

## ORIGINAL ARTICLE

**Basic knowledge in psychodermatology**

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**Abstract**

**Background** The authors try to define the framework of this approach, what should be acquired by “well-informed” dermatologists and what is required to be a psychodermatologist.

**Objective** To better define the necessary knowledge to practice psychodermatology.

**Results** 1) The first level is dermatology psychology: there is a psychotherapeutic implicit effect of the dermatological consultation with a goal that is not psychological change. This effect can be improved by acquiring better communication skills and information. The second level needs a possibility to change the emotional individual process and the relational context in a continuum between counselling and psychotherapy. To practice this level a complete psychotherapeutic education with some specificity is needed. This can be reached by a dermatologist also being a psychotherapist or by a team consisting of both dermatologist-psychotherapist. 2) The psychodermatological patient is characterized by alexithymia. He/she needs to be understood through the body language he/she presents. This kind of patient is coming from families where the theme of loss seems to dominate the histories and be associated with deep emotional experiences of separation anxiety. These characteristics must be known together with the different psychodermatological disorders and the mind-body interaction to handle these patients. 3) Taking all of this complexity into account, the psychodermatologist or the psychodermatological team should be able to integrate the different points and adapt attitudes to the patient's difficulty during the whole therapeutic process. 4) The evaluation of the problem should be done using psychological tools here described.

**Conclusion** The European Academy of Dermatology and Venereology (EADV) together with the European Society for Dermatology and Psychiatry (ESDaP) are able to provide the specific education for dermatologist and psychotherapist. In the future, they could be responsible for the recognition of these special abilities and treatments on a governmental and European political level.

**Introduction**

Practising dermatology has led us to encounter several patients for whom the medical approach alone is not enough. Either the dermatological disease makes them suffer so much that psychological support is clearly needed, or the disease does not respond to well-managed

treatment. Furthermore, some patients have psychiatric disorders but do not want to consult psychiatrists. These patients thus need psychologically adapted care in dermatology.

Psychodermatology is not a new topic in the field of dermatology<sup>1</sup> and in the past decades teaching books for psychodermatology have been published.<sup>2,3</sup> However,

**Table 1** Different levels of the psychodermatological process

Qualification	Aim	Result
Level 1: managed by well-informed dermatologists	There is no request for psychological change	Dermatological psychology
Level 2: managed by dermatologist + psychotherapist (or dermatologist recognized as psychotherapist)	The psychological change is accepted	1. Counselling: focused on explicit asking 2. Psychotherapy: working with the patient's resistances

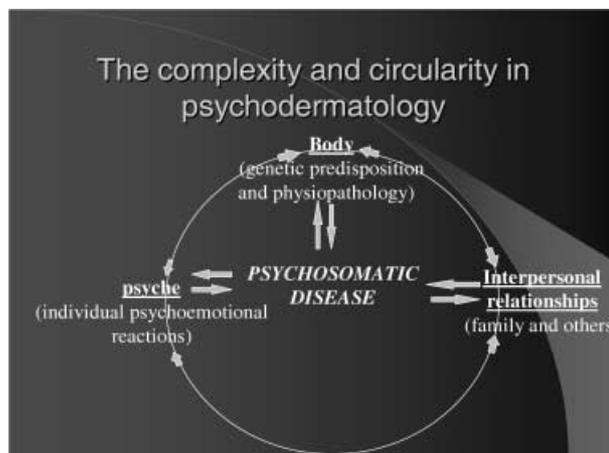
there are no guidelines for teaching psychodermatology to dermatologists and for practising this approach. The designing of a European certificate for psychotherapy will be an opportunity to better elaborate what is needed for psychodermatological patients and what are the minimal requirements expected. This is necessary to clarify the role of both dermatologists and psychotherapists (psychologists or psychiatrists) and the terms of their interactions. It will also provide security for the patients.

### What is meant by a psychodermatology consultation?

In psychodermatology we go one step beyond the usual dermatological consultation. First of all, we intend to devote more time to the patient than the quarter of an hour (or less, unfortunately) usually given in dermatology. But what else is needed in order to call the consultation a psychodermatology consultation? According to the name used to define this special field of interest, we can say that the two parts (psycho and dermato) must be taken into account and worked together.

