

Correspondence: **Dan Vâță**
Clinica Dermatologică, Spitalul Clinic Județean de Urgență „Sf. Spiridon” Iași
Str. Ciurchi 111, 700368, Iași, România
Tel.: +40.232.476.732
E-mail: danvata@yahoo.com

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IMPORTANCE OF PSYCHIATRY IN DERMATOLOGY. FOCUS ON BACTERIAL SKIN INFECTIONS

Dan VÂȚĂ, Diana DIACONU, Laura GHEUCĂ SOLOVĂSTRU

Dan VÂȚĂ: *M. D., Drd., Assistant Professor, Department of Dermatology, University of Medicine and Pharmacy “Gr. T. Popa” Iași, Senior dermatologist, Dermatology Clinic “Sf. Spiridon” Emergency Hospital Iași, România*

Diana DIACONU: *M. D., Assistant Professor, Department of Dermatology, University of Medicine and Pharmacy „Gr. T. Popa” Iași, România*

Laura GHEUCĂ SOLOVĂSTRU: *Associated Professor, M. D., Ph. D., Department of Dermatology, University of Medicine and Pharmacy “Gr. T. Popa” Iași, România, Dermatology Clinic “Saint Spiridon” Emergency Hospital Iași, România*

Abstract:

Psychodermatology covers all aspects of how the mind and body interact in relation to the onset and progression of various skin disorders. Unlike most internal illnesses, skin disease is often immediately visible to others, and therefore people suffering from dermatological conditions may suffer social and emotional consequences. Skin is an organ that has a primary function in tactile receptivity and reacts directly upon emotional stimuli. Dermatological practice involves a psychosomatic dimension. This review intends to present the relationship between the ‘skin’ and the ‘mind’ specifically from the dermatology point of view, with focus on bacterial skin infections. The effects on the quality of life as a result of psychodermatological conditions are highlighted. A multidisciplinary approach for treatment from both dermatologic and psychiatric viewpoints is very important.

Keywords: psychodermatology, quality of life, infections

Rezumat:

Psihodermatologia acoperă toate aspectele legate de modul în care mintea și trupul interacționează în ceea ce privește debutul și progresia diverselor afecțiuni cutanate. Spre deosebire de cele mai multe boli interne, bolile de piele sunt vizibile, adesea, imediat de către ceilalți și, prin urmare, persoanele care suferă de afecțiuni dermatologice pot suferi consecințe sociale și emoționale. Pielea este un organ care are o funcție primară în receptivitatea tactilă și reacționează direct la stimuli emoționali. Practica dermatologică implică o dimensiune psihosomatică. Această trecere în revistă intenționează să prezinte relația dintre „piele” și „minte”, în special, din punctul de vedere al dermatologului con-

centrându-ne pe infecțiile bacteriene cutanate. Sunt evidențiate efectele asupra calității vieții, ca urmare a bolilor psihodermatologice. O abordare multidisciplinară pentru tratament, din punct de vedere atât dermatologic, cât și psihiatric, este foarte importantă.

Cuvinte-cheie: psihodermatologie, calitatea vieții, infecții

INTRODUCTION

When considering the impact of skin disease, many people fail to realise just how important are the psychological aspects. Skin disease is considered to be a cosmetic problem by many medical professionals, but unlike most internal illnesses, skin disease is often immediately visible to others. It is for this reason that traditional views do not account for the often profound psychological impact that it can exert on those affected. Skin diseases affect the quality of life, self-esteem and body image, as well as the way patients live their quotidian lives.

The way that skin disease affects a person often has no relation to medical severity. To understand their effect we need to understand the person behind the condition. (1)

The unique nature of skin disease has the potential to make it both the easiest and most difficult disease to suffer from, and how a person copes and adapts to the challenges presented is due to a great number of factors. Recent years have seen a considerable increase in research concerned with the psychological effects of skin disease on patients and their families, and we are beginning to appreciate the degree to which a variety of problems confront both patients and their wider social networks. (2)

PSYCHOCUTANEOUS DISORDERS

Skin has a special place in psychiatry with its responsiveness to emotional stimuli and ability to express emotions such as anger, fear, shame and frustration, and by providing self-esteem. Skin plays an important role in the socialization process.

