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OPINION ARTICLE

The Emotional Impact of Skin Diseases☆

El impacto emocional de la enfermedad dermatológica

A. Guerra-Tapia,[a,*] Á. Asensio Martínez,[b] J. García Campayo[c]

[a] *Departamento de Medicina, Universidad Complutense de Madrid. Servicio de Dermatología, Hospital Universitario 12 de Octubre, Madrid, Spain*
[b] *Departamento de Psicología y Sociología, Universidad de Zaragoza y RedIAPP (Instituto de Salud Carlos III), Zaragoza, Spain*
[c] *Hospital Universitario Miguel Servet, Zaragoza, Spain*

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> ''We may expect [physiology and chemistry] to give the most surprising information and we cannot guess what answers it will return in a few dozen years to the questions we have put to it. They may be of a kind that will blow away the whole of our artificial structure of hypothesis...''
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> Sigmund Freud, 1955.

The relationship between the mind and the organs of the body—in our case as dermatologists between the mind and the skin—has been a controversial issue throughout the history of medicine. The lack of tests capable of defining psychodermatological processes, the paucity of pathognomonic signs that can establish a diagnosis with certainty, and the shortage of accredited evidence on the effectiveness of treatments are all factors that have most probably served to strengthen the arguments of those whose attitude to this relationship is one of agnosticism or frank opposition. There is, however, a growing belief that, in predisposed individuals and in the presence of a defective adaptation mechanism, biological and psychosocial factors can trigger a response located in the skin rather than in other organs.

Consequently, best practice in dermatology requires a basic understanding and knowledge of psychiatric dermatology or psychodermatology, a medical subspecialty which focuses on the psychological factors that can play a significant role in the origin, development, and exacerbation of certain skin diseases and on the mental disorders that cause or are associated with others.

The latest Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5)[1] defines a mental disorder as ''a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning''. However, a culturally approved response to a specific event is not considered to constitute a mental disorder. Whatever its cause, the disorder must be deemed to be an individual manifestation of a behavioral, psychological, or biological dysfunction. Thus, deviant behavior or conflicts between the individual and society are not considered to be mental disorders unless the deviance or conflict is a symptom of a dysfunction.

The impact of mental disorders on the health of the population is considerable: they account for 40% of chronic diseases and are the leading cause of years lived with disability. By 2020, depression will be the leading cause of disease

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* Corresponding author.
E-mail address: auroraguerratapia@gmail.com (A. Guerra-Tapia).

in the developed world. In Spain, 9% of the population is currently affected by a mental illness, and more than 15% of the population will have a mental disorder during their lifetime. The mental health conditions that appear with greatest frequency in the general population are the depressive (26.23%) and anxiety (17.48%) disorders.[2]

On the basis of these statistics, we might expect that a similar proportion of patients in the general population with skin disease would be affected by these mental disorders; however, the actual proportion among dermatologic patients is higher than the statistics would suggest. It is estimated that at least 30% of patients with skin diseases have psychological or psychiatric disorders.[3] The incidence of mental disorders is 20% higher in dermatology outpatients than in the general population, and between 20% and 30% higher among dermatology inpatients than in the rest of hospitalized population. In at least one-third of the patients who consult a dermatologist, the outcome of therapy depends to a large degree on the treatment of emotional factors. Patients who develop unsightly skin conditions in puberty may develop introspective and solitary personalities or, in some cases, aggressive and antisocial personalities. Unsightly skin conditions that develop in midlife often trigger anxiety, insecurity, depression, or insomnia in affected individuals and have a negative impact on their school, social, work, family, and sexual lives.[4]

Adjustment and stress related disorders are one of the most significant groups of mental health conditions in dermatology. Stress is defined as a relationship or transaction in which a process of adjustment and interaction between the person and the environment is detrimental to the individual's welfare of and leads to psychological disorders, unhealthy behaviors, and ultimately, disease. Adjustment disorders, which occur when an individual does not respond well to a stressful situation, are also associated with the onset of skin conditions.