Why is it important to keep these two parts together? Former interpretations of body and mind as separate fields have led to a dead end. The crisis that has shaken psychosomatic medicine is born precisely out of the contradiction between a demand for unity and totality from the patients and the dichotomous interpretations that inexorably betray this demand and divide this unity. It is also born from the contrast between the principle that psychosomatic disorders are complex disorders and reductionist methods that underestimate this complexity. A transition to other methods that take the multiple components involved in the phenomenon into account by establishing circular correlations between them was imperative.

This means that the healer or the healing team must have both a dermatological and a psychological knowledge and that they must be prepared to make connections and correlations between the different levels (fig. 1). Everybody knows what the requirements are to be a dermatologist or a psychiatrist. But not everybody, particularly among dermatologists, knows what is required to be a psychotherapist. This is important because human suffering must be ethically handled. This means that

**fig. 1** Complexity in psychodermatology.

psychological help must be given by healers who are correctly trained. In psychodermatology there is a relational process within a framework of a more or less formal contract (Table 1). In this definition we can recognize different levels: in the first one the relational process occurs within a special framework but its goal is not psychological change. Within this framework is found what we will call dermatological psychology with reference to medical psychology: there is an implicit psychological or psychotherapeutic effect of the dermatological consultation with a goal that is not psychological change.<sup>4</sup> All dermatologists should be able to manage this level and should be helped to develop their relational skills and their self-awareness and knowledge to be more psychotherapeutic in this sense. This can be achieved by attending conferences and congresses especially devoted to psychodermatology, balint groups<sup>5</sup> and through many other ways. When dermatologists reach this level they become what we will call *well-informed dermatologists*. In the second level the relational process is placed within a special framework with a possibility to explore and to change the emotional individual process and the relational context. To open this possibility without rising too much resistance, the complexity of the disease should be explained to the patient. Then his/her agreement can be obtained. At this point a clear therapeutic framework with some essential rules can

be set up. In this process there is a continuum between two different levels that we will call counselling and psychotherapy. In counselling, the psychological work is focused on explicit asking, is more directive, and provides behavioural models. In psychotherapy the therapist works with the patient's resistances, aiming to resolve these with a different logic than common sense or social reason. In order to work on this second level (counselling or psychotherapy), training in psychotherapy at different levels should be obtained. The actual designing of a European certificate for psychotherapy is an opportunity to better elaborate on the requirements that are needed. To adhere to the proposed European standards of being a recognized psychotherapist, the psychodermatologist or the therapist in the team should have a training in an orientation or method that is internationally and scientifically recognized and that has a complete training programme including theory of psychic disorders, of their causes, and models for intervention. At present only well established psychotherapy schools endorse this approach. Effectively, psychotherapists involved nowadays in psychodermatology are coming from different schools and backgrounds. This means that in this complex problem a healthy eclecticism is needed.<sup>6</sup> Of course there are common factors in the different psychotherapies, the most important of them being the therapeutic alliance.<sup>7</sup> This is one of the best predictors of the efficacy of psychotherapy. But the therapist in psychodermatology should also work by integrating different theoretical approaches and adapting them to the need of the patient. For example, psychoanalysis is difficult to propose to psychosomatic patients, while it could be important that the psychotherapist has psychoanalytical knowledge. A systemic tool like the genogram can be used in different psychotherapeutic approaches and could help, even if the therapist is not a family therapist. Behaviour recommendation should sometimes be used even if the psychotherapist is not a behaviourist, etc. There is thus also a need to develop training adapted to psychodermatology.

However, dermatologists are often not ready to invest so much in psychotherapy training, personal therapy and

