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Pointing the Way
in Psychosomatic Dermatology

Abstracts

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Habit Reversal

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A behavioural approach can be useful in a variety of psychodermatological conditions. A review of the literature in recent years reveals especially the successful use of habit reversal as a behaviour modification technique for the elimination of habitual self-damaging behaviours such as rubbing, picking, and scratching the skin in atopic eczema. The technique can be appropriately incorporated into the management of a variety of abnormal *grooming behaviours,* e.g. neurotic excoriation, and acne excoriee.

Behavioural change requires knowledge – including awareness and understanding – of the behaviour in question, motivation to change, an effective technique, and then, the putting of the technique into practice. Habitual behaviour is characteristically partly unconscious, with the original specific stimulus generalised to a variety of non-specific stimuli, such as circumstances, situations and activities.

Habit reversal requires the behaviour first to be made conscious. This can be achieved using a hand tally-counter to measure the frequency of the behaviour. Behavioural analysis is completed by establishing the antecedents to the habit, the methods used in the behaviour in question, and the consequences of the behaviour. The old undesirable behaviour is now replaced by a new behaviour, which is designed to make the old behaviour impossible to carry out. The new behaviour is practised, and becomes itself a habit – with desirable consequences reinforcing successful behavioural change.

How a Good Treatment for Alopecia Can Improve the Behavior and Psychological Characteristics of Men and Women with Androgenetic Alopecia.

Camacho, Francisco M.

5 years ago we decided to know the behavior and psychical characteristics of the Spanish patients with androgenetic alopecia (AGA), female (FAGA) and male (MAGA), before finasteride was introduced in the treatment of AGA. We reviewed the personal clinical history of 100 of FAGAs and the same number of MAGAs who visited our Trichological Unit from January 1993 to January 1995, when we incorporated a questionnaire on behavior to the clinical history.

With this study we conclude that the frequency of anxiety is similar in FAGAs than in MAGAs (78–41%), although this sign is less important than it seemed; that the aggressiveness was more evident in MAGAs than in FAGAs (22–4%); and that women had more depressive tendencies than men (55–3%). Our results agree with several publications. We explain the last conclusion with the fact that FAGA has a higher social repercussion than MAGA, developing a more important affectation of autoimage and a social behavior known as social phobia.

The portrait of the studied patient with AGA from a psychological point of view was an elusive person who, although came to the office with an accompanying person, normally came alone to the desk or to the examination room, with the exception of depressive people, and, if the companion explained some question in the clinical history, the patient were aggressive with him/her. Many times, the patient complained that a trichogram was performed or she/he was in doubt about its efficacy because it was already performed by the hairdresser's. They usually accepted the prescribed treatment, specially if it was the treatment that they wanted to hear, but 27 FAGAs and 12 MAGAs phoned before the next consultation because they wanted immediate and excellent results. A percentage of them came to the office thinking that surgery would be the solution to their problem. When we had capacity to convince them about our current possibilities, the lost of follow-up was only of 6% in FAGAs and 12% in MAGAs. 41 FAGAs and 84 MAGAs attended to Hair Centers. 94 FAGAs and 88 MAGAs came back to review. 5 FAGAs and 12 MAGAs had not made correctly the treatment. These results pointed out that women are more depressive, meanwhile anxiety, aggressiveness and hostility predominated in men.

Recently, we have performed another study, with the same questionnaire on behavior, although this was prospective, with 100 MAGA and 75 FAGA, 50 premenopausal and 25 postmenopausal, who were treated with finasteride. The premenopausal women treated with finasteride were SAHA syndromes and Adrenal hyperandrogenisms because ovarian hyperandrogenisms were treated by gynecologists. On the other hand, we only treated 25 postmenopausal FAGAs with finasteride because the majority of them were involutive-postmenopausal alopecias (15 cases) and in these cases we know that finasteride does not work because they have not increase of the level of androgens. Consequently we had 3 groups: 100 MAGAs, 50 premenopausal FAGAs and 25 post-menopausal FAGAs. Our results were: at first, depression was most frequent in FAGAs that in MAGAs (80–1%) being more evident in postmenopausal-involutive patients because they did not note any improvement; but in contrast with the previous retrospective study, anxiety (18–65%) and aggressiveness/hostility (2–4%) was also most frequent in FAGAs than in MAGAs. Also 67% of MAGAs and 100% of premenopausal FAGAs clearly improved with treatment, and another 31% of MAGAs were satisfied with the results, but only 36% (9 patients) of postmenopausal patients improved with treatment, although these nine women had had FAGA before menopause with high hormonal serum levels. In the rest of

