Psychodermatology: mind the skin

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Skin and nervous system arise from a common embryological origin: the embryonic ectoderm. This may be the reason by which the skin gives an account of our mental and emotional state through infections and injuries[1]. This is illustrated by the fact that up to 33% of dermatologic patients have concurrent psychiatric disorders or dysfunctional psychosocial aspects[2].

The importance of skin in the psychic function is rooted in it being an organ of communication and expression of emotions, role assumed from the first moments of life of the individual. The skin is the organ of "attachment", because the initial physical experiences in the newborn are mainly touch. These early (and first) experiences of interaction with the mother (or surrogate), established through the skin, are essential to achieve the proper organic and psycho-emotional development of the individual. Since the skin is the most accessible part of the human body, it is not uncommon for many people to express through the skin, aggressive, anxious or self-destructive nature impulses, thereby causing dermatological symptoms. On the other hand, people with dermatological diseases involving self-image (severe acne, psoriasis) may feel depressed, embarrassed or anxious as a result of their illness[3, 4].

In human beings, it is impossible to separate the physical illness from the mental illness although tragically these are seen as very different conditions. This relationship is clearly evident in infectious disease (where we have an identifiable causal agent), the patient's mental state affects the body's response to infection and treatment[5]. Also, diseases (mainly chronic) affect the mental state of the patient, which is over-imposed on the presentation and course of the disease process. In addition, there are primary psychiatric disorders that manifest themselves directly as physical signs and symptoms. Often in clinical practice this integrated approach is ignored.

Many medical specialties can claim their relationship with psychiatry, since there are many diseases linked with mental illness (e.g., inflammatory bowel disease in gastroenterology, bronchial asthma in pneumology, among others). However, in dermatology the relationship is much more evident. Common ectodermal origin of the skin and central nervous system to explain its ability to react together, and also the infinite variety of clinical conditions and diseases of the skin, an organ which is able to offer a complex nosology that disorients the inexperienced doctor [5] need better attention than they have received so far.

Psychosomatic mechanisms

Any approach to the diagnosis and treatment in psychodermatology should take into account the fundamental fact of the "hybrid state of psychosomatic medicine", which on the one hand is part of medicine with its empirical and scientific tradition and, on the other hand, it is related to psychology and human sciences, with all its hermeneutic approaches[6].

In 1984 a hypothetical scheme of psychosomatic mechanism was proposed, and it remains useful to date. In this scheme, it is proposed that psychosocial stressors, after being filtered by cognitive activity, are modulated to be printed in the subconscious and trigger the mechanism of emotional stress. If this mechanism takes the path of somatization it will act on the predisposed psychobiology of the individual [6], giving rise to a skin response (in a "reactive" skin site) instead of another organ (e.g. "reactive" sites of heart, stomach, lungs, etc.), resulting in a group of dermatosis with high incidence of psycho-emotional factors.

Therefore, even if we accept, for linguistic simplification purposes, the term "psychosomatic" for all conditions that the dermatologist sees in his/her daily medical practice[5,6,7], those conditions have been divided into three groups, that we have adapted to our daily practice (Table 1).

While all patients from the groups I and II primarily belong to the field of dermatology, patients from group III need primarily psychiatric help, but most of them go to see first a dermatologist because they perceive their skin problem but neglect, fear or refuse to accept the mental distress or disorder[7]. This classification attaches importance to the statistical incidence factor and stresses the "psychosomatic factor" that afflicts the first two groups of conditions (I and II), while psychiatric illnesses in group III are clearly distinct. Moreover, much importance is given to the group of psychosomatic forms (for example a skin angioma on the face, does not have psychosomatic

causes, but can cause significant psychological disorders).

Table 1: Psychosomatic Dermatology

Group I. Dermatologic diseases with high incidence of psycho-emotional factors	
• Hyperhidrosis • Dyshidrosis • Pruritus • Hives • Lichen simplex • Atopic dermatitis • Acne • Rosacea	• Telogen effluvium • Alopecia areata • Psoriasis • Seborrheic dermatitis • Perioral dermatitis • Lichen planus • Herpes • Nummular eczema

Group II. Dermatological conditions with psychosomatic rebound		
In children • Ichthyosis • Alopecia • Epidermolysis bullosa • Nevus • Angioma	*In teenagers* • Acne • Alopecia	*In adults* • Rosacea • Alopecia • Seborrheic dermatitis • Psoriasis • Skin aging

