

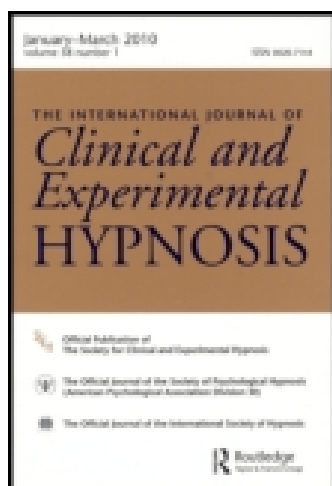
This article was downloaded by: [UQ Library]

On: 13 November 2014, At: 11:33

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954

Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



## International Journal of Clinical and Experimental Hypnosis

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/nhyp20>

### Hypnotic Approaches for Alopecia Areata

Ria Willemsen<sup>a</sup> & Johan Vanderlinden<sup>b</sup>

<sup>a</sup> Academic Hospital UZ Brussel, Brussels, Belgium

<sup>b</sup> University Psychiatric Center KULeuven, Campus Kortenberg, and Catholic University of Leuven, Belgium  
Published online: 27 Oct 2010.

To cite this article: Ria Willemsen & Johan Vanderlinden (2008) Hypnotic Approaches for Alopecia Areata, International Journal of Clinical and Experimental Hypnosis, 56:3, 318-333, DOI: [10.1080/00207140802041942](https://doi.org/10.1080/00207140802041942)

To link to this article: <http://dx.doi.org/10.1080/00207140802041942>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly



# HYPNOTIC APPROACHES FOR ALOPECIA AREATA

RIA WILLEMSSEN<sup>1</sup>

*Academic Hospital UZ Brussel, Brussels, Belgium*

JOHAN VANDERLINDEN

*University Psychiatric Center KULeuven, Campus Kortenberg, and  
Catholic University of Leuven, Belgium*

**Abstract:** Alopecia areata (AA) is an autoimmune disease leading to loss of scalp hairs. The disease seems triggered by stress. Data on the possibility of using hypnotherapy in the treatment of AA are very limited. Twenty-eight patients with extensive AA, all refractory to previous conventional treatment, were treated with hypnosis at the Academic Hospital UZ Brussel, Brussels, Belgium. This paper describes in detail the authors' hypnotherapeutic approach combining symptom-oriented suggestions with suggestions to improve self-esteem. Twelve out of 21 patients, including 4 with total loss of scalp hair, presented a significant hair growth. All patients presented a significant decrease in scores for anxiety and depression. Although the exact mechanism of hypnotic interventions has not been elucidated, the authors' results demonstrate that hypnotic interventions may ameliorate the clinical outcome of patients with AA and may improve their psychological well-being.

Alopecia areata (AA) is a highly unpredictable, autoimmune skin disease resulting in loss of hair on the scalp and other parts on the body. It occurs in approximately 0.1% to 0.2% of the population. AA usually starts with one or more small, round, smooth bald patches on the scalp. These patches mostly grow back after months. Nevertheless, a minority of 7% to 10% of patients will progress to total scalp hair loss (alopecia totalis, AT) or complete body hair loss (alopecia universalis, AU).

Research in the last few years has led to a better understanding of the pathogenesis of AA. It appears that AA is an organ-specific autoimmune disease mediated by T lymphocytes directed to hair follicles,

Manuscript submitted October 27, 2006; final revision accepted May 9, 2007.

<sup>1</sup>Address correspondence to Ria Willemsen, Department of Dermatology, UZ Brussel, Laarbeeklaan 101 1090 Brussels, Belgium. E-mail: riawil@scarlet.be

especially expressing the T-helper type 1 cytokines (Arca, Musabak, Akar, Erbil, & Tastan, 2004; Madani & Shapiro, 2000; Price, 2003). These excreted cytokines are inhibitors of hair follicle growth and may cause premature cessation of hair growth (Hoffman, Eicheler, Huth, Wenzel, & Happle, 1996). It is assumed that the disorder is caused by a combination of both genetic as well as environmental factors such as stress (Madani & Shapiro).

A number of treatments can induce hair growth in AA but none has been shown to alter the course of the disease (MacDonald Hull, Wood, Hutchinson, Sladden, & Messenger, 2003). Cortisone injections locally into the bare skin patches are mostly effective in milder cases. For extensive AA with more than 50% hair loss, topical immunotherapy is considered to be the most important treatment (Madani & Shapiro, 2000). It involves applying a chemical such as squaric acid dibutylester (SADBE) or diphenylcyclopropenone (DPCP) to the scalp while gradually increasing the concentration leading to an allergic reaction that stimulates hair growth. Approximately 50% to 60% of patients treated with topical immunotherapy will present a renewed growth of scalp hair after about 6 months of treatment. Relapses may occur during or after treatment. Patients with total hair loss are less likely to respond (MacDonald Hull et al., 2003). Recovery from such severe forms of AA is observed in less than 10% of patients.

Preliminary data on a hypnotherapeutic treatment of a large sample of patients with extensive AA were recently published (Willemsen, Vanderlinden, Deconinck, & Roseeuw, 2006) and seem to support the use of hypnosis in the treatment of AA. This paper first presents an overview of psychological factors associated with AA. Next, a hypnotherapeutic management of AA will be demonstrated by means of several case examples together with its results and some critical comments.