postmenopausal women only 18% (3 cases) showed improved with 3–5% minoxidil solution.
The portrait of the patient with AGA treated with finasteride changed in relation with the previous study. From a psychological point of view, men and premenopausal women were less elusive and, when they came to the office with an accompanying person, normally he/she did not made opposition to that the accompanying inform or even came with him/her to the examination room, with the exception of 7 postmenopausal women who came alone and were depressives as in the previous study. All of them accepted the treatment prescribed by us once we explained that we already had finasteride. Nobody had attended before to Hair Centers with the exception of 13 postmenopausal women. All of them with exception of a postmenopausal women, very depressive, came back to review, and all of the AGAs performed a biochemical hormonal examination including PSA in men. All of them correctly made the treatment, and nobody phoned asking for a quick improvement, probably because all of them were informed that the first improvement could be note 6 month after the beginning of the treatment, and loss of follow-up was not found.
In conclusion, psychological characteristics of AGA patients have changed since finasteride was introduced because patients noted the improvement and in this way they had a normal behavior, especially in women with previous increase in serum androgen levels. After this experience, we are sure that all patients with AGA must be treated because if not the psychological and social repercussion of their alopecia, as dysmorphophoby, will influence their life-quality and 'familial environment'. And this difference is explained because we now have an excellent treatment for all cases of AGA with increase of androgen serum levels.

Blistered Epidermiolysis. The Difficulty of a Fundamental Delimitation

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Introduction: The body and its surface are the starting place of the internal and external perceptions of every person. The ego is the psychic projection of the surface of the body, and the skin is the system of protection of the individual and the means of exchange with others. When a person has Blistered Epidermiolysis, the skin is damaged to a high degree and this is reflected in a serious alteration of the ego-body relationship proper to children and their process of socialization.
Material and method: Over a 7 year period, 17 babies/children (10 days – 7 years old) suffering from simple and dystrophic Blistered Epidermiolysis and their mothers were interviewed. It was through these psychosomatically directed and semi-directed interviews that attitudes of family rejection and overprotection were detected that influenced the behavioral problems of the baby/child. The successive phases of the illness were studied as well as the feelings and sensations that contributed to the formation of the corporal image, and self-esteem. The importance of the voice as the organizer of corporal space and the delimitation of what is internal and external was observed.
Conclusions: Recognition of the body is a process and must symbolize for each child, the difference between himself and others, between the inside and the outside. This process is seriously interrupted in children with dermatological illnesses which affect great areas of their skin. Voices are the first thing in which children train themselves to perceive differences. The introjection of the voice lived as something pleasant rather than aggressive will be what helps us to conform, to a greater or a lesser degree, a corporal space that allows children with Blistered Epidermiolysis to live within their bodies.

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How to Manage Chronicity in Dermatology

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Most of skin diseases are chronic. Dermatologists are confronted with two principal and indissociable problems linked to chronicity:
– the compliance with treatment,
– the quality of life.
In order to help dermatologists to resolve these problems at best, the author will show the traps of the dermatologist-patient relationship linked to chronicity and indicate different ways of thwarting the latter (how to negotiate a treatment; how to establish a good communication and a motivational approach with the patient).
In that way a true therapeutic alliance will join together dermatologist and patient enabling to improve the compliance with treatment and the quality of life.

