Emotionally-linked skin disorders

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Emotional factors play the primary and essential pathogenetic role in only a few skin diseases, but they contribute identifiably to the skin problems of at least 40% of the patients who seek treatment. Moreover, since almost all dermatologic disorders alter personal appearance, they influence patients' emotional development and self-images.

Your counseling may help many of these patients to identify emotional difficulties that cause or aggravate skin conditions. Their skin problems may respond readily after counseling and with appropriate topical medication. This counseling may also better prepare patients to accept psychiatric referral if that is necessary.

On the following pages I discuss some of the important relationships you should watch for between skin disease and emotional factors.

**Dermatosis artefacta**

In dermatosis artefacta, self-inflicted damage may be caused by cigarettes, razor blades, knives, acids, caustics, or fingernails. This self-mutilation occurs most commonly in patients (often young women) with hysterical personalities who lack love and affection or who have strong inferiority complexes. I have seen patients injure themselves due to unrequited love or during divorce proceedings, for example. Interestingly, there are reports of a high incidence of these injuries among nurses.

Patients will deny any responsibility for the injury; this, in fact, is one of the clues that differentiates dermatosis artefacta from neurotic excoriations. Also, in dermatosis artefacta the lesions are often sharply defined and unnaturally regular in arrangement (Figure 1). They appear suddenly—often overnight—and most commonly include erosions, ulcerations, and burns.

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**Figure 1**—Dermatosis artefacta. This woman's face is marked by new excoriations as well as older lesions that healed, leaving hyperpigmentation and scarring.

**Figure 2**—Trichotillomania of the scalp. Close examination reveals twisted and broken hairs of irregular length, but no inflammation or scarring.
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The lesions are on the face or other areas easily reached with the fingers, especially those of the dominant hand.

Medically, such injuries should be treated with bland preparations and if there is secondary bacterial infection, with systemic antibiotics. But the chief goal in dealing with dermatosis artefacta patients is to establish enough rapport to motivate them to obtain professional psychiatric help.

Acne excoriée
Although acne is primarily a genetic and endocrine disease, there is no doubt that emotional stress plays a major role in precipitating and perpetuating it. Many patients realize that their acne worsens during periods of stress. Often, however, patients are not so aware of their own role in aggravating the lesions through unconscious picking and squeezing, which often occurs when they are worrying about any of the problems so common in adolescence.

To prevent milder forms of the disease from gradually becoming acne vulgaris or, in the extreme, acne excoriée, patients need to be made aware that the habit of excoriating or squeezing the comedones and papules increases the problem. Reassure patients that medical treatment will be effective in relieving, if not curing, the disease.

What you should not do is tell acne patients that they will “grow out of it,” or that it is a matter of no consequence; such an approach will reinforce misconceptions about the disease and may result in emotional as well as physical scarring. Also, try to dispel the idea that acne is related to masturbation or diet.

Trichotillomania
Patients with trichotillomania pluck out, pull out, or otherwise attempt to twist off hairs. Al-

Figure 3—Dermatosis resulting from delusions of parasitosis. There is no primary lesion to explain the deep excoriations on the thigh.

Figure 4—Skin atrophy caused by steroid abuse. The patient suffers from cutaneous hypochondriasis. The vein appears prominent because of the skin change.
though this is done primarily to scalp hairs (Figure 2), any body hair, including the eyebrows, is vulnerable. The incidence of trichotillomania is low, but the condition often goes undiagnosed because it is not well known. Many physicians give these patients topical or systemic antifungal agents without carefully inspecting the areas of hair loss.

Trichotillomania is more common in children, especially between the ages of 4 and 10 years, than in adults. The damage is most commonly done when children are reading or writing or in bed, often without anyone else in the room. Usually, patients are under some emotional stress; I have seen trichotillomania, for example, in children who have recently moved to a distant city and thus been abruptly taken away from their old school and friends.

Clinically, the bald area that results is patchy; there is no scarring or inflammation. Close inspection reveals twisted and broken hairs of irregular length that do not fluoresce with Wood's light.