The relationship between skin and the brain exists due to more than a fact, that the brain, as the centre of psychological functions, and the skin have the same ectodermal origin and are affected by the same hormones and neurotransmitters. Psychodermatology describes an interaction between dermatology and psychiatry and psychology. (3). Regardless of psychiatric morbidity, skin diseases can greatly affect patients' quality of life. (4)

Psychiatry is more focused on the 'internal' non-visible disease, and dermatology is focused on the 'external' visible disease.

Dermatologists have stressed the need for psychiatric consultation in general, and psychological factors may be of particular concern in chronic intractable dermatologic conditions.

Patients with psychocutaneous disorders frequently resist psychiatric referral, and the liaison among primary care physicians, psychiatrists and dermatologists can prove very useful in the management of these conditions. Thus consideration of psychiatric and psychosocial factors is important both for the management of psychodermatologic disorders and for some aspects of secondary and tertiary prevention of a wide range of dermatologic disorders. (5)

The drugs used in the treatment of dermatological diseases, such as steroids and retinoids, may lead to psychiatric symptoms.

There is a common opinion that many cases of skin disease are caused by psychological stress, or are related to certain personality traits, or represent a complication of a psychiatric disorder. (6)

Multidisciplinary approach is needed with the cooperation of psychiatric and dermatologic terms and simultaneous diagnostic procedures and treatment of patients with psychodermatologic disorders.

Through the course of our work we have encountered individuals whose skin disease covers the majority of the surface of their skin but whose social and psychological functioning were unaffected by the condition. Conversely, individuals with the smallest of lesions in non-visible areas have been so affected by their condition that occupational, social and sexual interactions have fallen prey to their functional inability to cope with their condition.

Depression is frequently encountered in a dermatology practice. Patients report depressed mood or anhedonia. Feelings of worthlessness, hopelessness, and excessive guilt are common. Patients may also report somatic symptoms such as loss of appetite, weight loss, sleep disturbance, decreased energy, and difficulty in concentrating. Preoccupation with physical health may occur. The symptoms may cause significant subjective distress and social or occupational dysfunction. (7)

CLASSIFICATION

Although there is no single universally accepted classification system of psychocutaneous disorders and many of the conditions are overlapped into different categories, the most widely accepted system is that devised by Koo and Lee. (1)

Psychodermatology is divided into three categories according to the relationship between skin diseases and mental disorders. (2)

1) Psychosomatic disorders caused by skin diseases triggering different emotional states (stress), but not directly combined with mental disorders:

- Psoriasis;
- Atopic dermatitis;
- Urticaria;
- Acne excoriata.

2) Primary psychiatric disorders responsible for self-induced skin disorders:

- Psychogenic excoriation;
- Delusions of parasitosis;
- Trichotillomania;
- Obsessive-compulsive disorder;
- Dysmorphophobia;
- Dermatitis artifacta (Factitial dermatitis);
- Psychogenic pruritus.

3) Secondary psychiatric disorders caused by disfiguring skin, which can lead to states of fear, depression or suicidal thoughts:

- Alopecia areata;
- Vitiligo.

Bacterial skin infections are not found in this classical classification, although skin infections due to gram-positive organisms are recognized as a common and significant public health problem. These skin diseases are most commonly caused by staphylococci and streptococci. They include folliculitis, impetigo, furuncles, ecthyma, erysipelas, cellulitis and infection of cuts and scrapes. The uncomplicated cases are easy to treat and will heal in a short period of time, unable to seriously affect the patient's state of mind.