Depression in Dermatology

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It has been established that up to 30% of dermatological outpatients are suffering from significant psychiatric problems, the commonest being depression. The depressed dermatological patient never says to the dermatologist, 'I am depressed', but presents with various skin offerings, including generalised pruritus, angioedema and contact dermatitis.
Depression is the commonest psychiatric problem in patients with dysmorphophobia and is also common in patients with delusions of parasitosis. Reactive depression is common patients with eczema, psoriasis, and especially in acne and alopecia areata where important body image areas are involved. Depression may be a clinical feature of some patients with systemic lupus erythematosus and great care must be taken with oral corticosteroids in patients with a past history of bipolar affective disorder.
Depressed patients may be referred to dermatologists by their psychiatric colleagues because of the development, for instance, of acne or psoriasis due to lithium therapy. Whilst most patients given Roaccutane for acne become less depressed as the acne improves, a small proportion of patients can develop profound depression, which can lead to suicide as an idiosyncratic and unforeseeable reaction to the drug. Depression may be severe enough in our patients to lead to suicide. This is more likely in patients with dermatological non-disease, especially with facial symptomatology, and in patients with acne, including acne scarring.

Quality of Life and Quality of Care in Chronic Skin Diseases: Measurement and Applications

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Quality of life reflects patients' subjective evaluation of the impact of a disease and/or treatment on their physical, psychological and social functioning and well-being.
Quality of care reflects the degree to which health services increase the likelihood of desired health outcome. The strong need for the measurement of (cost-) effectiveness of medical interventions and health care, and the demand for health services in chronic skin disease, account for an ever-growing interest in data on quality of life and quality of care.
Quality of life and quality of care are most commonly assessed by the patients. Quality of life by means of generic and/or disease-specific questionnaires. Quality of care, for instance, by measuring patients' subjective evaluation of clinical outcome and the impact of treatment on quality of life, as well as by measuring patients' compliance and satisfaction with dermatological treatment. An overview of current questionnaires and methods will be given.
As an example, a quality-of-care program in chronic skin disease, recently carried out in four European countries, will be described. The program aims at optimal care in the topical treatment of psoriasis patients. It consists of a set of patient-centered interventions, such as disease education, disease-management training and psychological support. 330 patients were included in the study. Research methods will be discussed. The program resulted in a high degree of compliance, a substantial decrease of disease severity, a moderate improvement of quality of life, and a high degree of patient's satisfaction.

Management of the Delusional Patient

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The most common form of delusional disorder seen by dermatologists are patients suffering from somatic delusionals. The delusion often takes the form of a false belief of infestation leading to various attempts by the patient to seek relief including self-mutilation. The challenge facing the dermatologist is the engagement of the patient in a treatment program that may often require a focus on medications that are targeted at the underlying psychopathology rather than the patient's perceived dermatologic condition. Available data on the pharmacologic treatment of delusional disorder suggest that it often responds to serotonin reuptake inhibitors. More recently the availability of 'atypical antipsychotics' (clozapine, olanzapine, risperidone, quetiapine) has offered a new approach to this condition. These drugs differ from older conventional antipsychotics in possessing a lower extrapyramidal side effect liability and having antidepressant properties. These features may be highly desirable in delusional disorder patients given the comorbid depressive elements and lack of insight into their illness. In this presentation, the current understanding of the management of delusional disorder will be reviewed in the context of patients most likely to present to a dermatologist. Also a discussion through case studies of a new pharmacological approach to these disorders involving the combined use of serotonin reuptake inhibitors with atypical antipsychotics will be outlined.

Recent Research in Psychosomatic Dermatology

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In the past two years psychodermatological research showed new methods and new theoretical data on the field of psychosomatic dermatology. Many experimental and controlled studies and new hypotheses were published [Millard, 2000]. The main fields of research have been controlled studies with psychological tests and questionnaires that reflected the importance of psychosocial factors on the different dermatoses [e.g. Picardi et al., 2000].

A prospective study on the influence of chronic stress on children suffering from asthma, published last year in The Lancet [Sandberg et al., 2000], shows that high levels of stress significantly increase the risk of new asthma attacks. The authors conclude that severely negative life events increase the children's risk of asthma attacks over the next few weeks. The same seems to be true for the relationship between dermatological diseases and stress: Another recent study [Kodama et al., 1999] looking for the influence of stress on atopic eczema shows that severe stress leads to significantly more exacerbation. The authors investigated 1,457 patients with atopic dermatitis using a self-developed questionnaire given to patients who experienced the Great Hanshin Earthquake in Japan. Patients were divided into 3 groups according to the severity of damage to their buildings. Exacerbation was found in 38% of patients whose houses were severely damaged, whereas similar exacerbation was seen only in 7% of control patients. Therefore, we can presume that atopic eczema is really exacerbated by stress and the management of stress is an important approach in prevention programs.