supervision sessions. They need thus to work in a team with psychotherapists who fulfil these conditions. On the other side, the psychotherapist is not always trained in taking care of psychosomatic patients. They are different from patients requiring care for merely psychic suffering. Dermatological patients are not clearly asking for psychotherapy at the beginning. They are asking to be cured and the medical approach by itself failed to do so. When they come for psychological care they are often unaware of what they need to change about their ways of thinking or behaviour, and even of their psychic suffering. The disease is their major problem. Even if psychodermatological patients, disappointed by medical care, go directly to psychotherapists, often after having tried parallel medicine, they need a dermatological examination, because sometimes they do not have the best dermatological care adapted for their disease. When the dermatologist is not trained or when a team is not created, the 'well-informed' dermatologist has to prepare the patient to be sent to a therapist specially trained in psychodermatology or to a team, as described above.<sup>8</sup> The dermatologist must keep his/her limits very clear. This will protect the patient from 'wild psychotherapy' and the dermatologist from dealing with patients he/she cannot handle. However, particularly with patients suffering from delusion and patients with factitious disorders, it is sometimes very difficult to send the patient to the psychiatrist. The patient will often deny all psychic disturbances and become angry, and even aggressive. It is a little easier to send the patient to a psychodermatologist if the consultation takes place in the dermatological department. However, it is not easy for the psychodermatologist to intervene when he/she is presented as the last possibility, which is sometimes done. Wouldn't it be better to say, for example, that there are specialists that take into account different aspects in the therapy of skin diseases, including psychological suffering? When the patient cannot accept that proposal, the well-informed dermatologist should thus be able to prescribe some psychotropic or antidepressant medications (Table 2), with eventual supervision by a psychodermatologist

**Table 2** Special ability of the well-informed dermatologist. The well-informed dermatologist should be able to manage

Patient's problem	Ability needed
Delusional patients	Prescription of antipsychotic drugs
Patients not able to undertake psychotherapy:	Prescription of antidepressant or other psychotropic drugs together with relational skills
Social or financial problem	
Cultural difficulties	
Difficult patients	Relational skills
Patients needing psychotherapy	Ability to recognize need and to send patient to a psychodermatologist or to a psychodermatology team
Patients with factitious disorders	Ability to recognize disorders and to react on it

Psychophysiological disorders	All skin diseases exacerbated by psychological conditions: e.g. psoriasis, atopic dermatitis, acne, urticaria, pruritus, alopecia
Primary psychiatric disorders	E.g. OCD,* trichotillomania, BDD, † delusions, factitious disorders
Secondary psychiatric disorders	Psychosocial impact of skin disorders
Comorbidity with psychiatric disorders	The impact of skin disorders is linked to psychiatric morbidity: e.g. on quality of life when there is also depression

\*Obsessive compulsive disorders. †Body dysmorphic disorders.

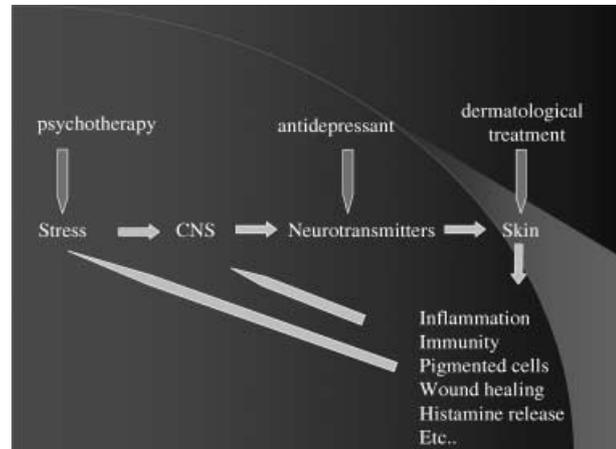
when he/she does not feel self-confident about dosages or possible side-effects. In other cases, when psychotherapy is not possible, for example for social and cultural reasons, the well-informed dermatologist should be able to listen and show empathy, and eventually to prescribe antidepressant medications. The general practitioner is then the best coworker if the dermatologist cannot follow the patient over a long time.

### The psychodermatological patient

It has been observed by dermatologists, and it is now widely documented, that psychiatric disorders are frequent among patients with skin problems, and are more frequent than in the general population.<sup>9</sup>