### CONTRIBUTION OF PSYCHOLOGICAL FACTORS AND PSYCHOTHERAPY

The influence of psychological factors in the outbreak of the disease is well documented (Gupta & Gupta, 1996; Gupta, Gupta, & Watteel, 1997; Poot, Janne, Tordeurs, Reynaert, & Salomon, 2000). Although the results of some studies have been negative (Picardi & Abeni, 2001; Vandersteen, Boezeman, Duller, & Happle, 1992), other authors demonstrated that acute psycho-trauma or stressful events as well as family problems can precede an outbreak of AA (Gupta & Gupta, 1996; Madani & Shapiro, 2000). In 2001, Picardi and Abeni reviewed all controlled retrospective studies. Five out of eight studies could demonstrate a link between AA and the presence of stressful events in the period 6 months up to 1 year before the outbreak of the disease. Since many studies were characterized by a small sample size, Picardi

and Abeni assumed that only some preliminary evidence exists for an association between stressful events and the onset or exacerbation of alopecia areata. They therefore encouraged further research. Recently, three other studies were published (Brajac, Tkalcic, Dragojevic, & Gruber, 2003; Gulec, Tanriverdi, Duru, Saray, & Akcali, 2004; Picardi et al., 2003). Results of two of these studies (Brajac et al.; Gulec et al.) corroborated the link between AA and stressful events. Brajac et al. compared 45 adults with AA to a control group and showed that the presence of anxiety and stress are risk factors for provoking the disease. In addition, AA tends to be associated with higher levels of avoidance of intimate or attached relationships, high scores on alexithymia, and poor social support (Picardi et al.).

### RELATION BETWEEN AA AND ALEXITHYMIA

Because studies linking AA with emotional stress were unable to reveal univocal results, research has investigated personality factors that make people more prone to develop AA. Alexithymia is the incapacity to experience feelings and to communicate about these feelings. Alexithymic persons show a limited adaptation for emotional regulation and present lower emotional intelligence (Taylor, Bagby, & Parker, 1997). Because of this, they fail to cope with stress. Several authors found a higher prevalence of alexithymia in patients suffering from AA compared to a healthy control group (Cordan Yazici et al., 2006; Picardi et al., 2003; Sayar, Köse, Ebrinç, & Çetin, 2001). The hypothesis of Guilbaud and colleagues is that chronic stress one is not aware of leads to changes in the neuroendocrine-immune system that make alexithymic people more vulnerable to psychosomatic disorders (Guilbaud, Corcos, Hjalmarsson, Loas, & Jeammet, 2003). Alexithymia can more frequently be observed in other psychosomatic skin diseases (Misery & Rousset, 2001), in irritable bowel syndrome, bronchial asthma (Taylor et al., 1997), and cervical neoplasia (Dewaraja et al., 1997; Todarello, Casamassima, Marinaccio, & La Pesa, 1994).

Multiple factors seem to play a role in the etiology of alexithymia including genetic influences, inhibitions in affect development, and neurobiological deficits or variations in brain organization. Some authors consider alexithymia as a way of coping with painful emotions (Elzinga, Bermond, & van Dyck, 2002). A few studies have assessed that severe traumatic experiences, such as physical or sexual abuse, could lead to inhibition of affect development in childhood leading to alexithymic features in adulthood (Honkalampi et al., 2004). Some authors suggest that the development of alexithymia seems connected with disturbances in the emotional atmosphere of the family during childhood, such as harsh discipline and emotional neglect.

Several neurological models for alexithymia have been suggested but the exact underlying neural structure of people with alexithymia still remains to be elucidated (Kano et al., 2003, Taylor & Bagby, 2004). Some research found evidence for a reduced coordination and integration of the specialized activities of the two cerebral hemispheres (Hoppe & Bogen, 1977). Another neurological model for alexithymia correlates it to corpus callosum dysfunction. Because the corpus callosum appears to be necessary for the transfer of more complex information between the hemispheres, there is some indication for reduced callosal function between the right frontal region and the left hemisphere in some alexithymic individuals (Larsen, Brand, Bermond, & Hijman, 2003). Other researchers speculate that alexithymia might involve a deficiency in the activation of the anterior cingulate cortex during emotional processing, suggesting that people with alexithymia have a deficit in the conscious awareness of emotion (Lane, Ahern, Schwartz, & Kaszniak, 1997).

It has been observed that patients with alexithymia present increased basal sympathetic activity and decreased sympathetic reactivity in acute stress situations (Guilbaud et al., 2003). Taylor and Bagby (2004) speculate that parasympathetic nervous influences could contribute to alexithymia. Moreover, some authors found that patients with alexithymia present a decreased cellular-mediated immunity (Dewaraja et al., 1997) or an increased cortisol secretion. One of the hypotheses to explain the relationship with AA can be the fact that hair growth and skin immunity are controlled by nerve fibers. Indeed, immune cells and hair follicle cells possess receptors for neurotransmitters, which are synthesized by neural endings (Misery & Rousset, 2001). These sensory nerves transmit information about the effects caused by environmental stressors to the central nervous system. Accumulating evidence from research data suggests that neurohormones, neurotransmitters, and cytokines released during stress response may also significantly influence the hair-growth cycle (Botchkarev, 2003). Peters, Arck, and Paus (2006) have demonstrated that stress leads to neurogenic inflammation around the hair follicle in mice. This inflammation produces cessation of hair growth and premature regression of the follicle.