The results of Schäfer et al. [2000] indicate that factors other than allergy are responsible for the higher prevalence of atopic eczema in East Germany. Also, dermatological diagnoses like burning mouth syndrome and its psychiatric conditions have been described [Nicholson et al., 2000]. On the other hand, some very interesting methodological investigations (e.g. questionnaires) [Klassen et al., 2000], psychoimmunological and psychophysiological studies came through and showed the clear interaction between the skin immune system and psychological reactions. Moreover there are some studies on life quality in dermatologic patients [Harlow et al., 2000]. The authors demonstrate similaraties for separate diseases and show that they are only slightly lower in ranking than those in hospital-based studies. Some of the most interesting papers will be presented in summary.

Our new journal 'Dermatology + Psychosomatics' is running one year now [Gieler, 2000]. We hope you have already enjoyed it and hopefully it will have a splendid future with the help of all participants of the 9th International Congress on Dermatology and Psychiatry.

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Central Pruritus: Theoretical and Clinical Issues

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Although pruritus is a prominent feature of many skin diseases, it also appears in many other conditions. Among these are cholestasis, uremia, and malignant diseases. It has also been recognized for some years that it can complicate many neurological disorders, such as stroke and multiple sclerosis. Pruritus originating in the central nervous system has also been seen in anorexia nervosa and can be seen as a component of obsessive compulsive disorder. The mechanisms by which central pruritus is mediated are unknown at present. However, recent work on the role of endogenous opioid peptides in pruritus done by Bergasa and Jones as well as a PET scan study of itch by Hsieh, Hagermark, and colleagues will be discussed since they are starting to explore the nature of central pruritus.

Since patients who complain bitterly of pruritus, to the point of developing prurigo nodularis, in the absence of evidence of any skin disease or systemic disorder are among the most difficult for both dermatologists and psychiatrists to treat, case vignettes will be presented illustrating some of the treatment issues.

Trichopsychodermatology

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Currently available reports in the literature suggest that male pattern baldness can be associated with significant impact on quality of life, and often very serious psychological problems [1]. Negative effects include lower self-esteem, perception of physical unattractiveness, depression, emotional distress, greater self-consciousness, anxiety and psychosocial maladjustment. In addition, dissatisfaction with appearance, preoccupation with hair loss, worry about reactions of others, and fear of social teasing have been reported.

Further studies suggest that people's initial impression of men with male pattern baldness are generally less favorable that in men without hair loss. Balding men are viewed as less desirable in a physical, personal and social sense.

On the other hand, Maffei [2] suggests that the presence of a preexisting personality disorder may determine whether a person has a psychological problem with alopecia. The same degree of alopecia will be tolerated differently depending on the preexisting personality or psychological disorder of the balding man. Probably dermatologists would be more helpful if they were aware that patients who present with the physical symptom of androgenetic alopecia may also have preexisting psychopathologic symptoms.

So, the question that arises in front of a patient with male pattern baldness is: Will he be better treated and consequently more satisfied if he receives effective anti alopecia agents as finasteride or get more benefit if he is evaluated and treated for his psychological disorder?

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Psychosomatic Aspects of Psoriasis

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Psychosocial factors have been implicated as being important in the onset and exacerbation of psoriasis in 40–80% of patients. Furthermore, psoriasis patients were more likely to report that psychosocial stress predated the onset and/or exacerbation of their condition in comparison to a wide range of dermatological disorders that are known to be exacerbated by stress, further emphasising the importance of psychosomatic factors in psoriasis. Pruritus is rated as one of the most bothersome symptoms of psoriasis, and there is a direct correlation between pruritus severity and the severity of depression in psoriasis patients. The depressed clinical state has been associated with alterations in the central nervous neuropeptide levels, and it is possible that this plays a role in enhancing pruritus perception in psoriasis. Topical capsaicin, a potent depletor of substance P, is also effective in the treatment of pruritic psoriasis, supporting the role of neuropeptides in psoriasis.