These disorders are usually classified by dividing them into four categories (Table 3). In the first one psychophysiological disorders (i.e. psychological conditions, such as depression or anxiety) that have been found to exacerbate skin diseases are grouped together. These include alopecia areata,<sup>10</sup> psoriasis,<sup>11</sup> atopic dermatitis,<sup>12</sup> urticaria,<sup>13</sup> acne,<sup>14</sup> and generalized pruritus.<sup>15</sup> The second category includes primary psychiatric disorders such as obsessive-compulsive disorders, trichotillomania, body dysmorphic disorders, delusion of parasitosis or factitious disorders. These disorders are primarily psychiatric, but present dermatological manifestations. In the third are secondary psychiatric disorders, that is to say, a psychiatric disorder that develops as a consequence of the psychosocial impact of the skin disorder. It is well known that skin disorders such as psoriasis, acne and atopic dermatitis have a strong impact on the quality of life of patients.<sup>16–18</sup> Finally, in the fourth category we have problems due to comorbidity with psychiatric disorders: for example impairment of quality of life is increased when there is a psychiatric morbidity in patients with skin conditions.<sup>19,20</sup> All together the study of Picardi *et al.*<sup>21</sup> showed a prevalence of psychiatric disorders of 25% in outpatients with vitiligo, 26% for psoriasis, 32% for acne, 35% for alopecia, 27% for parasitosis, and 34% for urticaria. A study by Gupta and Gupta<sup>22</sup> found a 5.6% prevalence of suicidal ideation among patients with acne and a prevalence of 5.5% among more severely affected patients with psoriasis, whereas the prevalence in the general medical population is 2.4–3.3%. The most com-

**Table 3** Classification of psychodermatological disorders



**fig. 2** How to explain the NICE system to the patient and the necessity of a complex approach.

mon psychiatric disorders observed in dermatology are major depressive disorder, obsessive-compulsive disorders and body dysmorphic disorder.

The interrelationship between mind and skin has been investigated also at a cellular level. The neuro-immuno-cutaneous-endocrine (NICE) model<sup>23</sup> is a construct featuring four organ systems intimately involved in the bridge between body and mind. These intimately linked systems share a language of neuropeptides, cytokines, glucocorticoids, and other effector molecules. Stimuli from environmental factors are converted into biochemical information in the form of neurotransmitters, hormones, and cytokines.<sup>24,25</sup> A simple way to explain this complexity to the patient is shown in fig. 2.

But beyond this biochemical functioning we also have to look to the meaning of the symptom. We know quite well, through our clinical experience, that dermatological manifestations can express, in some obscure way, a deeper malaise that is linked to the subject's psychological dynamics and his/her relationship with the people around him/her (starting with the primary kinship group, the family). Although psychosomatic medicine is inspired by the implicit principle of the unity of the human being, its conceptual procedures and practices are often ambivalent. This ambivalence concerns a disorder that, although expressed through the body with clear somatic manifestations,

appears to refer to something beyond the biological body. However, while this other reality is seen as a neutral, separate entity that we can call the psyche, we remain in a dichotomy, despite all the principles of unity. This is also the case if we try to unify the realities at work simply by subordinating one of these realities to the other or by introducing linear cause-and-effect links between them such that one determined or dictated the other. So we can see that in psychogenic theories, each psycho-emotional factor is reduced to a pure neurophysiological reaction of a biological organism and in the somatogenic theories symbolization processes explain each manifestation of the body. However, it was inevitable that none of these theories would provide a comprehensive explanation of these psychosomatic manifestations.<sup>26</sup> This is because each of the theories proposes a way of interpreting these manifestations without trying to reintegrate them into a context that would give them their full meaning. Indeed, it appears important to restore to the psychosomatic illness its essential nature, that of a painful crossing point between biological and psychosocial factors.<sup>27</sup> The psychosomatic disorder takes place within a body that has been lived in and thus carries a history. The symptom can thus recover the meaning of a language, a communication: for it brings together in itself, recomposes, and synthesizes the meaning of the relational contexts in which it appears, albeit with its own rules and characteristics. Starting with Freud<sup>28</sup> and thereafter, through the various currents of psychoanalytic psychosomatic theory, the reasons why a malaise in these cases takes a somatic path and why the symptom is expressed through the body have frequently been discussed. In particular, people have wondered whether these non-verbal or analogous forms of expressing suffering could be linked to an inability or difficulty in verbalizing certain emotional experiences. This gave rise to the creation of a concept that Sifneos<sup>29</sup> named alexithymia. This concept is linked to an earlier one, that of operative thought. The authors of the French school Marty, De M'Uzan, and David<sup>30</sup> used the term operative thought to indicate a type of concrete, utilitarian thought characterizing psychosomatic patients and designating, at the same time, an apparently impoverished quality of fantasized life and emotional expression. Nemiah<sup>31</sup> who worked frequently with Sifneos, tried to give this structural alteration of the patient a neurophysiological foundation by supposing the existence of some lesion in the connections between the limbic system and the neo-cortex. So, in all this research, which was characterized by observation of the patient only, the individual remains at the centre of the pathology. However, the results of recent research enable us to revise this last concept and approach this problem in a more functional way.<sup>32</sup> Research on the structure and dynamics of families with psychosomatic