## PSYCHOLOGICAL CONSEQUENCES

Besides these conflicting data concerning the eliciting factors of the disease, more consensuses exist regarding the psychological consequences of AA. Many studies demonstrate that patients with AA are seriously affected in their psychological well-being as a consequence of their disease. They present an increased risk for psychiatric disorders such as a major depression, generalized anxiety

disorder, social phobia, or paranoid disorder (Koo, Shellow, & Hallman, 1994; Ruiz-Doblado, Carrizosa, & Garcia-Hernandez, 2003). Gupta, Gupta, and Watteel (1997) found that patients whose AA was exacerbated by stress also had higher depression scores, suggesting that comorbid depression may render the condition more stress reactive.

### PSYCHOPHARMACOLOGICAL APPROACH

In contrast to the comprehensive literature on the results of a conventional treatment of AA, data on outcomes with the use of psychopharmacology are very limited. The beneficial efficacy of the antidepressant drug imipramine was demonstrated in a randomized, placebo-controlled study (Perini et al., 1994). More recently, the beneficial effects of two different SSRIs, citalopram (Ruiz-Doblado, Carrizosa, Garcia-Hernandez, & Rodriguez-Pichardo, 1998) and paroxetine (Cipriani & Perini, 2001), were demonstrated in an open and in a randomized placebo-controlled study, respectively.

### PSYCHOTHERAPEUTIC APPROACH

Data concerning the psychotherapeutic management of AA are even more lacking. Some favorable results were described with insight-oriented psychotherapy (Koblenzer, 1995), family therapy (Poot et al., 2000), and hypnosis (Shenefelt, 2000). Using hypnotherapy, Harrison and Stepanek (1991) treated 5 patients presenting with AU and 2 with extensive AA. This approach resulted in a cosmetic hair regrowth in 1 out of 5 patients only. Teshima, Sogawa, Mizobe, Kuroki, and Nakagawa (1991) treated 11 patients with a therapy-resistant AU with a low dose of an immunosuppressive medication. This medication was combined with relaxation-imagination sessions in 6 patients. The authors observed new hair growth in 5 of the 6 patients treated with this combined treatment, whereas they found only 1 patient with hair growth in the 5 patients treated only with immunosuppressive medication.

Recently, a hypnotherapeutic approach was used at the University of Brussels in 28 patients (10 males, 18 females; age range, 15–66 years; average age, 33.4) with extensive AA, AT, or AU (Willemsen et al., 2006). All were treated in the outpatient clinic of dermatology, UZ Brussel. Inclusion criteria included more than 30% scalp hair loss for at least 3 months duration. Hypnosis was added as a complementary treatment to an earlier unsuccessful conventional treatment or was used as the only treatment. Each patient's psychological well-being was evaluated with the Symptom Check List-90 (SCL-90; Derogatis, 1977), measuring, in addition to a total neuroticism score, eight

different psychological symptoms. The scores on the SCL-90 were compared at the start and at the end of the hypnotic treatment. All responders were followed for at least 6 months. The results of 21 patients, those who completed their treatment, could be analyzed; 7 patients withdrew because of lack of motivation. Twelve patients suffered from an extensive loss of scalp hair (AA), while 9 patients had lost all scalp hair (AT) or scalp as well as body hair (AU). Significant hair growth was observed in 12 patients (57%) after 3 to 8 sessions of hypnotherapy. Moreover, hair growth was observed in 4 patients with AU, a form of AA mostly resistant to treatment. These 4 patients, who had previously failed to respond to conventional therapy, presented complete hair growth on the entire scalp shortly after the start of the hypnotic sessions. Treatment was unsuccessful in 9 patients (43%). Three out of these 9 patients even presented a worsening of their disease during the hypnotic sessions. Two of them were young adults with severe family problems resulting in lots of stress. For all 12 responders, minimal relapses were found at follow-up periods ranging from 4 months to 4 years. Five of them showed a significant relapse.

Our hypnotherapeutic approach significantly improved the psychological well-being of our patients. The data of SCL-90 subscales could be analyzed in 17 of the 21 patients. After treatment, all patients presented a statistically significant lower score for anxiety and depression as well as a lower total SCL-90 score.

In sum, the hypnotherapeutic approach resulted in significant scalp-hair growth in 12 of the 21 patients including 4 with AU, which is mostly refractory to treatment. All patients presented a significant decrease in their scores for anxiety and depression.

## HYPNOTHERAPEUTIC APPROACH

In the next part, we describe the different hypnotherapeutic ingredients and demonstrate our approach with some case examples. Hypnotic sessions were held every 2 or 3 weeks. All patients were asked to practice their self-hypnosis exercises at least twice a week.

### *Induction*

Hypnosis was introduced with suggestions of relaxation. We asked the patients to concentrate on their quiet breathing and to observe other physical sensations. Next, the patient was invited to observe and to focus on the most relaxed part of his or her body and to extend this feeling to other body parts. After this hypnotic induction, patients were invited to imagine a place where they felt safe and secure.



### *Symptom-Oriented Suggestions*

First, we offered the patients a possible explanation of the origin of the AA. We explained to them that in AA the affected hair follicles are mistakenly attacked by lymphocytes of their own immune system, resulting in an arrest of the hair growth. In a second step, different kinds of symptom-oriented suggestions were proposed for correcting this immune deviation.

