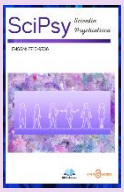

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Basic Concept and Approach to the Psychodermatology Patient

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A B S T R A C T

The association of the nervous system with skin is well documented, with close anatomical, physiological and functional connections between skin and nervous system, known to be ontogenetically related. Psychodermatology is a branch of science that is still underdeveloped, described concerning possible interaction between dermatology and psychiatry. The physician often feels challenges for treating patients with Psychodermatology conditions, due to the difficulty of extracting the medical history, which makes a lot of misunderstanding between clinical symptoms and the diagnostic criteria. The treatment of psychodermatological disorders focuses on elaborating on how an effective approach to the psychodermatology patient can help build such an alliance and improve outcomes. The aim of the approach is to improve function, reducing physical distress, diagnosing and treating depression and anxiety associated with skin disease, managing social isolation, and improving self-esteem of the patient.

1. Introduction

Psychodermatology is a relatively new subspecialty branch of science that is still underdeveloped, as it is consist of interaction between dermatology and psychiatry. More than a third of patients treated with skin disorders have psychiatric problems that underlie their skin condition.[1] Despite the high prevalence of psychodermatological problems in daily practice, it is still not well-recognized or understood by most dermatologists and psychiatrists, because of the lack of understanding and confidence in discussing, diagnosing, and treating the patients.[2]

The skin and the nervous system are both derived from the same embryogenic origin, both come from the same germ layer. The immune, neuroendocrine, and endocrine systems, as well as the skin, interact with each other.[3,4] Contemporary psychosomatic medicine employs biological, psychological, and social concepts at multiple levels, all of which contribute to the pathogenesis across any disease through convoluted interactions over time. This concept seeks to integrate the meaning of the term "psychosomatic" – which implies a link between "psychological" and "physical" situations and is typically defined as a disease caused solely by stress that is completely reversible by removing the source of stress.[4]

In treating psychodermatology disorder, forming a therapeutic relationship with the affected person is critical, especially in terms of empathic and supportive behavior. Dermatologists usually found the issue initially of people with psychodermatology problems. Because these individuals are frequently difficult to treat, they should always be given longer medical appointments or set to begin as the day's last patient.[2] Several reports have been written which identify skin

disorders caused by psychological problems, and significant associations have now been discovered. Although psychiatric and dermatological illnesses have been linked, this article focuses on psychiatric diseases that are associated with and lead to dermatological issues or vice versa, and hoe to approach the patients with such conditions effectively.

Categorization of psychodermatology

Psychodermatology deals with the interaction between the mind and the skin. Psychiatric more focus on the invisible disease on the psyche and dermatology is focused on the visible disease on the skin.[1,3] Connecting the two disciplines requires a complex interaction between the neuroendocrine and immune systems, involving the release of various mediators to play an adverse role in inflammatory skin diseases and psychiatric conditions.[1,4] In more than one third of dermatology patients, effective management of the skin condition involves consideration of associated psychological factors.[1,2] Dermatologists have emphasized the need for psychiatric consultation in general, and psychological factors can be of particular concern in chronic intractable dermatologic conditions such as eczema, prurigo, and psoriasis.[3,4]

The term psychodermatology itself actually covers a broad spectrum, for example from stress that can worsen eczema, or eczema that worsen to stress.[1,4] Among the many conditions, psychodermatology is classified into 4 subcategories: psycho-physiological disorders, primary psychiatric disorders, secondary psychiatric disorders, and skin sensory disorders.[1,3] The subcategories of psychodermatological diseases are not mutually exclusive, for example, acne can be triggered by stress and psycho-physiological conditions, but acne can also cause social anxiety and depression due to blemishes on the patient's skin, which would be categorized as a secondary psychiatric condition.[1,3]

Psycho-physiological disorders

These are purely skin disorders that appear to be exacerbated by stress and/or emotional factors. The most common examples are psoriasis, eczema, and hyperhidrosis. Griesemer *et al.* study shows that emotional triggers various different skin problems, ranging from 0% for nevus and 100% for hyperhidrosis.[1,4]

Primary psychiatric disorders

Condition in which a psychiatric disorder induced signs and symptoms on the skin, with no primary skin lesions. This category is the most typical psychodermatological disorder that has received dermatological attention. Some examples of major psychiatric disorders include trichotillomania, delusional parasitosis, and *neurotic excoriations*.[1]

