The skin is the largest organ of the body covering a surface area of 1.5 to 2 square metres in the average adult. It plays a vital role in the interface with external elements and because of its visibility has tremendous social significance. The skin and the nervous system share a common embryonic origin from the ectoderm and hence pathology in one organ system is likely to affect the other. The purpose of this module was to alert the clinician to potentially treatable psychiatric disorders that may underlie some dermatological disorders and to review the salient clinical features and psychiatric treatments that have been reported to be effective.

It is estimated that approximately one third of dermatology patients have some type of associated psychiatric or psychological problem. Effective management involves an integrated approach to the patient, including consideration of associated emotional factors (Gupta et al, 1996). Psychiatric intervention is often the most crucial element in the treatment of these patients. However, many of these patients lack insight into the possible psychogenic origin of their symptoms and are often reluctant to accept a psychiatric referral.

**Classification**

Psychodermatological disorders can be classified as follows:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorders (eg. acute stress reaction, adjustment disorder, and post traumatic stress disorder) which may arise as a result of chronic, disabling or disfiguring skin disorders such as:</td>
<td>Primary hyperhidrosis, Psoriasis, Acne vulgaris</td>
</tr>
<tr>
<td>Psychiatric disorders which present via skin lesions or abnormalities such as:</td>
<td>Delusional parasitosis, Trichotillomania, Dermatitis artefacta</td>
</tr>
<tr>
<td>Skin conditions secondary to psychotropic medication such as:</td>
<td>Lithium related psoriasis</td>
</tr>
<tr>
<td>Psychiatric disorders secondary to treatment of skin conditions such as:</td>
<td>Depression secondary to corticosteroids</td>
</tr>
<tr>
<td>Concurrent dermatological and psychiatric illness occurring coincidentally</td>
<td>Depression following the use of Isotretinoin</td>
</tr>
</tbody>
</table>

**Dermatological conditions giving rise to emotional disorders**

- **Primary hyperhidrosis** is characterised by abnormally excessive sweat production to stressful stimuli. Perspiration occurs independently of the thermoregulatory mechanism and anxiety often exacerbates the situation. Severe embarrassment may lead to social withdrawal, depression and suicidal ideation. Topical applications and systemic anticholinergics provide limited benefit. Surgery (thoracic sympathectomy) provides symptomatic relief by causing anhidrosis but is a limited option due to complications. Antidepressants (eg selective serotonin reuptake inhibitors) can be used to treat underlying depressive and anxiety symptoms.

- **Psoriasis** is a chronic condition, with skin symptoms such as silver scaly patches called plaques, that varies in severity presenting in small patches or covering the entire body. Adverse life events may precede or exacerbate the condition and psychological distress as a result of the physical disability can lead to significant depression and social isolation (Gupta et al, 1996). Treatment is based on the site, extent and severity of the lesions, with careful consideration given to age, gender and any comorbid illness.

- **Acne vulgaris** is an inflammatory skin disorder affecting the pilosebaceous gland. It can interfere with social and occupational functioning as a result of its impact on the emotional state and self esteem. Factors linked to the development of acne include hormonal activity (puberty), stress, bacterial infection and androgen containing medications. Treatment options include exfoliating and the use of antibiotics. Isotretinoin is effective in severe acne but there are concerns that it may cause depression or sudden and unexpected suicidal urges and behaviour, therefore psychiatric assessment is mandatory in susceptible patients. Adjunctive treatment with biofeedback assisted relaxation and cognitive imagery have been shown to be effective in reducing the severity of acne. (Arnold, 2000).
Psychiatric disorders presenting as skin conditions

- **In delusional parasitosis** patients have a fixed delusion that there is an infestation of parasites or insects on or in the skin. It is important to exclude an organic skin disorder and ensure that the delusion is not secondary to another mental or physical illness. A neurochemical basis has been suggested and it has also been reported in association with chronic drug use, medical and other psychiatric disorders. Treatment of choice is an antipsychotic. The principal obstacle in management is convincing patients to accept psychotropic medication (Koenig et al, 2003).

- The essential features of **trichotillomania** are the recurrent pulling of one's own hair which results in noticeable hair loss, great tension before pulling out hair or when attempting to resist the behaviour and the sense of relief while or after pulling hair out. An association with obsessive compulsive disorder has been suggested although there are clear phenomenological differences (Christenson et al, 1996). Patients respond best to a combination of pharmacotherapy and psychotherapy. SSRIs have been studied most extensively and remain the most popular pharmacologic intervention. Behaviour therapies such as thought stopping, aversive conditioning, simple self-monitoring, hypnosis and relaxation training can be useful.

- **Dermatitis artefacta** is a condition characterised by the self-infliction of cutaneous lesions by patients who deny it. They can present as a variety of skin lesions and may therefore resemble other cutaneous disorders. It is associated with factitious disorders (Munchausen's syndrome and malingering), personality disorders (commonly with borderline features), physical or sexual abuse and significant early losses. It can occur as a result of a response to another psychiatric condition such as delusional parasitosis, or can occur directly in relation to another real dermatological condition such as eczema. A supportive and empathic approach is recommended to encourage engagement. Insight-oriented psychotherapy may be used once a therapeutic relationship is established. Other useful adjunctive therapies include relaxation exercises and a course of anxiolytics or antidepressants where indicated.

References