Often the problem is solved simply by explaining the cause to patients and their parents. If the parents seem skeptical, try applying flexible collodion to the affected area. New hairs will gradually push the film upward, since patients will not be able to pull them out without first ripping off the protective collodion.

Delusions of parasitosis
Most patients with this rare condition scratch continuously, even in the waiting and examining rooms, making other people—and you—nervous. Characteristically, patients will produce tissues, or a small dirty box, said to contain the offending insects.

Since there is a possibility, however remote, that some unusual bird mite or other small creature is causing the itch, these "samples" should be inspected under the microscope. Almost always, however, you will find they are only fragments of skin, hair, bread crusts, or clothing debris.

Often a patient with delusions of parasitosis offers elaborate explanations of the life cycles of the supposed tormenters, noting their diurnal periodicity, their likes and dislikes, and his own frustrations at being unable to rid himself of them. Prior to seeking medical help, he may have called the police about a "negligent" landlord, washed and boiled his clothes and bed linen daily, and applied a bewildering array of bleaches and caustic agents to his skin and clothes.

On physical examination, the most common finding is excoriations without any primary lesions and without any living or dead organisms on the skin or clothing (Figure 3). Patients invariably explain the excoriations by saying they were just digging out the insects. Real gougcs often result! Once infestation and organic psychoses have been excluded, psychiatric referral is indicated for these patients.

Cutaneous hypochondriasis
In this disease, patients express undue concern and anxiety over what to others seem to be trivial lesions of the skin, hair, and nails. For example, a 40-year-old man is disturbed about becoming bald because he saw a few hairs on his hairbrush, despite a negative family history of baldness and despite the fact that examination shows only the normal daily hair loss; his anxiety probably stems from deeper-rooted fears, as of loss of virility or marital problems. Similarly, a woman in her mid-thirties may worry about freckles that she has had for many years but which she now fears make her look older than she really is.

The real problem here is when these patients abuse medications, such as topical steroids prescribed by a well-meaning but frustrated physician. When used for prolonged periods, steroids may lead to perioral dermatitis or atrophy, thinning, and striae of the skin (Figure 4).

Many of these patients respond to reassurance and counseling aimed at clarifying the problem; others may require psychiatric referral.

Lichen simplex
Clinically, lichen simplex and lichen simplex chronicus (localized neurodermatitis) present as chronic low-grade inflammations. The immediate cause is rubbing or scratching, and the predominant symptom is pruritus. Scratching is often out of proportion to the extent of objective skin change, however, and not all patients will develop lichenification.

Another early clue to the diagnosis: Patients who rub and scratch their skin habitually are prone to a number of other nervous habits, such as nail biting, lip biting and licking, and chain smoking.

The pathogenesis of lichen simplex is not known, but we suspect that the initial scratch response is triggered by nervous tension, setting up an itch-scratch cycle that is difficult to break without medication.

Triamcinolone acetonide, as a 0.1% cream for topical use or in a USP suspension diluted to 2.5 to 5 mg/ml for intralesional use, is very helpful. Its effectiveness may be enhanced by the con-
comitant use of flurandrenolide tape; this protects the lesions from further scratching and serves to occlude the medication.

**Pruritus**

Organic disease must always be ruled out first in patients with anogenital or generalized pruritus.

The differential diagnosis of anogenital pruritus includes diabetes, vaginal infections caused by *Candida albicans* and *Trichomonas vaginalis*, urinary tract infection, threadworm infestation, psoriasis, and contact dermatitis.

Once these disorders have been ruled out, ask patients about their general outlook, sexual attitudes, and anxiety level. Psychologic problems that may be associated with pruritus include fear of pregnancy, inhibitions concerning intercourse, and suppressed homosexuality. Some authorities regard pruritus and scratching of erotic areas as a form of masturbation, while others consider it to be a form of self-mutilation.

Treatment of anogenital pruritus once again requires breaking the itch-scratch cycle, often with a combination of topical, intralesional, and systemic measures including sedatives and tranquilizers.

The differential diagnosis of generalized pruritus involves more possibilities: scabies, insect bites, contact dermatitis, atopic dermatitis, urticaria, dermatitis herpetiformis, mycosis fungoides, pregnancy, hepatic disease, leukemia, cancer, diabetes, and myxedema.