Secondary psychiatric disorders

These disorders are psychiatric conditions, such as depression, anxiety, and social phobia that are a consequence of skin diseases. Some skin disorders, such as acne and alopecia areata, although not life-threatening, have a severe psychosocial impact on the patient's quality of life.[1,3]

Cutaneous sensory syndrome

This disorder is an abnormal skin sensation in a patient without a primary skin lesion or diagnostic identification that is responsible for the abnormal skin sensation. Different types of sensations may include itching, burning, biting, stinging, or creeping, without a clear etiology.[1,3]

Underlying mental disorders

Psychodermatology disorders can be categorized with underlying psychiatric disorders that contribute to the skin condition. Some dermatologists feel uncomfortable making psychiatric diagnoses in their patients. Fortunately, there are only a few psychiatric diagnoses that can significantly impact the skin. This condition is also usually quite noticeable and difficult to ignore. The four most important points in psychiatric disorders commonly seen in dermatological impact are anxiety, depression, obsessive-compulsive disorder (OCD), and psychosis.[1]

Anxiety

Anxiety is characterized by excessive worry about events or activities that are difficult for the patient to control. Associated symptoms may include frequent urination, shortness of breath, restlessness, irritability, fatigue, difficulty concentrating, muscle tension and sleep disturbances. When a patient presents with a complaint of "stress" or "tension," it is important to investigate the underlying anxiety disorder.[1,4]

Depression

Depression is characterized by a depressed mood, which may be associated with a loss of interest or pleasure. Related symptoms of depression may include changes in appetite, changes in sleep, fatigue, psychomotor retardation or agitation, feelings of hopelessness, helplessness and worthlessness, difficulty concentrating, and recurrent thoughts of death or ideas about death, suicide. These depressive symptoms usually lead to a significant decline in social and occupational functioning.[1,4]

Obsessive-compulsive disorder

OCD is characterized by strong obsessions and compulsions. An obsession refers to persistent and intrusive thoughts that cause a great deal of difficulty which are perceived as foreign and inappropriate to the patient. Usually, patients try to suppress unwanted thoughts through rituals or other behaviors. A urge is defined as a repetitive behavior or physical action that the person feels compelled to perform with or without an obsession. A related sign of OCD, is that the patient has inaccurate insights into his obsessions and compulsions. If the patient has no insight at all of this, a different diagnosis such as delusions or psychotic disorders should be considered.[1,3]

Psychosis

Psychosis is defined by false or delusional ideas that persist in the patient. In pure delusion, the patient has no insight or *insight* that his thoughts or ideas are wrong. By definition, patients with delusions are unable to express their beliefs. Patients with OCD may resemble delusional patients because of their preoccupation with their skin condition. However, the difference is that OCD patients have a more irrational insight into their thoughts and behavior.[1]

Psychodermatology disorders

In psychodermatology disorders, the primary etiology is emotion. Patients will be introspective, aloof, but there are also sufferers who are uncooperative and aggressive. This group includes parasitic delusions, compulsive movements, neurotic excoriation, artificial dermatitis, hyperhidrosis, trichotillomania.

Parasitic delusions

Delusions of parasitosis are mainly found in women, aged over 40 years although sometimes also occur in young children. The patient is sure that his skin is infected by parasites, causing feelings of guilt and fear. Sufferers have an obsessive personality, meaning that fantasies still haunt them. Treatment is usually difficult and can persist for years.[1,3]

Compulsive movements

Movements in this condition include some mechanical manipulation, for example: (a) Licking the lips to the point that the perioral skin appears thickened, scaly, crusty, and hyperpigmented; (b) Digging the fingernails or rubbing the hand; (c) Scraping the scalp, forming nodules (*pickerous nodules*); and (d) Biting or gnawing on the skin.[1,4]

Neurotic excoriations

In some parts of the body, especially on the face, upper arms, and back, excoriations with hemorrhagic or suppurative crusts and cicatrix appear. The lesions were apparently made by the patient himself by scratching them from a a *tic* habits.[1,3]