*Suggestions for vasodilatation.* Patients received suggestions to imagine the healing effects of the sun on the skin of the scalp. We asked them to feel the rise in scalp temperature leading to vasodilatation of all blood vessels. We gave the suggestion that fresh blood would flow to all hair follicles leading to a reduction of inflammation around the hair follicles.

*Imagining gardening.* Patients were told that the land must be free from weeds before new plants can grow. New plants need water and sunlight. For this, patients were invited to imagine a garden and to garden in it.

*Tree metaphor.* Suggestions were given to choose a big old tree and to imagine putting their arms around it and feeling its strength. We suggested that patients imagine becoming a part of this tree and see or feel how their roots enter deeply in the ground to absorb everything that they need to grow as firmly and as big as the tree. We invited them to explore those ingredients in the ground that could help them (vitamins, minerals, water, but also self-acceptance, self-confidence) to develop such beautiful leaves as those in the big old tree.

*Personal image.* Patients were encouraged to find an additional personal metaphoric or symbolic image of their growing hairs.

*Healing imagery.* Patients were invited to explore all possible resources within their inner minds that could help them to heal their bodies. Next, the patients were asked to visualize, to feel, or to hear this healing energy and to direct it to their scalp. Finally, they were invited to imagine that this healing energy was able to ameliorate the immune deviation. We asked patients to imagine the healing energy working on the hair follicles while stimulating the hair growth.

*Mindful meditation.* A useful alternative approach of this healing hypnotic metaphor can be found in the practice of the mindful meditation of John Kabat-Zinn, which is mainly based on awareness. We invited our patients to extend their awareness from their respiration to their bodies as a whole and to feel the breathing of their entire skin surrounding their whole body (Kabat-Zinn et al., 1998). We asked them to observe the particular feeling of the waves of breathing, going in and out, across the skin itself, and to imagine the intimate contact of their mind with their skin. We suggested that patients direct healing

energy to their own skin just by breathing in and out and by bringing loving kindness and acceptance to those regions of the skin that were inflamed and stressing them the most, such as their scalp.

#### *Suggestions to Improve Self-Esteem*

Many patients reported shame and embarrassment because of their hair loss. Some showed symptoms of social phobia or agoraphobic reactions (such as avoiding public places). In these patients, ego-strengthening suggestions were added to the symptom-oriented approach. They were asked to remember a past peak experience with regard to their self-esteem. Next, this feeling was used as an anchor. Patients were asked to imagine behaving with less shame to a specific stressful event or situation in the future. This way, hypnotic suggestions were also aimed at decreasing the negative psychological consequences of the disease, such as feeling ashamed, having low self-esteem, being anxious in public places, etc.

#### *Suggestions for Alexithymic Patients*

Patients with alexithymic characteristics need to recognize and to connect emotions with their affective responses and bodily sensations. We offered them an affect bridge and invited them to remember a moment in the past when they had felt happiness and joy but also sorrow, anxiety, or anger. Moreover, we asked them to try to connect these feelings with bodily sensations. Finally, patients were invited to build a communication with their scalp and to relate these messages with bodily sensations and emotions.

### CASE ILLUSTRATIONS

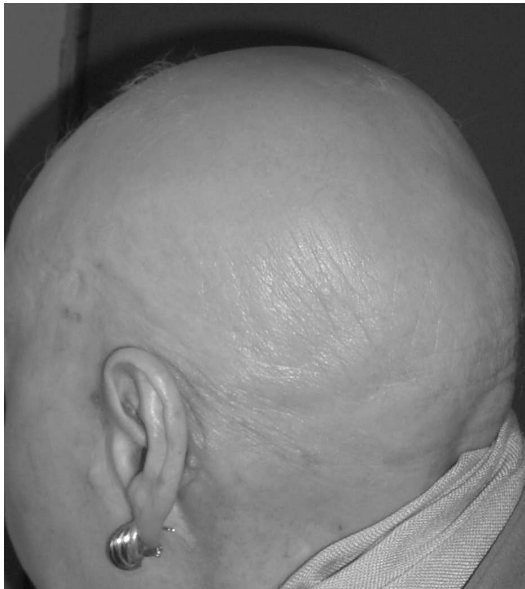
#### *Hypnosis as a Means of Relaxation and a Symptom-Oriented Approach*

*Case 1: A woman who was upset by the failure of her conventional treatment.* A woman, 66 years of age, presented her first AA outbreak 8 years ago. She perceived this event as a consequence of a very painful divorce. Recently, when she was confronted with the divorce of her daughter, she felt very tense again. A new outbreak of AA resulted this time in AT. She was treated with local conventional treatment for 6 months but unfortunately she had to stop this treatment because of a severe local itching and painful allergic reaction on the scalp. The failure of this treatment, which had been her last hope, made her very upset. She felt continuously stressed and presented with a sleep disorder. Finally, she was referred for hypnosis. Hypnosis was induced by means of relaxing suggestions. After hypnotic induction, we asked her to imagine herself being on a nice and quiet beach at the sea. The patient was invited to feel the warmth of the sun on her scalp, and meanwhile it was suggested that this feeling would result in an enhancement of

the scalp blood flow. We asked her to visualize her empty hair follicles and to imagine new hair growth on her scalp. After four sessions, the beginning of growth of tiny vellus hairs all over the scalp was observed (Figure 1), resulting in a generalized new hair growth after only a few more sessions (Figure 2).