There is no doubt that fear and tension can induce vascular changes in the dermis; some authorities believe that such tension creates a chronically low threshold for "itchability."

If no organic cause for the itching can be demonstrated, systemic antihistamines are very helpful. I use hydroxyzine hydrochloride because it provides tranquilizing and sedative effects as well as antipruritic action, and it comes in a variety of dosage forms to make individualization practical. Other useful agents include topical corticosteroids, colloidal oatmeal baths, and nondrying soaps.

Since topical antihistamines can cause contact dermatitis, they are best avoided. Once such topical sensitization occurs, later systemic administration of the same antihistamine could induce a severe, generalized contact-type dermatitis.

**Hyperhidrosis**

Excessive sweat production can be aggravated by emotional problems. This is especially true of hyperhidrosis of the palms, soles, and axillae. Sweating can be either continuous or phasic, appearing only in response to emotional or mental activity. Patients with hyperhidrosis may have a higher incidence of contact dermatitis; those with hyperhidrosis of the soles are also more prone to pitted keratolysis (due to *Propionibacterium*) and to plantar warts.

Both the severity of the condition and the patient's emotional reaction to it affect treatment. Simple reassurance and the use of absorbent powders and nonirritating antiperspirants may be adequate. For more severe cases, I recommend an anticholinergic such as propantheline bromide or diphenamid methylsulfate; either will inhibit perspiration for several hours.

I regard surgical sympathectomy as a last resort, to be used only in patients with the most extreme and recalcitrant cases of hyperhidrosis. A somewhat less radical procedure that is helpful in some severe cases involves removal of the skin of the axillary vault containing as much as 90% of the offending sweat glands.

**Atopic dermatitis**

Atopy is a complex entity characterized by a marked familial tendency to allergic rhinitis, a high degree of hypersensitivity to protein substances, and nervous system disturbances char-
characterized by unusual reactions to heat, cold, and tension.

Atopic dermatitis is often, but not always, associated with atopy. It is estimated to be eighth in order of frequency of dermatoses in persons under age 25. Psychologic and psychosocial influences often affect the course of atopic dermatitis. Patients characteristically tend to repress their emotions. They have difficulty in expressing aggression toward the outside world, and instead direct their aggression toward themselves.

Scratching may become a form of self-punishment for these patients. For instance, one atopic dermatitis patient recently reported that “When I want to tell someone off, and I can’t, I scratch.”

It has been postulated that both early maternal rejection (particularly in the first few months of life) and maternal overprotection are key factors involved in the pathogenesis of atopic dermatitis.

Clinically, atopic dermatitis often begins during childhood. Lesions occur on the face, neck, antecubital fossae, hands, wrists, and popliteal fossae. Since the objective changes are caused chiefly by rubbing and excoriation, thickening and lichenification are characteristic, though not universal, findings (Figure 5). Partial depigmentation may also occur; in chronic cases there is often a characteristic fold (mongolian fold or Dennie’s lines) below the lower eyelid.

In schoolchildren, excessive sweating during physical education classes may exacerbate the skin problems and cause excessive absences. These children may also have difficulty concentrating because of the associated pruritus.

Management should be aimed at controlling the itching. A specific approach is a lukewarm colloidal oatmeal bath; this is followed by topical application of the least potent corticosteroid ointment that is capable of controlling the condition. The least potency is indicated here since the disease is of a chronic nature and many atopic dermatitis patients are children. Hydroxyzine hydrochloride syrup may also be given orally. Use of mild superfatted or nondetergent soaps may be helpful, and patients should be advised to avoid excessive exposure to sun or wind.

The development of secondary viral infection (either herpes simplex or vaccinia/Kaposi’s varicelliform eruption) is the most serious complication. Secondary bacterial infection with impetiginization is also common and requires systemic antibiotic therapy; the most effective agent is oral erythromycin. For adults, give either erythromycin base, 250 mg 4 times a day, or erythromycin ethylsuccinate, 400 mg 4 times a day; give proportionately less for children.

The incidence of penicillin-induced anaphylactoid reactions is higher in atopic patients, so it is best to avoid giving them systemic penicillin.

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