patients have clearly revealed that one of the most typical dysfunctional characteristics in these families is the tendency to avoid expressing conflicts and emotional tensions. We can then understand and verify how difficulty in verbalizing emotional experiences is not the consequence of a lack of imagination and emotions, but results rather from the fact that emotions are carefully filtered so as to avoid tensions and conflict, and so as to conserve a pseudo-harmony in the family system.<sup>33</sup> It should be noted, in addition, that not only the patient, but also all family members cooperate to achieve this aim. What is more, if we evaluate not just verbal communication, but also non-verbal communication (observing the family context makes this last form of communication particularly visible), we can see that emotions and affects are not at all absent. Rather, the expression of emotions undergoes a process of selection aimed at protecting the family's unity. It then becomes possible to assert that the language of the symptom, even if the patient expresses it somatically, is not just the language of the patient's body, but also that of the entire family, which seems to come together around the unspoken myth of unity. This myth of unity seems to form the far-reaching cement of the family, within which fantasies of rupture and fears of the family's disaggregation exist. There is no doubt that the family myths and fantasies take shape and appear in the course of a history, down a path in time that the family members have taken in part together and in part individually, in a complex network of entanglements and reciprocal influences. This history often refers back to the parents' families. This makes it thus necessary to investigate three generations. In two of the authors' (Onnis, Poot) work we were struck by the frequency with which it was possible to discover in these families' pasts (and in the parents' relationships with their respective families) the presence of traumatic events, such as early mourning that has not been expressed, premature separations, serious illnesses, and abandonment. More precisely, the theme of loss often seems to dominate these histories and be associated with deep emotional experiences of separation anxiety. We then asked ourselves if these myths of unity at all cost, which was so frequent in these families, arose as shared defensive constructions, bulwarks against fears of loss and separation anxiety. This prompted us to learn about these families' histories more systematically by constructing and working on their genograms.<sup>34</sup>

### **The psychodermatologist (or the psychodermatological team)**

Because of all this complexity, the psychodermatologist has the difficult task of integrating the different points (physical symptoms, psychic suffering, family fears and

dysfunction), and to explain these to the patient in a way that can help him/her to understand the meaning of the symptom. This will give him/her a choice, a chance, to get rid of the symptom by bringing to consciousness the point where he/she is stuck. During this process the psychodermatologist will have to evolve, to change progressively, attitudes and roles from a medical to a psychotherapeutic intervention. Guidelines must be settled to protect the patient from counter-transference movements. Counter-transference refers to the therapist's feelings from his/her own past being projected on to the patient. Counter-transference movement occurs when the therapist acts on these feelings. This is why the psychodermatologist working at the second level or the psychotherapist in the team must have worked on themselves, on their family history, on their roles in their own family, on alliances and triangulation they got caught up in without being aware, on their unsolved conflicts, etc. With this awareness they will be able to distinguish between the patients' and their own issues. This is why sessions of psychotherapy and supervision are essential for the therapist. Supervision should continue throughout the psychotherapist's work, but may eventually become less frequent as he/she becomes more and more experienced.

Therapeutic efficacy relates to characteristics of the therapist whatever school he/she comes from. This involves absence of emotional problems from their own life, confidence in their work and in their way of helping the patient, real ability and competence, engagement with the patient (perceived from the patient's point of view), empathy and relational skills.<sup>35</sup>

The psychodermatologist and also the well-informed dermatologist should define as well limits to involvement with patients and protect themselves from burnout. They need to alternate between being very close and empathic during the consultation to switching off and returning to their own lives in a flexible manner. Some of our patients are 'borderline' and are very demanding. With these patients boundaries must be in place, and need to be worked on each time the patient breaks them.