*Hypnotherapy with Metaphorical Suggestions for Hair Growth*

**CASE 2: The plumber with crushed tubes.** A man with AU working as a plumber was asked, while in a hypnotic state, to create a metaphorical image to stimulate his hair growth. He imagined his scalp containing a complicated construction of different kinds of tubes bringing water to his empty hair follicles. At the start of the sessions, he noticed that many tubes were injured leading to metal fatigue. With this image, the patient was expressing his feelings of being offended by his mother and other people. In the next hypnotic session, he spontaneously started to replace injured tubes with new ones. This adaptation would enable him to protect himself from future insults. After this session, he spontaneously mentioned that he had achieved more will power and



**Figure 1.** Case 1: A 66-year-old woman with alopecia universalis. Regrowth of vellus hair from fourth hypnotic session. No other treatment was used. Reprinted from *Journal of American Academy of Dermatology*, Vol. 55, No. 2, R. Willemsen, J. Vanderlinden, A. Deconinck, & D. Roseeuw, "Hypnotherapeutic management of alopecia areata," 233–237, Copyright 2006, with permission from the American Academy of Dermatology, Inc.



**Figure 2.** Case 1: Evolution to generalized hair regrowth. Reprinted from *Journal of American Academy of Dermatology*, Vol. 55, No. 2, R. Willemssen, J. Vanderlinden, A. Deconinck, & D. Roseeuw, "Hypnotherapeutic management of alopecia areata," 233–237, Copyright 2006, with permission from the American Academy of Dermatology, Inc.

felt assertive. A few weeks later, tiny vellus hairs appeared on his beard and the pubic parts of his body.

#### *Hypnosis With Suggestions for Ego Strengthening*

**CASE 3: The young man with feelings of guilt and social phobia.** A man, 25 years of age, presented with AA a few weeks after the sudden death of his father. The latter died unexpectedly of a heart attack a few hours after a severe quarrel between this young man and his mother in the presence of the father. For this reason, the man felt very guilty about his father's death. At the same time, he became gradually more and more ashamed because of the ongoing loss of his eyebrows, resulting in the avoidance of social contacts.

During hypnosis, he demonstrated an enormous capacity for creative imagination. At first, we offered him an imaginary farewell ceremony to help him to better cope with the death of his father. After this session, he told us that his feelings of guilt had almost disappeared. In the next session, we tried to teach him to deal better with the curiosity of strangers concerning the loss of his eyebrows. During the

hypnotic state, he was invited to imagine this stressful situation and then was asked to react to these remarks in a direct and assertive way. He succeeded in integrating this new assertive behavior into his daily life and consequently his interpersonal contacts improved. He started to practice sports again. Finally, he went again to the sauna with a friend. As of today, all his social phobic symptoms have disappeared. This AA patient improved significantly on all psychological measures, but, unfortunately, new hair growth did not occur.

### *Hypnosis as a Future-Oriented Fantasy*

*CASE 4: The woman with low self-esteem.* A 32-year-old female product manager in a pharmaceutical company was suddenly told that she would be fired and hence lose her job. The patient was completely overwhelmed by this bad news. Two months later, a rapidly extending and therapy-resistant AA appeared. Meanwhile, the patient had become pregnant. First, she received three sessions of hypnotic relaxation, in which she imagined herself lying on a quiet beach. It was suggested to her to focus on the warmth of the sun on her scalp, while her blood flow increased and brought "new and healing energy" to her bald areas. After only three sessions, complete new hair growth was obtained. A few months later, a relapse was noticed when she planned to apply for a new job. She received hypnotherapy for two more sessions. By means of finger signals, she indicated that "more self-confidence" would help her hair to grow back. Subsequently, we invited her to imagine her future solicitation for a new job. During this future-oriented fantasy, the patient was able to observe herself while staying quiet and feeling comfortable during the whole conversation. Afterward, she succeeded remaining calm and quiet during the real application and received the new job. In the next month, all her hair grew back.

## DISCUSSION

In this paper, we described in detail our hypnotherapeutic approach in AA together with its results. We realize that the interpretation of our results is difficult because most of the patients received hypnosis in addition to another treatment due to ethical considerations. Although the efficacy of hypnosis for AA is still controversial, we consider our results as very encouraging (Willemsen et al., 2006). Hair growth was observed in severe forms of AA that are mostly resistant to treatment, while full recovery from severe AA forms is unusual. Moreover, the results of the questionnaire (SCL-90) in our study also showed a significant improvement of the psychological well-being of our patients. They reported less depressive feelings and anxiety. These findings were supported by the subjective stories of our patients. On the other hand, our preliminary data could also indicate some limitations

of the hypnotic approach. First of all, hypnosis was not helpful for 2 adolescents who presented an extension of their hair loss leading to total baldness. Both were confronted with severe conflicts in their family of origin. Some authors consider difficulties in the separation-individuation process between parents and children as the most stressful events in infantile alopecia (Andreoli et al., 2001). Maybe hypnosis combined with a family-oriented treatment would have been more appropriate for this kind of patient. Second, our preliminary results demonstrate that a limited number of hypnotic sessions do not seem to prevent future outbreaks or relapses of the disease. This finding suggests that probably a longer follow-up of these patients is needed. Meanwhile, the patients must be encouraged to go on with the use of hypnotic suggestions—even after hair growth—to prevent future relapses of this treatment-resistant disease. We plan to study this hypothesis in the near future. Finally, we must raise the question of how the healing mechanism of hypnosis in AA can be elucidated or understood. Using thermography, Teshima and colleagues (1991) detected that an increase in blood flow as well as a rise in the scalp's skin temperature was associated with the mental visualization of a better blood flow by patients. Later, a study by Claudatus, Pugliese, and d'Ovidio (2001) corroborated these findings. These authors also used thermography in 12 treatment-resistant patients with AA, AT, or AU who were treated with a daily visualization/imagination hypnosis program. The researchers could demonstrate a better blood flow surrounding the hair follicles together with new hair growth. This preliminary research suggests that the healing mechanism of hypnosis could be based on the autonomic innervation of the scalp, leading to vasodilatation and an enhancement of blood flow caused by suggestions of warmth and sun on the scalp.