At a closer inspection we think that we could add them to all the three categories according to the relationship between skin infection and mental disorder. We can consider bacterial skin infections to be psychosomatic disorders caused by skin diseases triggering different emotional states (stress), but not directly combined with mental disorders. Different emotional states alter the capacity of the organism to effectively defend itself against bacteria. *Staphylococcus aureus* has always been one of the most common causes of cutaneous infections. It is also a cause of serious systemic infection such as septicemia, wound infection, pneumonia, and contamination of indwelling catheters. With the emergence of methicillin-resistant *S. aureus*, the organism has become a major cause of difficulty in treatment, serious infections. This organism can be of importance to dermatologists because of chronic furunculosis, increased frequency of wound infections, contamination of dermatological operating sites, and spread to patients with damaged epidermis (atopic dermatitis) and immunological disorders (HIV infection).

We consider that bacterial skin infections can also be part of the second category of psychodermatology: primary psychiatric disorders responsible for self-induced skin disorders because personal hygiene also has an important influence on skin infections. Primary psychiatric disorders

can reduce the use of soap in some patients, inducing bacterial skin infections. Washing with antimicrobial soaps or with non-medicated soaps removes bacteria from the skin because of the surfactancy of the soap base and the mechanical action of the wash procedure. Improved hygiene can help prevent skin infections and interrupt the transmission of infectious disease transferred by the hands. Thus, the regular use of soap for personal cleansing has a recognized role in the prevention of disease.

Bacterial skin infections can also be part of the third category of psychodermatology: secondary psychiatric disorders caused by disfiguring skin, which can lead to states of fear, depression or suicidal thoughts. The skin, being our exposed or external organ, is readily accessible to a vast number of microbial organisms. We are exposed to these organisms on a nearly continuous basis during many of our normal daily activities. While the skin and our natural host and immunological defences are well adapted to protect us from this onslaught, skin infections remain a major cause of human morbidity. Virtually everyone will have one or more cutaneous infections, at least episodically. It is all too easy to fear *S. aureus* and with such antipathy, to gloss over the special relationship which has evolved between us and one of our most faithful microbes. We all have a high titre of circulating antibodies against *S. aureus* and so we must be challenged subclinically on a regular basis. Getting a serious *S. aureus* infection is actually remarkably difficult and mostly requires immense effort on our part via injury, surgery, indwelling medical devices, etc. But some patients still fear *S. aureus* with a pathologic intensity leading to stigmatisation of carriers and to other secondary psychiatric disorders. Staphylococcal infection also can produce scars that can affect patients.

In approaching psychodermatological patients, it is important to have strategies that will help the clinician understand what types of psychodermatological cases one is dealing with.

Two strategies that will help guide dermatologists to select the approach to patients:

- by the category of psychodermatological condition;
- by the nature of the underlying psychopathological condition.

The idea of diagnosing and treating psychiatric problems may seem intimidating to the dermatologist. The selection of appropriate psychotropic medications is dictated by the nature of the underlying psychopathologies that need to be treated. It is not at all unusual for a nonpsychiatrist to be prescribing psychotropic agents.

Even though these patients can be very challenging, the dermatologist who has an open mind, a thorough knowledge of the differential diagnosis, and good interpersonal skills can be effective in helping significant proportion of these patients who might otherwise be lost between the two specialties of dermatology and psychiatry.

CONCLUSION

Psychodermatologic disorders are conditions involving interaction between the mind and the skin.

The treatment of psychodermatological disorders, including bacterial skin infections should be carried out through a multidisciplinary approach, including dermatologist, psychiatrist and psychologist.

It is very important to educate dermatologists in the diagnostic procedures and therapy of psychiatric disorders, which sometimes coexist with the skin disease.

The cooperation of the dermatologist and a psychiatrist in order to increase the life quality of the patients is of utmost importance.

The management of psychodermatologic disorders requires evaluation of the skin manifestation and the social, familial and occupational issues underlying the problem. Once the disorder has been diagnosed, management requires a dual approach, addressing both dermatologic and psychological aspects. A mutual, respectful collaboration between dermatologists and mental health professionals might be of help for many psychiatric patients.

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