DSM-5[1] conceptualizes adjustment disorders as the development of emotional or behavioral symptoms in response to an identifiable stressor or stressors within 3 months of the onset of the stressor. These symptoms or behaviors must be clinically significant, as evidenced by one or both of the following features:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, even taking into account the external context and cultural factors that could influence symptom severity and presentation;
2. Significant impairment in social, occupational or other important areas of functioning.

Moreover, the stress-related disturbance must not meet the criteria for any other mental disorder or merely represent an exacerbation of a preexisting mental disorder. Neither should the symptoms represent normal bereavement nor persist for more than a further 6 months once the stressor, or its consequences, has disappeared.

Psoriasis is the skin disease most commonly associated with psychological stress, considered to be a trigger in over 50% of cases. Moreover, mood disorders, depression, and anxiety are all involved in the etiology and pathogenesis of psoriasis. Psychological and social factors play an important role in the onset, maintenance, and exacerbation of this skin condition in between 40% and 80% of patients.

Another mental disorder closely associated with skin disease is anxiety. The DSM-5[1] defines anxiety as ''excessive worry (apprehensive expectation), occurring on more days than it has been absent for at least 6 months, about a number of events or activities (such as work or school performance)''. When excessive anxiety and worry about a wide range of events or activities persists for more than 6 months and the individual finds it difficult to control this state of constant worry, the condition is defined as generalized anxiety disorder. Atopic dermatitis is the skin disease most closely associated with anxiety, and stress is also involved in the development of this type of eczema. A similar relationship is also observed with seborrheic dermatitis.

Obsessive compulsive disorder (OCD) is defined in the DSM-V[1] as a condition in which the patient has recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress. The individual recognizes that the thoughts, urges, or images are products of his or her own mind. These thoughts, urges impulses, or images are not simply excessive worries about real-life problems and the individual attempts to ignore, suppress, or neutralize them with other thoughts or with compulsions. Compulsions are repetitive behaviors or mental acts that the individual compelled to perform in accordance with certain rules that must be applied strictly in order to prevent or reduce distress. Different types of OCD patients can be distinguished depending on the nature of their obsessions and compulsions. One type is the individual obsessed by a fear of contamination from dirt or germs, who tries to neutralize this fear by repeated washing and scrubbing. Compulsive washing results in skin irritation, wounds, or eczematous dermatitis and can exacerbate existing skin conditions, such as acne or psoriasis. Another OCD type is the scratcher, a person whose compulsion leads to neurotic excoriations, that is, cutaneous lesions caused by repetitive and compulsive scratching of the skin. These patients are continuously trying to remove small irregularities and experience relief upon excoriation. However, the relief is quickly replaced by a feeling of depression or anxiety. Excoriated acne, which is a type of neurotic excoriation, can result in scars that will persist into adult life, impairing the patient's personal and social life.

In the case of trichotillomania, there is some debate about whether this disorder is a clinical entity in its own right, an obsessive-compulsive spectrum disorder, or a symptom of several different psychiatric disorders. It is currently classified as an impulse control disorder. Affected patients repeatedly pull out their own hair and this compulsion leads to noticeable hair loss. They experience a growing feeling of tension immediately before plucking the hair or when they attempt to resist the urge, and a feeling of wellbeing, gratification, or relief once they pluck the hair. The disorder causes clinically significant distress and has a negative impact on the individual's social and working life as well as on other important areas of activity.

Depression is one of the diseases most often encountered in the dermatology office. According to DSM-5,[1] people who are depressed have a number of the following symptoms almost every day and most of the day: depressed mood

(feeling sad), markedly diminished interest or pleasure in all or almost all activities, decrease or increase in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, recurrent thoughts of death and/or recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide. Depressive symptoms play a significant role in chronic urticaria and idiopathic pruritus. Pruritus can both cause symptoms of depression and anxiety and also be caused by stress, anxiety, or depression. Conversely, certain skin diseases, such as vitiligo for example, can have a severe psychological impact on the patient and can, with relative ease, lead to depression. In general, the number of indicators of depression observed in most patients with dermatological disorders—such as acne, alopecia, or pigmented lesions—is much higher than in the population as a whole, and the results of quality of life assessments are negative in a high percentage of these patients.[5]