In addition to this hypothesis, we assume that hypnosis could lead to a change in cytokine expression by lymphocytes leading to a local immuno-modulation. Unfortunately, until today, the influence of hypnotic interventions on T-cell activation and cytokine expression has only been studied in blood samples. Wood and colleagues (2003) examined 7 healthy, highly hypnotizable volunteers during three 1-day sessions. Hypnotic intervention entailed a standardized induction, suggestions for ego strengthening and optimally balanced functioning of the immune and neuro-endocrine systems. Blood samples were analyzed for T-cell activation and intracellular cytokine expression and compared with hypothalamo-pituitary-adrenal (HPA) axis mediators. Wood et al. noted statistically significant immunological effects following hypnotic intervention such as altered T-cell responses with significant changes in cytokine expressions. T-cell activation response was positively correlated with changes in HPA mediators. Wood's observation on the effect of hypnosis on cytokine expression of T-cells could be

relevant to the beneficial effect of hypnosis in AA. Recent studies have suggested that cytokines play a critical role in the pathophysiology of AA (Arca et al., 2004; Teraki, Imanishi, & Shiohara, 1996). The effect of hypnosis on local immunity in skin diseases and specifically in AA deserves further exploration and study. Our study did not clarify if alexithymia is a predictor of treatment outcome in patients with AA. This will be a topic of our future research.

#### REFERENCES

- Andreoli, E., Mozetta, A., Foglio Bonda, P. G., Provini, A., Cacciaguerra, G., & Paradisi, M. (2001, March). *Types of stress in infantile alopecia*. Presentation 9th International Congress European Society of Dermatology and Psychiatry, Madrid, Spain.
- Arca, E., Musabak, U., Akar, A., Erbil, A. H., & Tastan, H. B. (2004). Interferon-gamma in alopecia areata. *European Journal of Dermatology*, 14, 33–36.
- Botchkarev, V. A. (2003). Stress and the hair follicle: Exploring the connections. *American Journal of Pathology*, 162, 709–712.
- Brajac, I., Tkalcic, M., Dragojevic, D. M., & Gruber, F. (2003). Roles of stress, stress perception and trait-anxiety in the onset and course of alopecia areata. *Journal of Dermatology*, 30, 871–878.
- Cipriani, R., & Perini, I. G. (2001). Paroxetine in alopecia areata. *International Journal of Dermatology*, 40, 600–601.
- Claudatus, J., Pugliese, S., & d'Ovidio, R. (2001). Alopecia areata. SyM a new approach to therapy and understanding. Presentation European Academy of Dermatology and Venereology. *Journal of the European Academy of Dermatology*, 15(Suppl 2), 254.
- Cordan Yazici, A., Basterzi, A., Tot Acar, S., Ustünsoy, D., İkizoglu, G., Demirseren, D., et al. (2006). Alopecia areata and alexithymia. *Turkish Journal of Psychiatry*, 17, 101–106.
- Derogatis, L. R. (1977). *SCL-90: Administration, scoring, and procedures manual for the revised version*. Baltimore: Johns Hopkins University School of Medicine Clinical Psychometrics Research Unit.
- Dewaraja, R., Tanigawa, T., Araki, S., Nataka, A., Kawamura, N., Ago, Y., et al. (1997). Decreased cytotoxic lymphocyte counts in alexithymia. *Psychotherapy and Psychosomatics*, 66, 83–86.
- Elzinga, B. M., Bermond, B., & van Dyck, R. (2002). The relationship between dissociative proneness and alexithymia. *Psychotherapy and Psychosomatics*, 7, 104–111.
- Guilbaud, O., Corcos, M., Hjalmarsson, L., Loas, G., & Jeammet, P. (2003). Is there a psychoneuroimmunological pathway between alexithymia and immunity? Immune and physiological correlates of alexithymia. *Biomedicine and Pharmacotherapy*, 57, 292–295.
- Gulec, A. T., Tanriverdi, N., Duru, C., Saray, Y., & Akcali, C. (2004). The role of psychological factors in alopecia areata and the impact of the disease on the quality of life. *Internal Journal of Dermatology*, 43, 352–356.
- Gupta, M. A., & Gupta, A. K. (1996). Psychodermatology: An update. *Journal of the American Academy of Dermatology*, 34, 1030–1046.
- Gupta, M. A., Gupta, A. K., & Watteel, G. N. (1997). Stress and alopecia areata : A psychodynamic study. *Acta Dermato- Venereologica*, 77, 296–298.
- Harrison, P. V., & Stepanek, P. (1991). Hypnotherapy for alopecia areata. *British Journal of Dermatology*, 124, 511.
- Hoffman, R., Eicheler, W., Huth, A., Wenzel, E., & Happle, R. (1996). Cytokines and growth factors influence hair growth in vitro: Possible implications for the pathogenesis and treatment of alopecia areata. *Archives of Dermatologic Research*, 288, 153–156.
- Honkalampi, K., Koivumaa-Honkanen, H., Antikainen, R., Haatainen, K., Hintikka, J., et al. (2004). Relationships among alexithymia, adverse childhood experiences,