The effect of psoriasis upon the quality of life and the resulting psychosocial disability is often rated to be greater than the physical disability in psoriasis. A recent position paper proposes that a quality of life standard is better than body surface area measurement for delineating psoriasis severity. Furthermore psoriasis has been shown to impact the quality of life of the patient to the same degree as other more life-threatening disorders such as diabetes, heart disease and cancer. The impact of psoriasis upon the quality of life can also result in significant daily stress and greater psychological morbidity for the patient, which in turn can affect the course of the disorder. Comparison of the psychocutaneous characteristics of patients who reported that stress exacerbated their psoriasis (i.e., the high stress reactors or HSR) to the subgroup that reported no significant association between stress and their psoriasis (i.e., the low stress reactors or LSR) revealed that the HSR had more cosmetically disfiguring psoriasis in 'emotionally charged' areas, i.e., their psoriasis was more severe in body regions such as the face, neck, scalp, forearms, hands and genital region in contrast to the LSR. Among the HSR, psoriasis in these regions is more likely to be cosmetically disfiguring and affect socialisation and sexual functioning. As expected, the HSR reported greater psoriasis-related stress than the LSR. The HSR also reported more frequent flare-ups of their psoriasis. It is possible that in some cases, the chronic low-grade stress or daily hassles resulting from having to cope with the impact of psoriasis upon the quality of life can in turn exacerbate the psoriasis. These findings suggest that even clinically mild disease, when cosmetically disfiguring or affecting the genital regions, should be treated aggressively.

The psoriasis should be assessed within a developmental context. In general, patients in the age group between 18 and 45 years experience more frequent problems related to both appearance/socialisation and occupation/finances. The adverse effect upon the quality of life lessens in the over 45 years age group, with a further decline in the over 65 years age group. This most likely reflects the fact that in earlier adulthood, when the individual is first establishing social relationships, entering the workforce and starting their career, the social stigma associated with psoriasis has the greatest impact.

Younger patients with early onset (onset < 40 years age) psoriasis are more likely to have greater genetic susceptibility and tend to experience more severe and recurrent disease. Psychologically, patients with early onset psoriasis (onset < 40 years age) are also likely to have certain personality traits, such as greater difficulties with the expression and assertion of anger. Most of the psoriasis-related stress arises from the social stigma and resultant reactions of people in social situations, and difficulties with assertiveness may render these patients more vulnerable to the psoriasis-related stresses. The clinician should be especially sensitive to this possibly more vulnerable subgroup of patients, who are less likely to readily express or volunteer their feelings. It is important to recognise the presence of depressive disease in psoriasis, which may be primary or secondary to the psoriasis. In a survey of 217 patients, 9.7% of patients reported wishes to be dead and 5.5% reported active suicidal ideation at the time of the study. Suicidal ideation in psoriasis was associated with higher depression scores and higher patient self-ratings of psoriasis severity. In summary, psychosocial factors such as stress plays an important role in the onset or exacerbation of psoriasis and alternately the impact of psoriasis upon the quality of life has been rated as possibly the most distressing feature of the disorder, and can result in significant stress and psychological morbidity for the patient.

School Refusal Among Students with Atopic Dermatitis

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Psychosomatic diseases are often accompanied with psychosomatic diseases in other organs. School refusal is considered to be a psychosomatic disorder in adolescents, and it is an increasing problem in Japan. We have investigated the relationship of atopic dermatitis and school refusal.

1. The ratio of school refusal among outpatients was investigated by a questionnaire. The patients who have been absent from school more than 30 days a year were 10% of junior high school (age 12–15 years) and 17% of senior high school (age 15–18 years). It reveals a higher percentage than the general statistics of the Japanese Ministry of Education.

2. 133 hospitalized school-aged patients were investigated retrospectively. 24 patients had an obvious history of school refusal before admission. Prognoses of dermatitis and social phobia of the patients who have been treated with dermatological and psychosomatic treatment were much better than those of the patients who have been treated with just dermatological treatment.

Atopic dermatitis itself has a high potency to induce school refusal because it disturbs regular sleeping with pruritus and involves going out with disfigurement. However we must be aware that the psychosocial background of school refusal might also aggravate atopic dermatitis.

