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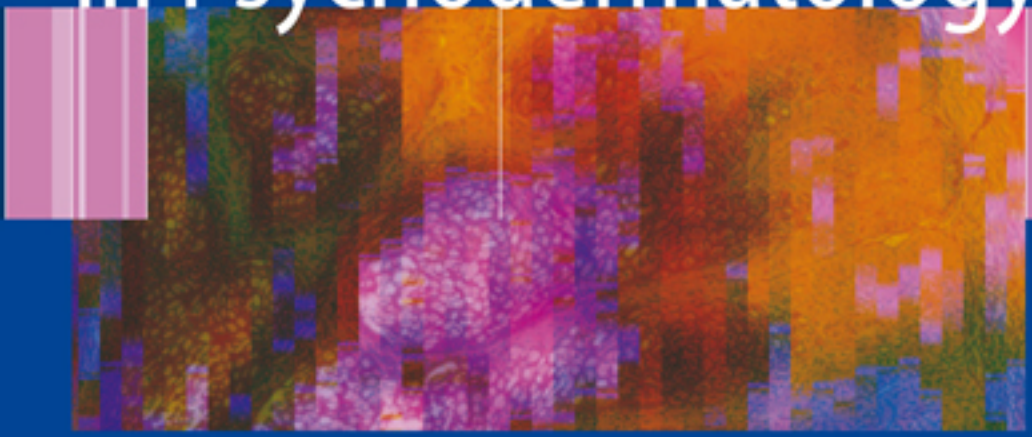

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Foreword

Every doctor and certainly every dermatologist knows that chronic skin diseases located on visible areas of the skin may lead to considerable emotional and psychosocial stress in the affected patients, especially if the course is disfiguring or tends to heal with scars. In the same way, as we know, emotional or psychovegetative disorders may trigger skin events.

Emotional or sociocultural factors of influence have dramatically changed the morbidity, pathogenetic understanding of causality, and therapy concepts in dermatology over the past decades; the relationship between the skin and the psyche or between the psyche and the skin is being given increasing attention.

There is a circular and complementary relationship between the skin and the psyche that becomes more evident during mental or skin disease. Not only is the skin part of the perception, but it is also a relational organ. The understanding of this multilevel relationship will help physicians understand the psychic and skin changes during disease.

This book is dedicated to such relationships. The picture atlas offers the morphologically trained dermatologist a summarizing presentation of diseases in psychosomatic dermatology for the first time.

The objective of this publication is to depict the relationships between skin diseases and psychiatric disorders to make the diagnostic vantage point for such disorders more clear. This affects, for example, the systematization of body dysmorphic changes, factitious disorder patients, little-known borderline disorders, and special psychosomatic dermatoses that have received little attention to date. Patients with skin or hair diseases that are rather insignificant from an objective point of view, such as diffuse effluvium, can endure great subjective suffering.

The present clinical atlas should help physicians recognize masked emotional disorders more quickly in patients with skin diseases and thus initiate adequate therapies promptly. This informative textbook has been admirably written by authors with much experience in the area of psychosomatic disorders in dermatology and venereology, and it provides many insights and aids from a psychosomatic perspective that, for various reasons, were not infrequently all but ignored.

This publication can be recommended to all doctors working in the areas of practical dermatology and psychosomatics, since it deals not only with the diseased skin but takes into account the suffering human in his or her physical and emotional entirety.

O. Braun-Falco
Munich, October 2007

Preface

The present textbook offers for the first time a summarizing overview of special clinical patterns in psychosomatic dermatology. The specialty is considered from an expanded biopsychosocial point of view.

Thus, both common and rare patterns of disease are presented for doctors and psychologists as an aid in recognizing and dealing with special psychosocial traits in dermatology.

Dealing with and treating skin diseases involves special features. While the skin and central nervous system are ectodermal derivatives, a good part of an individual's perception takes place through the skin. This experience is expressed in characteristic patient quotes and expressions such as "He's thin-skinned" or "My scaly shell protects me," or, increasingly, "I'm ugly and can't stand myself."

In recent years, psychosomatic medicine has developed, out of the limited corner of collections of personal experiences and individual case reports, into evidence-based medicine.

Cluster analyses and current psychosomatic research demonstrate that in addition to parainfectious, paraneoplastic, and allergic causes, psychosocial trigger factors can also cause disease in subgroups of multifactorial skin diseases.