- sociodemographic variables, and actual mood disorder: A 2-year clinical follow-up study of patients with major depressive disorder. *Psychosomatics*, 45, 197–204.
- Hoppe, K. D., & Bogen, J. E. (1977). Alexithymia in twelve commissurotomized patients. *Psychotherapy and Psychosomatics*, 28, 148–155.
- Kabat-Zinn, J., Wheeler, E., Light, T., Skillings, A., Scharf, M. J., Cropley, T. G., et al. (1998). Influence of a mindfulness meditation-based stress reduction intervention on rates of skin clearing in patients with moderate to severe psoriasis undergoing phototherapy (UVB) and photochemotherapy (PUVA). *Psychosomatic Medicine*, 60, 625–632.
- Kano, M., Fukudo, S., Gyoba, J., Kamachi, M., Tagawa, M., Mochizuki, H., et al. (2003). Specific brain processing of facial expressions in people with alexithymia: An H2 15O-PET study. *Brain*, 126, 1474–1484.
- Koblenzer, C. S. (1995). Psychotherapy for intractable inflammatory dermatoses. *Journal of the American Academy of Dermatology*, 32, 609–612.
- Koo, J. Y. M., Shellow, W. V. R., & Hallman, C. P. (1994). Alopecia areata and increased prevalence of psychiatric disorders. *International Journal of Dermatology*, 33, 849–850.
- Lane, R. D., Ahern, G. L., Schwartz, G. E., & Kaszniak, A. W. (1997). Is alexithymia the emotional equivalent of blindsight? *Biological Psychiatry*, 42, 834–844.
- Larsen, J. K., Brand, N., Bermond, B., & Hijman, R. (2003). Cognitive and emotional characteristics of alexithymia: A review of neurobiological studies. *Journal of Psychosomatic Research*, 54, 533–541.
- MacDonald Hull, S. P., Wood, M. L., Hutchinson, P. E., Sladden, M., & Messenger, A. G. (2003). British Association of Dermatologists. Guidelines for the management of alopecia areata. *British Journal of Dermatology*, 149, 692–699.
- Madani, S., & Shapiro, J. (2000). Alopecia areata update. *Journal of the American Academy of Dermatology*, 42, 549–566.
- Misery, L., & Rousset, H. (2001). Is alopecia areata a psychosomatic disease? *Revue de Medecine Interne*, 22, 274–279.
- Perini, G., Zara, M., Cipriani, R., Carraro, C., Preti, A., Gava, F., et al. (1994). Imipramine in alopecia areata: A double-blind, placebo-controlled study. *Psychotherapy and Psychosomatics*, 61, 195–198.
- Peters, E. M., Arck, P. C., & Paus, R. (2006). Hair growth inhibition by psychoemotional stress: A mouse model for neural mechanisms in hair-growth control. *Experimental Dermatology*, 15, 1–13.
- Picardi, A., & Abeni, D. (2001). Stressful life events and skin diseases: Disentangling evidence from myth. *Psychotherapy and Psychosomatics*, 70, 118–136.
- Picardi, A., Pasquini, P., Cattaruzza, M. S., Gaetano, P., Baliva, G., Melchi, C. F., et al. (2003). Psychosomatic factors in first-onset alopecia areata. *Psychosomatics*, 44, 374–381.
- Poot, F., Janne, P., Tordeurs, D., Reynaert, C., & Salomon, V. (2000). Psychosomatics and dermatology: Comparison between objective data and subjective impressions given by patients and dermatologists. *Dermatology and Psychosomatics*, 1, 19–26.
- Price, V. H. (2003). Therapy of alopecia areata: On the cusp and in the future. *Journal of Investigative Dermatology Symposium Proceedings*, 8, 207–211.
- Ruiz-Doblado, S., Carrizosa, A., & Garcia-Hernandez, M. J. (2003). Alopecia areata: Psychiatric comorbidity and adjustment to illness. *International Journal of Dermatology*, 42, 434–437.
- Ruiz-Doblado, S., Carrizosa, A., Garcia-Hernandez, M. J., & Rodriguez-Pichardo, A. (1998). Selective serotonin re-uptake inhibitors (SSRIs) and alopecia areata. *International Journal of Dermatology*, 38, 796–800.
- Sayar, K. O., Köse, S., Ebrinç, S., & Çetin, M. (2001). Hopelessness, depression and alexithymia in young Turkish soldiers suffering from alopecia areata. *Dermatology and Psychosomatics*, 2, 12–15.
- Shenefelt, P. D. (2000). Hypnosis in dermatology. *Archives of Dermatology*, 136, 393–399.
- Taylor, G. J., & Bagby, M. R. (2004). New trends in alexithymia research. *Psychotherapy and Psychosomatics*, 73, 68–77.



- Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (1997). *Disorders of affect regulation. Alexithymia in medical and psychiatric illness*. Cambridge, UK: Cambridge University Press.
- Teraki, Y., Imanishi, K., & Shiohara T. (1996). Cytokines in alopecia areata: Contrasting cytokine profiles in localized form and extensive form (alopecia universalis). *Acta Dermato-Venereologica*, 76, 421–423.
- Teshima, H., Sogawa, H., Mizobe, K., Kuroki, N., & Nakagawa, T. (1991). Application of psychoimmunotherapy in patients with alopecia universalis. *Psychotherapy and Psychosomatics*, 56, 235–241.
- Todarello, O., Casamassima, A., Marinaccio, M., & La Pesa, M. W. (1994). Alexithymia, immunity and cervical intraepithelial neoplasia: A pilot study. *Psychotherapy and Psychosomatics*, 61, 199–204.
- Vandersteen, P., Boezeman, J., Duller, P., & Happel, R. (1992). Can alopecia areata be triggered by emotional stress? *Acta Dermato-Venereologica*, 72, 279–280.
- Willemsen, R., Vanderlinden, J., Deconinck, A., & Roseeuw, D. (2006). Hypnotherapeutic management of alopecia areata. *Journal of the American Academy of Dermatology*, 55, 233–238.
- Wood, G. J., Bughi, S., Morrison, J., Tanavoli, S., Tanavoli, S., & Zadeh, H. H. (2003). Hypnosis, differential expression of cytokines by T-cell subsets, and the hypothalamo-pituitary-adrenal axis. *American Journal of Clinical Hypnosis*, 45, 179–196.

### Hypnosetherapeutische Ansätze bei Alopecia Areata

Ria Willemsen und Johan Vanderlinden

**Zusammenfassung:** Bei Alopecia Areata (AA) handelt es sich um eine Autoimmunerkrankung in deren Folge die Kopfhare ausfallen. Diese Erkrankung scheint durch Stress ausgelöst zu werden. Es gibt nur wenig Befunde bezüglich des potentiellen Einsatzes von Hypnosetherapie bei der Behandlung von AA. 28 Patienten mit ausgeprägter AA, alle nicht auf vorherige Behandlung ansprechend, wurden an der Freien Universität Brüssel (Belgien) mit Hypnosetherapie behandelt. Dieser Artikel geht im Detail auf den hypnosetherapeutischen Ansatz der Autoren ein, bei dem symptomorientierte Suggestionen mit Suggestionen zur Förderung des Selbstwertgefühls kombiniert wurden. 12 von 21 Patienten, darunter 4 mit vollständigem Haarverlust, wiesen signifikantes Haarwachstum auf. Alle Patienten zeigten eine signifikante Reduktion der Werte von Angst und Depression. Obwohl die genauen Mechanismen der hypnotischen Interventionen nicht klar sind, zeigen die Resultate dass hypnotische Interventionen die Beschwerden von Patienten mit AA reduzieren und ihr psychologisches Wohlbefinden verbessern können.

RALF SCHMAELZLE

University of Konstanz, Konstanz, Germany

### Les approches hypnotiques pouvant soulager l'alopecie en aires

Ria Willemsen et Johan Vanderlinden

**Résumé:** L'alopecie en aires (AA) est une maladie auto-immune entraînant la perte des cheveux. Le stress semble être la cause de cette maladie. Les données existantes sur la possibilité d'utiliser l'hypnothérapie dans le traitement de l'AA sont très limitées. Vingt-huit patients atteints d'AA

avancée, tous réfractaires aux traitements classiques, ont été traités par hypnose à l'Université libre de Bruxelles (Belgique). Cet article donne une description détaillée de l'approche hypnothérapeutique des auteurs, laquelle combine des suggestions axées sur les symptômes avec d'autres suggestions visant à améliorer l'estime de soi. Douze des 21 patients, y compris 4 ayant perdu tous leurs cheveux, ont présenté une repousse capillaire notable. Tous les patients ont montré une baisse significative de leur anxiété et de leur dépression. Bien que le mécanisme exact des interventions hypnotiques n'ait pas été élucidé, les résultats obtenus par les auteurs démontrent que les interventions hypnotiques peuvent améliorer l'avantage clinique et le bien-être psychologique des patients atteints d'AA.

JOHANNE REYNAULT

*C. Tr. (STIBC)*

### Enfoques hipnóticos para la alopecia areata

Ria Willemsen y Johan Vanderlinden

**Resumen:** La alopecia areata (AA) es una enfermedad autoinmunitaria del pelo que conduce a la pérdida de pelos en el cráneo. Parece ser que el estrés provoca la enfermedad. Hay pocos datos sobre la posibilidad de usar hipnoterapia en el tratamiento de AA. Tratamos a 28 pacientes con AA extenso, todos refractarios al tratamiento convencional previo, en la Universidad Libre de Bruselas, Bélgica. Este trabajo describe en forma detallada el enfoque hipnoterapéutico de los autores, combinando sugerencias enfocadas en los síntomas con sugerencias para mejorar la auto-estima. Doce de 21 pacientes, incluyendo 4 con pérdida total de pelo en la cabeza, mostraron un crecimiento significativo de pelo. Todo los pacientes presentaron una disminución significativa en puntuaciones de ansiedad y depresión. Aunque no ha se elucidado el mecanismo exacto de las intervenciones hipnóticas, los resultados demuestran que las intervenciones hipnóticas pueden mejorar el resultado clínico de pacientes con AA y su bienestar psicológico.

ETZEL CARDEÑA

*Lund University, Lund, Sweden*