Depressive Equivalents – Do They Exist? If so, why? And how?

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The mechanisms whereby we cope with stress are determined by the interaction of our inherent physical and personality characteristics, our early life experience and the environmental factors to which we are exposed. Failure of these mechanisms may result in illness – either physical or mental. For some patients, physical illness may serve as a defense against the overt expression of underlying mental illness.

Two very instructive cases will be presented in which profound depression developed, once cutaneous symptoms had resolved with treatment. An attempt will be made to try to understand the underlying mechanisms with a view to enabling early recognition of this possible complication of treatment.

Psychosomatic Disorders and Neurophysiological Parameters in Patients with Severe Forms of Atopic Dermatitis

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We examined the psychic status in 134 patients with severe forms of atopic dermatitis (AD) (74 males, 60 females; mean age 23.1 years); mean SCORAD index was 72.6 ± 3.08. The clinical psychodiagnostic examination was complemented with MMPI-test and STAI; mean Dermatological Life Quality Index was 21.4 ± 0.6. The main therapy in all cases consisted of modern psychotropic drugs, depending on the revealed psychopathological syndrome, in adequate doses and individual combination. Short latency cortical somatosensory evoked potentials (SEPs) was registered before and after treatment (n = 32).

The clinical picture of borderline psychic disorders in most patients (89.2%) with AD were fluctuated about affective, neurotic and supervaluable types. The majority of the demonstrated syndromes were depressive, anxiety-phobic, and neurasthenic ones. In patients with more severe skin lesions the depressive syndrome had higher incidence, than in all others. In all investigated patients the relative amplitudes of the late components of short latency SEPs were significantly increased. Also we observed a reduction of levels of the motor answers and painful sensations, associated by diffuse reduction of levels of sensitivity. After 3–4 weeks of psychotropic therapy appreciable improvement (51.5%) and clinical recovery (34.3%) were observed in 85.8% patients. Mean SCORAD index fell to 26.4±1.8 ($p < 0.001$). DLQI has improved the parameters and to 7.22 ± 0.3 have decreased. Psychopathological symptomatology also dynamically regressed. In parallel, the parameters of cortical SEPs demonstrated a significant tendency to returning to normal values.
Thus, the prevalent psychopathological syndrome in patients with severe AD was the complex anxiety-depressive syndrome. Psychotropic medication in AD is a necessary component in individual therapeutic regimen leading to improvement in efficiency of therapy and quality of life. The record of SEP can be used as a effective method for monitoring of pharmacological activity of psychotropic drugs in AD.

Skin, Self-Damage and Gender – The Unkindest Cut of All

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Deliberate damage to one's own body, without lethal intent is defined as Self Injurious Behaviour (SIB). Socially accepted self induced skin damage, such as tattoos and piercing show equal sex preponderance except for males who have ritualistic group behaviour. Socially tolerated damaging behaviour, such as nail biting, nail and nose picking and hair pulling, progress in a small group to a debilitating illness. Chronic trichotillomania, onycho and rhinotillexomania are all commoner in women. Furthermore, 'acne excoriee des jeunes filles' and their older sisters with so called neurotic excoriations show the same gender emphasis [1]. Even when the primary psychiatric disease is present in others, women are far more likely to exhibit a 'folie a deux' whether they are a relative or just an acquaintance. Covert and denied destructive acts on the skin such as dermatitis artefacta are also predominantly seen in female patients, both adolescents and adults [2].
Female preponderance in the psychodermatoses is a significant finding [3], but so also is the excess of female patients with chronic inflammatory skin disease attending in outpatient clinics. Some of the reasons for this gender difference have been discussed previously and amongst factors considered are the restricted social role of women, their dependence on a relationship, and enforced patriarchal passivity. The role of women in the family as family carer and managers of disease may contribute to their own disease and a retreat into these forms of illness.