Group III. Psychiatric conditions with dermatological expression		
Self-inflicted injuries • Dermatitis artifacta *Body-focused repetitive behaviors* • Trichotillomania • Excoriation (skin picking) disorder • Thumb sucking • Other repetitive behaviors	*Phobias* • Dysmorphophobia • Glossodynia • Others	*Delusions* • Delusional Infestations

Some of the old theories on specific types of personality applied to psychosomatic diseases are uncertain because of their tendency to simplify[1]. It is important that in clinical settings, preconceived ideas should be avoided as far as possible, such as "this condition corresponds to this personality and this psychic trauma and this drug", always giving priority in daily clinical practice to the "non-specific theory" which proclaims that any stress or prolonged strong emotion can cause pathological and/or mental disorders. Everyone has one or more susceptible organs, which are vulnerable to stress, because of genetic or other causes (post-natal stimuli), so that a person can respond with a disorder or cardiac dysfunction, another with gastric problems and another with skin reactions. Additionally, some individuals show "psychosomatic" functional responses to stress and injury, in the form of vascular, muscle, stomach, or other spasms[8].

Classification

The problems of terminology in the field of psychodermatology are difficult to treat because of the special position that this issue occupies in the world of the pathophysiology, between mind and body. In psychodermatology one cannot ignore the fact that when the patient presents to a dermatologist, with a condition that provides "reasonable suspicion of psychosomatic factors", it can be recognized and diagnosed as

1. A psychophysiological disorder;
2. A primary psychiatric disorder; or
3. A secondary psychiatric disorder (see Table 2).

Table 2: Classification in psychodermatology

Group	Pathophysiology	Conditions
Psychophysiological disorders	Psychic sphere is involved in their pathology, among other multiple causes.	Alopecia areata Psoriasis Neuro-dermatitis Seborrheic dermatitis
Primary psychiatric disorders	The primary disease is psychiatric, manifested with signs or symptoms in the skin.	Delusional infestation Dermatitis artifacta Trichotillomania Excoriation (skin picking) disorder
Secondary psychiatric disorders	The dermatologic disease is the primary trigger for a psychological impact.	Vitiligo Alopecia areata Psoriasis Acne

The three groups are very different and individual conditions of each of them require specific treatment. In the first group are included dermatoses in that psychophysiological influence is involved, as another element of the pathophysiology of the disease. It is the case of psoriasis, seborrheic dermatitis or alopecia areata. In general, we tend to consider mental impairment as a trigger or aggravating, rather than a single nexus. This is the case of diseases in the second group, the primary psychiatric disorders, in which the primary disease is mental. The paradigmatic disorder of this group is delusional infestation (previously known

as Ekbom's syndrome). The third group includes dermatologic disorders with psychological impact, mainly by altering the image of the individual. In this case, the direction of the pathophysiology goes from the skin to the central nervous system, while in the first group it goes from the mind to the skin. In the first and the last group there are common disorders, such as psoriasis, atopic dermatitis and alopecia areata, since the psychological disorder is both cause and consequence of the disease, and it is difficult to separate one and another aspect[9].

We emphasize that the relationship between body and mind is a constant that coincides with the complex reality of the individual in health and disease. Therefore, the term "psychosomatic", may one day become superfluous as and when the fundamental unity between body and mind is accepted for all diseases in medical sciences.

Mind the skin

Patients with any of the above-mentioned diseases initially consult a dermatologist (or a general physician), who has responsibility to discover whether or not the skin condition is related to psychological or psychiatric factors. If so, the professional can then refer the patient to a psychiatrist. However, in reality this situation is hindered because of the patients' reluctance of seeking help as they may not see the condition as a psychiatric disorder. An ingenious solution, often practiced in Europe and now in use at the National University of Asunción (Paraguay) is conducting a "psychodermatology" assessment. This is a multidisciplinary consultation, in which a dermatologist and a liaison psychiatrist are closely involved in joint assessments. The consultation takes place, usually in the dermatology facility. The simultaneous presence of two doctors, one that looks and touches and another one who listens, improves the link between the skin and psyche and allows the patient to feel considered as a whole. This helps obviate the patient's reluctance to a psychiatric evaluation and forms an effective and accurate therapeutic alliance, which ensures the success of treatment[10,11,12].

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