In the present atlas, the psychosomatic subgroup will receive equal consideration and systematic presentation with the biomedical focal points, in order to facilitate diagnostics with clear diagnosis criteria for the somatization patient and to point out the good possibilities and rich experiences that exist today with adequate psychotherapy and psychopharmaceutical therapy.

The authors hope to reduce the fear of contact and encourage incorporation of the biopsychosocial concept in human medicine. Moreover, the sometimes varying language of doctors and psychologists is to be made more understandable and uniform. For this reason, the classification codes of the ICD-10 and current evidence-based guidelines are especially used in this reference work.

We wish to express particular thanks to Asst. Prof. Dr. Volker Niemeier, who contributed extensively and constructively to discussions in preparation of the manuscript, and to Asst. Prof. Dr. Hermes for providing numerous images. To our patients, who contributed the clinical descriptions and images in this book, we also express our thanks, since we were always impressed that their sometimes very problematic and difficult life histories helped us understand their world. Additional thanks are due to the editors at Springer, who, from the beginning of this book project, shared our enthusiasm and supported us in finishing it.

Last but not least, the authors wish the readers pleasure in reading this picture atlas of psychosomatic dermatology.

Wolfgang Harth, Uwe Gieler, Daniel Kusnir,
Francisco A. Tausk
Spring 2008

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Prevalence

Introduction

The basis of a successful strategy for combating a skin disease is elucidation of the various factors leading to the onset, course, and healing process of dermatoses.

The psychodermatology practice includes modifications to the regular dermatological practice, not targeting the patient's underlying psychiatric disease in general but specifically geared to overcome his or her psychiatric/psychological difficulties to obtain a good diagnosis and promote the endurance needed for compliance with treatment, dealing with the inherent stress and the psychosocial context.

Dermatoses, by their localization on the border (Schaller 1997) between internal and external, body and environment, visual exposition and stigmatization (Anzieu 1991), present with distinctive features in the objective assessment as well as in the individual's subjective assessment and in interpersonal communication.

Although many pathogenetic causalities have been revealed by medical advances, it has been found that the influence of individual psychic disposition and sociocultural factors can play an important role in the genesis and chronification of cutaneous diseases, in the transmission of infectious diseases, and as promoters of carcinogenesis. Historically, psychosomatic dermatology can only have existed since the term "psychosomatic" was introduced in 1818 by Heinroth (Heinroth 1818). The interactions between the patient and his or her disease and those conditions (or the context) in which the patient perceives a disease are related to the individual character and the circumstances configuring the context.

Psychosomatic dermatology addresses skin diseases in which psychogenic causes, consequences, or concomitant circumstances have an essential and therapeutically important influence.

In this respect, dermatoses are viewed as a unit in a biopsychosocial model.

Psychosomatic dermatology in the narrower sense encompasses every aspect of intrapersonal and interpersonal problems triggered by skin diseases and the psychosomatic mechanisms of eliciting or coping with dermatoses. Emotional disorders are present in one-third of all patients in dermatology. In addition, there are negative influences in coping with disease. The coping process (coined by Lazarus in 1966) is often equated with overcoming stress. The stress factor plays an important role, especially in chronic dermatoses (Consoli 1996).

Patients with emotional disorders are hospitalized for medical reasons two to four times more often than those without emotional disorders (Fink 1990). When associations with psychological and psychiatric disorders are initially concealed, the resulting physical symptoms often cannot be cured without adequate psychodermatologic intervention. In general, consequences of undiscovered psychiatric/psychological disorders in hospitalizations lead to

- Considerably longer in-hospital treatment episodes
- Greater use of posthospitalization care and readmissions

Moreover, patients with psychiatric disorders undergo surgery more frequently than patients with only organic diseases; however, they receive comparable somatic treatment without treatment of the psychiatric condition (Fink 1992).

In light of such basic data, the purely biomechanistic model of disease is being continually expanded with psy-

chosocial concepts in all medical specialties (Niemeier and Gieler 2002).

The biopsychosocial model (Engel 1977) enjoys broad recognition these days and serves as one of the modern approaches to a dermatosis/disease. The patient is increasingly viewed as a holistic individual in whom lifestyle, perception, interpretation of the perceived, reality testing, past experiences and psychosocial context are decisive in the development of disease.