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Dimensional Diagnostics in Psychodermatology

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The main requirement for diagnostics and classification systems is the clinical relevance of diagnoses with respect to treatment and prognosis. Various empirical studies showed that classical categorical classification systems of mental disorders do not fulfill this requirement. Diagnostic categories in common classification systems for mental disorders, e.g. DSM-IV and ICD-10 are simply not characterized by a special pathogenesis or particular constellations of conditions as postulated in classical nosology. Categorical classification systems of mental disorders and on that account also classifications of psychodermatological disorders have been established according to botanic classification systems: particular phenomena and signs (in case of plants classification: color and number of petals, stamens etc.; in case of mental disorders classification: psychic and physical phenomena) are the basis for the attribution of the disorder to a particular diagnostic category. It is not surprising that such a classification is of minor value concerning pathogenesis-oriented treatment approaches. No botanist would expect to gain information on the function and origin of a plant purely on the basis of its allocation to a specific classification category. It thus becomes necessary to change the paradigm in diagnostics in order to develop more effective pathogenesis-oriented treatment strategies. A possible alternative to the classical categorical approach may be a dimensional approach. Such diagnostics avoid nosological and nosographical classification and focus on the constellation of conditions of single psychopathological phenomena and/or

symptoms. Dimensional diagnostics follow a dynamic model of vulnerability regarding the predisposition to become mentally ill as a dynamic process. That means that in different stages of a person's life the degree of vulnerability varies in intensity. When vulnerability is high, minor stressors are sufficient to trigger a disorder whereas major stressors are necessary in periods of low vulnerability. The degree of vulnerability depends on the mental and physical state of the patient. The pathogenesis of a psychodermatological disorder therefore has to be considered as a multidimensional process in which various mental, physical and social factors act as predisposing and triggering factors. They in turn provoke mental, physical and social reactions, which function as disorder maintaining factors thereby causing the disorder to persist. Following this argument the distinction between dermatological, psychosomatic and mental disorders becomes less valid. This multidimensional point of view implies a change of paradigm in diagnostics and therapy. A psychodermatological disorder has to be considered as a dynamic process in which the complex interaction of physical, mental and social conditions serves to predispose, trigger and maintain the disorder. A treatment plan can therefore no longer be based on diagnostic attributions in categorical classification systems, which are artificial and more or less useless with respect to treatment planning. Modern treatment strategies have to be based on an accurate differential diagnosis concerning the complex constellation of conditions underlying and establishing the dynamic process of a disorder.

Pointing the Way: Psychosomatics without the Hyphen

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The time is ripe for medicine to consider body and mind as a single entity. In this newborn year 2001 we recommend renouncing Winnicott's exhortation to study the unifying hyphen in the term psycho-somatic, and propose, instead, to abolish it altogether. Thus, the word, and therefore its meaning, becomes definitely a single unit, psychosomatic, without the dual and potentially dividing meanings suggested by the hyphen.

The very visible organ, the skin, with its expressive physiology and multiple polymorphous clinical manifestations, offers prototypes that are particularly apt for research in medical psychology, provided that the lines of research are correlated and coherent, not sectorial (ranging from clinical observations, to research on the immunofluorescence of tissue neuropeptides, to psychological investigations, including specific tests, etc.).

Certain dermatological affections seem to be true *experimenta naturae* for such navigational projects, pointing the way: one specific example is atopic dermatitis. This complex affection, involving genetic, immunological, and psychological implications (with the existential *leit motiv* of detachment/separation and the Socratic aspiration of the One), proposes itself as an experimental protocol, a course toward the new world, specific to this particular affection that can involve the entire life-cycle from infancy through old age.

Current Ideas Postulate Complexity to Explain the Mind-Body Relation

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The immune status seems to be an important link between the psyche and the somatic manifestation of certain diseases. Even if we increasingly discover genetic predispositions for numerous skin diseases we know that some patients who are genetically predisposed e.g., to psoriasis never develop it. Stress was already found as a critical factor in the onset or exacerbation of some skin diseases. Even in viral affections, it has been proven that stress can play a role in the early onset. Furthermore we know that depression and other mood modifications are associated with changes in the immunity. Neuropeptides seem to be a central pivot between the skin and the central nervous system.

The skin is also a communication organ that expresses the emotions and has a social impact. Families with psychosomatic problems tend to have characteristic dysfunctionning interactions. However there are also coping skills modulating the perceived stress. But the difficulty with these patients is their inability to express their feelings, called alexithymia. The psychosomatic approach needs a unifying vision to make correlations between those different components that interact with each other in a circular way.