According to the DSM-5,[1] patients with delusional disorders are individuals who hold a false belief not shaken by reasoned arguments for at least one month. However, except for matters directly related to the delusional belief or its ramifications, the psychological and social function of the individual is not markedly impaired and the behavior of these patients is not obviously bizarre. The delusion most often encountered by dermatologists is parasitosis (Ekbom syndrome). Patients with this condition have an unshakeable delusional belief that their skin is infested with parasites. They experience the sensation of the infestation in or on their skin, and may even come to believe that they have seen the parasites, which they may draw or fabricate and bring as specimens to their physician's office.

The DSM-5[1] defines body dysmorphic disorder as a preoccupation on the part of an individual with one or more real or perceived flaws or imperfections in their appearance, which are not apparent or appear of scant importance to observers. This preoccupation causes the individual clinically significant distress or leads to impairment of social, occupational, or other important areas of activity, and is not better accounted for by another mental disorder. These patients are convinced that the people around them are constantly focusing on their defect. The disorder is often associated with depressive and obsessive-compulsive disorders. It is a disorder commonly encountered in dermatology because most of the imaginary flaws or defects involve the skin.

Factitious disorder is defined by the DSM-5[1] as a mental disorder in which the individual falsifies physical or psychological signs or symptoms or induces an injury or illness in association with an identified deception. The person presents himself or herself to others as ill, disabled, or injured without any obvious external reward. The patient seeks to assume the role of a sick person in the absence of any external incentive that might explain such behavior, such as an economic benefit or a desire to avoid legal responsibility or to improve physical wellbeing, as is the case of malingering patients. Patients with factitious disorders seek emotional gains by assuming the role of a sick person (Munchausen syndrome). The factitious disorder most often encountered in dermatology is dermatitis artefacta or factitious dermatitis, a condition in which the patient consciously or unconsciously produces the signs of disease while denying authorship of the self-inflicted damage. While the factitious lesions may mimic those of other skin conditions, they tend to have specific peculiarities, such as very clean edges or a capricious or odd distribution. Moreover, they will generally be located in areas accessible to the patient.

Upon reading these descriptions, it may occur to us to wonder why the skin is so prominently involved—directly or indirectly—in so many mental disorders.

There is, however, no easy answer to that question. The modern hypothesis is that it is the visibility and accessibility of the skin that makes it a target for the attention the mind projects onto it in some patients. There are also pharmacological examples that throw some light on the mind's focus on the skin and the effect of skin conditions on the mind: a mood stabilizer, such as lithium, can stimulate flares of psoriasis and acne in some individuals; isotretinoin can correct exogenous depression triggered by the alterations in body image caused by acne, or may favor the presence of depression in at risk individuals. It is also quite possible that genetic factors modulated by biological or psychosocial factors favor a response located in the skin rather than in another organ. Psychoneuroendocrine immunology, which studies the relationship between cytokines, hormones, and neurotransmitters, attempts to decipher the biological connections that may be involved in these interactions.[6]

In any event, the intervention of a dermatologist is essential in the care and treatment of patients with psychodermatological conditions. Communication plays an important role in the care of these patients. Communication is, in itself, a complex process that largely determines the quality of the relationship between patient and physician, influencing the patient's health, adherence to treatment, and satisfaction with treatment. Communication tools are therefore a crucial component of the dermatology curriculum.

It is also essential that dermatologists use psychotropic drugs in the management of these conditions and become familiar with all aspects of their application (pharmacology, dosage, interactions, adverse effects, impact on pregnancy, and breastfeeding, etc.), without overstepping the indistinct line separating the dermatologists' sphere of activity from what falls beyond their competence and comes, rather, under the purview of the psychiatrist.[7] The criteria for referral of a dermatology patient to a psychiatrist should take into account not only the diagnosis of the disease, but all the pertinent circumstances, including the patient's personality and social situation.

We close this brief reflection, barely an introduction to the topic, with an insight from the renowned dermatologist Rook, who said that in at least half of all cases involving skin conditions the outcome of treatment would be inadequate if psychological factors were not taken into account.

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