### **How can we evaluate the patient's problem and propose a therapeutic way?**

At the beginning the patient is completely unaware of what the problem could be. At this stage the well-informed dermatologist has to answer different questions: is this patient depressed, is there a risk of suicide, violence, addiction, psychosis? The tools to explore the problem are:

1 The clinical observation: this is an informal way of carrying out a global evaluation. How does the patient behave, how are they talking, what about non-verbal

language, for example the position of the chairs in the room? Who is next to whom? How are they dressed? Who is talking first in the family?

- 2 The dermatologist's feelings: What is the atmosphere? Psychotic patients may give off some sense of unreality even though their conversation seems to be normal. For other patients the atmosphere is very different from what is said (closeness vs. openness, for example, or pseudo-harmony vs. hidden tensions).
- 3 Questions: sleep disturbances, appetite, weight gain or loss, mood, quality of life.
- 4 Questionnaires, including those specific for dermatological conditions.<sup>36</sup> These can help to define more accurately the problem and the consequences of the disease. They are needed when studies are conducted. They are very important for scientific work as they contribute to confirming psychodermatology as a special field and may help to better understand dermatological diseases and their connections with mental health. It is therefore important to correctly validate the used test in the language of the country where the study is carried out.
- 5 The genogram: The genogram involves setting the patient's family history down on paper by drawing their family tree. The construction of this family tree in the course of the consultation can be done from a medical standpoint by well-informed dermatologists. They will collect information on early death in the family, alcoholism, divorces, and recent difficult events. This will help to determine whether psychological care is needed. It has been documented that such points are linked with high utilization of medical care in general practice.<sup>37</sup> It will also help the patient in consulting a psychodermatologist. The genogram is also a useful tool for the psychodermatologist to access the patient's emotions. Through semidirected psychological interviews it reveals how the patient talks about their family, their starting point, and emotions about unresolved issues such as mourning, privileged ties, breaks, and losses. Through this genogram and thereafter, psychotherapeutic work can be done. It will provide another understanding of the symptoms.<sup>38</sup>

With all this information the well-informed dermatologist can start to formulate hypotheses to distinguish what help the patient needs. It will also help the psychodermatologist to lead the patient to explore particular directions.

The therapeutic intervention should aim at integrating two objectives: the resolution of the symptom and the patient's personal development, taking into account the patient's needs. With older patients, the chance of changing may be quite small, which is not the case with young patients. But there are different phases in the therapy and the patient can develop from wanting to being rid of a

symptom to being more autonomic, increasing their assertiveness and to developing their full potential. After some time the symptom can be forgotten.

## Discussion

This work has identified two different levels in psychodermatology. The well-informed dermatologist needs openness and communication skills. They should have knowledge about neuroleptics and antidepressant medications and the ability to recognize and refer patients needing psychological help. Self-awareness is also important in order to empathise with patients and to use pastoral and relational skills together with technical skills and scientific knowledge. Surprisingly this improves job satisfaction.<sup>39</sup> By identifying the patient's problem more accurately and by using better communication both patient and doctor will benefit. There are special requirements to practice psychotherapy as a psychodermatologist. These are contained in the European certificate for psychotherapy that is currently proposed. A healthy eclecticism in the different approaches will help together with specific psychosomatic theoretical knowledge.

## Conclusion

Looking at these different points we can see that a specific education tool needs to be developed in Europe under the umbrella of the European Academy of Dermatology and Venereology (EADV). Our organization has succeeded in restructuring dermatology all over Europe. This will enable young dermatologists from every European country to be educated to a high standard of practising dermatology in Europe. The fostering committee has this important task. Training in psychodermatology over the summer period is already foreseen. The European Society for Dermatology and Psychiatry (ESDaP), Sister Society of the EADV, is grouping together many European psychodermatologists. This will enable recognized teachers to educate trainees in dermatology. With the help of the EADV, ESDaP could also be the organization that certifies a psychotherapist in psychodermatology. In this way, in a not so far future, every European dermatologist will be well-informed in psychodermatology, and we will have psychotherapists or psychodermatology teams recognized as able to help our psychologically suffering patients in every European country. This could lead to recognition on a governmental and European political level to have these treatments chargeable on health insurance, which is alas not always the case at present. This will take time but we are on the way. If national, European and international organizations work together, it could happen quicker than we think.

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