Psychosomatic Dermatology in Spain

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The social changes that Spanish society has experienced in the last few years, have generated new needs in dermatological

practice that are difficult to meet without a psychosomatic conception of this field. Psychosomatic dermatology is understood as that which takes into account the somatic, psychic and social factors of the patient in the diagnosis, treatment and prevention of dermatoses. For several years now there has been a Spanish society of dermatologists interested in the formation and promotion of this concept of dermatology (AEDYP).

Alterations in the cutaneous tegument have a rapid repercussion in the psyche of the patient and at the same time these emotions clearly affect the genesis, maintenance, and poor response to treatment of many dermatoses. Cutaneous disorders which produce the greatest impact on body appearance, such as, alopecia, hypertrichosis, hirsutism and hypopigmentations like vitiligo, acne psoriasis or atopic dermatitis, can generate psychopathological alterations. These can reach the level of suicidal ideas although more usually they cause patients to withdraw and isolate themselves in their psychosocial relations.

Nowadays, in our society having a young body free of cutaneous stigma is considered as a valuable asset of great importance in the job market given that physical appearance is sometimes considered more important than possible work qualifications. As a result, it is not unusual to find that these trends generate a great demand for medical consultation on dermatological problems.

The practice of Psychosomatic Dermatology is also important in the public health system as it is well-known that at least 40% of patients who present with some form of dermatosis also show some kind of psychic disturbance. For this reason it is important for the dermatologist to have some training in these pathologies in order to be able to handle these cases effectively. In private practice, consultation by patients with dysmorphobias and trivial clinical problems which notwithstanding can have great psychic importance for the patient, is more and more common. As well, the dermatologist is more frequently implicated in the surgical resolution of aesthetic problems such as those carried out with lasers (resurfacing, photodepilation etc.) Unfortunately, these aesthetic procedures sometimes fail to produce the hoped-for psychosocial benefits in the patient's life.

Management with Patients Suffering from Vitiligo

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Background: Vitiligo is a specific, common, often heritable, acquired disorder characterized by well-circumscribed milky white cutaneous macules devoid of identifiable melanocytes. This disease, particularly in brown and black peoples and in white persons who can tan deeply, may be a psychological disaster. The psychological problems arising from the pronounced cosmetic disfigurement of vitiligo in pigmented races are easily understood. ***Methods:*** With a questionnaire we investigated in our study 320 members of a German vitiligo self-help group about life quality, degree of disability, condition of the feeling of visible and invisible lesions and coping behavior. ***Results and Comment:*** We found a distinct motivation to get a treatment in patients suffering from vitiligo. It shows a high difference between the feeling in their private life and in the social life and also between visible and invisible lesions. We report in addition about our long term experiences with narrow band phototherapy together with calcipotriol cream. A clinical case will illustrate the feeling of emotional as well as physical damage in a patient with vitiligo.

Hypnotherapeutic Management in Dermatological Interventions

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We evaluated the effect of hypnosis to control pain and to lower emotional distress in 34 adult patients who underwent dermatological surgery.

Method: Hypnosis, in addition to normal local anesthesia, was offered to patients with fear of a surgical intervention. The patients stayed under hypnosis during the intervention. The level of anxiety before and during the intervention and the level of pain were evaluated by means of a visual analogue scale scoring system: 0 (no anxiety/pain) and 10 (maximal anxiety/pain). ***Results:*** A hypnotic state could be induced in 26 of the 34 patients (76.5%). In this subgroup, the average anxiety level decreased from 7.5 (before the intervention) to 2.1 (during the intervention). The pain score amounted to 1.5. In the remaining 8 patients, the non-responders to hypnosis, in comparison to the first group a slight regression of the anxiety level (from 9.5 to 7) was found. The observed pain score was 5.5. ***Discussion:*** The results of this study are in concordance with literature data regarding the use of hypnosis for control of pain and distress in surgical patients. This is, to our knowledge, the first study showing the usefulness of hypnosis as an aid to local anesthesia in dermatological patients.

References

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