Artificial dermatitis

Artificial dermatitis is made by the patient himself, by chemical, physical, or mechanical substances,

localized especially on those that reachable by the patient's extremities. This dermatitis has an angular edge. Treatment is a psychiatric approach, as the patients cannot be asked frankly due to emotional problems.[1,4]

Hyperhidrosis

Usually found on the palms of the hands, soles of the feet, and the axillary region without any temperature stimulus. This situation can be accompanied by complications, namely bacterial or fungal infection and a reaction occurs hyperkeratotic.[1]

Trichotillomania

Trichotillomania occurs when the patient pulls hair in one area, such as hair on the head, eyebrows, eyelids, armpits, or pubic area. In children, the pulled hair is then eaten. There are also patients who rolled up their hair between the fingers.[1]

How to approach patient with psychodermatology conditions

Psychodermatology patients often present their own challenges for the treating physician. This is due to the difficulty of extracting the main complaint from the history, causing frustration and sometimes there is also a lot of misunderstanding between clinical symptoms and the diagnostic criteria, making it more difficult to make an accurate decision for the patient. According to the Frontline Medical Communication Journal, there are several possible ways to avoid frustration, namely empathy and expectancy management.[2,4]

Stress reduction is a common approach to treating patients with psychophysiological conditions, such as eczema, hypertrichosis, and acne.[2,3,4] Stress is unavoidable in everyday life and can be caused by relationships, work, children, the death of a family member, or even the death of a pet.[2] However, research has shown that there are several solutions to help patients find ways to control their stress to prevent worsening of their skin condition, include pharmacological and non-pharmacological treatments. If a patient has an underlying anxiety disorder that triggers the skin condition, the first line of pharmacological treatment is an anti-anxiety medication, such as a selective serotonin reuptake inhibitor (SSRI).[2,3] Non-pharmacological treatments include cognitive behavioral therapy or relaxation exercises, such as meditation or yoga. Patients can handle stress better when they adopt a balanced lifestyle that includes exercise, healthy relationships with friends and family, and a fulfilling career.[2]

Primary psychiatric conditions

Patients with primary psychiatric conditions can be the most challenging to manage. In particular, patients with delusional parasitophobia need to be approached differently because they have special needs and lack insight into their condition.[1,2] Showing empathy for a patient's delusions does not mean agreeing with them. Pretending to agree with them can reinforce a fixated idea or behavior. However, it is important to acknowledge the symptoms and let them know that you will work with them to find the cause, even though there may not be an intrinsic skin condition.[2,4]

Secondary psychiatric conditions

The most effective approach for patients with skin conditions that cause psychiatric disorders such as anxiety or depression is to treat the skin disorder with aggressive treatment. Although chronic skin disorders are not life-threatening, they can have a negative impact on the patient's psychosocial, physical, occupational, and quality of life.[4] For example, patients with vitiligo have suffered severe social stigma in certain cultures, discriminated in a marriage, and often referred to as white leprosy. By treating skin disorders aggressively, secondary psychiatric conditions are further improved, as well as expectancy management.[2,3]

Skin sensory disorders conditions

When a patient experiences unpleasant skin sensations, such as itching, burning, or stinging, an

organic etiology for these symptoms must be ruled out (peripheral neuropathy). Therefore, the patient may need a primary care or neurologic evaluation to ensure that there is no underlying condition to warrant treatment, such as diabetes. Assuming no medical condition is causing these symptoms, and the patient has pure skin sensory impairment, several journals suggest the screen for comorbid psychiatric conditions, such as depression or anxiety.[2] Therefore, the basic treatment for this psychotic condition can be to reduce discomfort, especially in patients without comorbid psychiatric conditions, with antihistamines or tricyclic antidepressants. If the patient cannot tolerate these drugs, a trial of SSRIs may be beneficial.[2,4]

2. Conclusion

Psychodermatology has developed as a new subspecialty that has emerged from psychiatry and dermatology. Unfortunately, the relationship between skin disease and mental illness is often underestimated. More than just a cosmetic defect, dermatological disorders are associated with various psychopathological problems that can affect patients, their families, and society together. Increased understanding of the issues, biopsychosocial approaches, and liaison between primary care physicians, psychiatrists and dermatologists can be very useful and highly beneficial to the continuity of therapy. The benefit of complex patient care in conjunction with a psychiatrist is highly recommended.

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