Thus, disorders may begin at the biological, psychological, or social system level and be offset by another or may also be negatively influenced by another (see Table 1).

Among the frequent problem areas in psychosomatic dermatology are the psychosomatic skin diseases, in which psychiatric factors play a basic role. Dermatitis artefacta is a psychiatric illness with skin reference, somatoform disorders, and sexual disorders, including problems in reproductive medicine and problems in coping with disease.

The problem of suicide among dermatologic patients (Gupta and Gupta 1998), especially in dermatoses such as acne vulgaris, has received little attention and has been underestimated in the past. One of the most serious and often concealed disorders in psychosomatic dermatology concerns the group of dermatitis artefacta patients. Patients with this group of diseases often have a borderline (or psychotic) disorder (Moffaert 1991).

Interpersonal contact difficulties are often in the foreground for many patients with skin diseases and result in a proximity–distance conflict. Feelings of shame and disgust are especially elicited by the patients' real or imagined perception of their skin disease.

The visibility of the skin and its changes makes it easy for patients to charge their diseased skin with psychological contents, thus reinforcing the splitting defense of their conflicts and often recruiting the aid of somatically oriented dermatologists. Overcoming this splitting may be very difficult in light of the concurrent proximity–distance problem that often exists (Gieler and Detig-Kohler 1994).

In dermatology, the question also arises as to the primary causality and reaction onset with respect to psyche or soma. If the genesis or the difficulties for successfully treating the disease lies in a psychiatric disorder, we speak of a psychosomatic disorder. If the somatic disorders are primary, we speak of a somatopsychic disorder. Thus, clear categorization and systematization are more important than ever in dermatology, not least for understanding the pathogenesis of a biopsychosocial disease that for planning therapy. Based on research results now available and on practical experience, classification in psychosomatic dermatology can now be differentiated in the following way:

- Dermatoses of primarily psychological/psychiatric genesis
- Dermatoses with a multifactorial basis, whose course is subject to emotional influences (psychosomatic diseases)
- Psychiatric disorders secondary to serious or disfiguring dermatoses (somatopsychic illnesses)

This division is used in the present book as a systematization and structuring of psychosomatic medicine in dermatology.

Table 1 Biopsychosocial resources (adapted from Becker 1992)

	Internal	External
Physical	Bodily disposition (genetics)	Healthy environment
		Healthy diet
		Safe working conditions
Psychosocial	Emotional health	Constitutional country
	Healthy living habits	Family ties
		Adequate workplace
		Material livelihood
		Established health network

References

Anzieu D (1991) Das Haut-Ich. Suhrkamp, Frankfurt/Main

Becker P (1992) Die Bedeutung integrativer Modelle von Gesundheit und Krankheit für die Prävention und Gesundheitsförderung. In: Paulus P (Hrsg) Prävention und Gesundheitsförderung. GwG-Verlag, Köln

Consoli S (1996) Skin and stress. Pathol Biol (Paris) 44: 875–881

Engel GL (1977) The need for a new medical model: a challenge for biomedicine. Science 196: 129–136

Fink P (1990) Physical disorders associated with mental illness. A register investigation. Psychol Med 20: 829–834

Gieler U, Detig-Kohler C (1994) Nähe und Distanz bei Hautkranken. Psychotherapeut 39: 259–263

Gupta MA, Gupta AK (1998) Depression and suicidal ideation in dermatology patients with acne, alopecia areata, atopic dermatitis and psoriasis. Br J Dermatol 139: 846–850

Heinroth J (1818) Lehrbuch der Störungen des Seelenlebens oder der Seelenstörung und ihre Behandlung, Teil II. Vogel, Leipzig

Lazarus RS (1966) Psychological stress and the coping process. McGraw-Hill, New York

Moffaert VM (1991) Localization of self-inflicted dermatological lesions: what do they tell the dermatologist? Acta Derm Venereol Suppl (Stockh) 156: 23–27

Niemeier V, Gieler U (2002) Psychosomatische Dermatologie. In: Altmeyer P (Hrsg) Leitfaden Klinische Dermatologie, 2. Aufl. Jungjohann, Neckarsulm, S 161–168

Schaller C (1997) Die Haut als Grenzorgan und Beziehungsfeld. In: Tress, W (Hrsg) Psychosomatische Grundversorgung, 2. Aufl. Schattauer, Stuttgart, S 94–96