now believed.[4] Many studies mention the possible psychogenic causes of alopecia and there have been case reports of children having sudden hair loss in times of unusual stress.[5] There has also been reported a high incidence of psychiatric comorbidity in patients with alopecia areata.[6]

The etiology of alopecia areata is no doubt multifactorial with genetic, infectious and autoimmune mechanisms. The immune system is no doubt influenced by psychological factors as proposed in many studies and reviews.[7] It is also demonstrated that diseases mediated by autoimmune processes are recognized to be exacerbated by stress.[8] Psychogenic factors in many cases may be a precipitant of alopecia areata.[9]

Research has shown that patients with alopecia areata often have psychiatric disorders in need of treatment. Majority of these patients suffer from anxiety disorders, depression, insomnia and obsessive compulsive phenomena.[10] Many patients with alopecia areata have reported feelings of inferiority and insecurity being shy and passive with an inability to express strong feelings verbally and in action.[11] These personality characteristics have been confirmed by other researchers.[12] Long standing emotional problems are of greater etiologic significance in alopecia areata than were recent trauma although a precipitating traumatic event could be identified in many cases.[13]

Mild to moderate emotional problems have been noted in children with alopecia areata.[14] Alopecia areata has been reported in young children two weeks after they had undergone a traumatic experience which represented a major threat to them in terms of his or her own life experience.[14] There seems little doubt from various studies that a high percentage of patients with alopecia areata, because of early childhood difficulties develop a type of personality configuration that confers upon them a particular vulnerability to stress. Whenever these patients are subjected psychosocial stress above the average , whether the stress is internal or external, effective mechanisms of coping break down and somatic symptoms develop. Because the scalp is already primed genetically, immunolgically and due to other factors alopecia areata represents that symptom.[15]

From a psychodynamic point of view, some authors report alopecia areata to be a form of a hysterical conversion reaction found to be rooted in early life in ambivalent mother child relationships and separation difficulties.[16] Alopecia areata is disfiguring and often causes much personal distress with body image disturbances along with depression and anxiety. Many patients have body image difficulties long before the onset of alopecia areata.[17]

PSYCHOLOGICAL MANAGEMENT OF ALOPECIA AREATA

An explanation of the understanding of the nature and possible causes of alopecia areata is of paramount importance. Given the significance that society places on beautiful hair and the unconscious symbolic meaning that hair has for most patients, conscious and unconscious symbolic fantasies about their disease cause great distress for many. It is important to verbalize the unspoken fears by making the patient realize that he or she does not have cancer, some infectious or contagious disease. It is also important to counsel patients that hair follicles are not destroyed and that potential for regrowth exists.[18] It is also necessary to explain to the patient the psychobiological theory of alopecia areata. The patient may be provided support and psychotherapy if needed. Supportive psychotherapy may be provided by the dermatologist and if required a psychiatry referral may be sought. Many patients are known to benefit from psychodynamic psychotherapy and cognitive behavior therapy.[19] In a few cases antidepressant and anti-anxiety medications may be needed.[20] Short term treatment done early in the illness is more effective and may obviate the need of long term treatment later.[21]

CONCLUSIONS

Not all patients with alopecia areata may need psychiatric treatment. With the surge in psychosomatic medicine and growth of consultation liaison psychiatry there is probably a greater chance that more cases of alopecia may involve the dermatology – trichology – psychiatry interface. There is a dearth of literature on the psychiatric aspects of alopecia. There is need for further research in this area which may uncover many unknown facts about alopecia.

REFERENCE

1. Ellis JA, Sinclair RD. Male pattern baldness : current treatments, future prospects. Drug Discov Today 2008 ; 13(17-18) : 791-797. | 2. King LE Jr, McElwee KJ, Sundberg JP. Alopecia areata. Curr Dir Autoimmun 2008 ; 10 : 280-312. | 3. Hordinsky M. Advances in hair diseases. Adv Dermatol 2008 ; 24 : 245-259. | 4. Willemsen R, Roseeuw D, Vanderlinden J. Alexithymia and dermatology : the state of the art. Int J Dermatol 2008 ; 47(9) : 903-910. | 5. Hawit F, Silverberg NB. Alopecia areata in children. Cutis 2008 ; 82(2) : 104-110. | 6. Folks DG, Warnock JK. Psychocutaneous disorders. Curr Psychiatry Rep 2001 ; 3(3) : 219-225. | 7. Kemeny ME. Psychobiological responses to social threat : evolution of a psychological model in psychoneuroimmunology. Brain Behav Immun 2009 ; 23(1) : 1-9. | 8. Tausk F, Elenkov I, Moynihan J. Psychoneuroimmunology. Dermatol Ther 2008 ; 21(1) : 22-31. | 9. Van Moffaert M. Psychodermatology : an overview. Psychother Psychosom 1992 ; 58(3-4) : 125-136. | 10. Koblenzer CS. What is psychocutaneous disorder. Int J Dermatol 1990 ; 29(2) : 105-106. | 11. Hansen RC. Pediatric psychocutaneous disorders. Curr Opin Pediatr 1997 ; 9(4) : 367-371. | 12. Picardi A, Pasquini P. Towards a biopsychosocial approach to skin diseases. Adv Psychosom Med 2007 ; 28 : 109-126. | 13. Merikangas KR. Vulnerability factors for anxiety disorders in children and adolescents. Child Adolec Psychiatr Clin N Am 2005 ; 14(4) : 649-679. | 14. Lee R. Childhood trauma and personality disorder : towards a biological model. Curr Psychiary Rep 2006 ; 8(1) : 43-52. | 15. Figueira ML, Ouakinin S. From psychosomatic to psychological medicine : what's the future. Curr Opin Psychiatry 2008 ; 21(4) : 412-416. | 16. Aybek S, Kanaan RA, David AS. The neuropsychiatry of conversion disorder. Curr Opin Psychiatry 2008 ; 21(3) : 275-280. | 17. Malick F, Howard J, Koo J. Understanding the psychology of cosmetic patients. Dermatol Ther 2008 ; 21(1) : 47-53. | 18. Murray-Swank AB, Dixon L. Family psychoeducation as an evidence based practice CNS Drugs 2004 ; 9(12) : 905-912. | 19. Lewis AJ, Dennerstein M, Gibbs PM. Short term psychodynamic psychotherapy : a review of the recent process and outcome studies. Aust N Z J Psychiatry 2008 ; 42(6) : 445-455. | 20. Fava GA, Visani D. Psychosocial determinants of recovery in depression. Dialogues Clin Neurosci 2008 ; 10(4) : 461-472. | 21. Matthew SJ. Treatment resistant depression : recent developments and future directions. Depress Anxiety 2008 ; 25(12) : 989-992.