

PSYCHOSOCIAL IMPACT OF SKIN CONDITIONS

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This article introduces the area of psychodermatology and summarises the literature on psychosocial adjustment in dermatological conditions. It briefly outlines the psychosocial impact that can be associated with skin conditions and details the factors that might be associated with individual variation. It presents an explanatory model that draws some of these factors together and makes suggestions for intervention. Lastly, some of the issues involved in assessment of psychosocial distress are outlined, highlighting interventions that are already available.

KEY WORDS

Psychodermatology
Psychosocial impact
Disfigurement
Adjustment and coping skills

It is increasingly acknowledged that while it is likely that a large number of people living with skin conditions adjust well to their condition, there is a risk for some to experience psychosocial distress. Indeed, it may be this distress that motivates a significant minority of people to seek referral from primary care into specialist dermatology services. This article is aimed at assisting dermatology nurses to identify and manage psychosocial distress.

The term 'skin condition' rather than skin disease will be used, in order to be inclusive of the full range of dermatological conditions and the

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psychosocial elements associated with such conditions. Psychodermatology can be thought of as being concerned with three groups of condition, which are not mutually exclusive (Table 1).

There are skin conditions that might be considered to be 'primary psychological' in nature, that is where the aetiology of the presenting complaint and the underlying maintenance mechanisms are connected with emotional or 'functional' issues. Such issues are often not consciously known to the patient, who usually presents with a strong belief that their condition has an organic cause, and will be resistant to suggestion to the contrary. These conditions can be relatively difficult to identify and it is always essential, as for example in so-called 'functional itch disorder' or 'psychogenic pruritus', to exclude organic explanation (Misery et al, 2007) and to involve psychological assessment. The second group are those that might be termed 'psychophysiological', where stress may be an exacerbating, maintaining and/or triggering factor, as has been discussed in relation to conditions such as psoriasis (Al'Abadie et al, 1994). Thirdly, there are those conditions that might be termed 'secondary psychological', where the issue is adjustment and the distress resulting from the skin condition. The latter group is by far the most frequently seen in the clinic and will be the main focus of this article.

What do people with chronic skin conditions have to live with?

In conjunction with managing the physical symptoms, there are often issues to be dealt with associated with the treatment itself, and additionally in managing the social and psychological reactions, as will be described below.

Table 1

Types of psychodermatological conditions

Type and examples of clinical diagnoses (note overlap)

Primary psychological:

- ▶▶ Delusions of parasitosis
- ▶▶ Trichotillomania
- ▶▶ Hypochondriasis
- ▶▶ Dysmorphophobia
- ▶▶ Neurotic excoriation

Psychophysiological:

- ▶▶ Psoriasis
- ▶▶ Acne
- ▶▶ Atopic dermatitis
- ▶▶ Rosacea
- ▶▶ Urticaria

Secondary psychological:

- ▶▶ Vitiligo
- ▶▶ Psoriasis
- ▶▶ Acne
- ▶▶ Alopecia areata

Treatment

Naturally patients want their symptoms to be alleviated or cured with treatment, however; there can be a gap between expectation and what is medically achievable. This may affect treatment adherence as well as psychosocial functioning. Treatment can involve messy and/or unpleasant smelling creams and ointments, and regular, time-consuming procedures involving attendance at the clinic or preparation at home. There can also be unpleasant side-effects associated with some treatments. The quotes below are taken from qualitative studies and demonstrate that for at least some people, there can be distress associated with the treatments themselves:

I don't want to go through all this rigmarole every day, putting this stuff [camouflage and sun-block] on.

(Quote from a woman with vitiligo cited in Thompson et al, 2002: 219)

Smearing on the evil-smelling, sticky, staining stuff could take up to two or more hours a day, soaking in it another hour or so. Visits to the clinic absorbed another five or six hours a week.

('Evidence' submitted by a man living with psoriasis to the All Party Parliamentary Group on Skin [APPGS], 2003: 5)

Social impact of skin conditions

Skin conditions are often visible to others and, as a result, social behaviours and attitudes associated with both appearance and illness are relevant to the adjustment process. As early as 1976, Jobling found that for people with psoriasis interpersonal difficulties were the worse psychosocial impact. Goffman's (1963) seminal work on 'stigma' describes how the visibility of a condition can mark one out as an object for negative reactions from others. Indeed, there is evidence that people hold negative implicit attitudes (attitudes that have not been modified in response to social desirability) towards people with visible skin conditions (Grandfield et al, 2005), that may in part account for the well acknowledged finding that people with a visible disfigurement do face the real prospect of intrusive reactions (e.g. Rumsey and Bull, 1986). Understandably,

qualitative studies bear testament to the impact of such reactions:

I mean it does get you sometimes. If you see them actually staring at you.

(Quote from a woman with vitiligo, cited in Thompson et al, 2002)

Unsurprisingly, visibility is one of the few objective factors that have been identified as being associated with psychological distress (Kent and Keohane, 2001), although it does not account for the whole picture (see below). Nonetheless, it is essential that clinic staff are aware of the reactions that patients can experience which can be discriminatory and affect occupational opportunity. Recently, Unite the Union (www.amicustheunion.org/) along with the Psoriasis Association (www.psoriasis-association.org.uk/) have been lobbying to have the employment rights of people with psoriasis protected (Figure 1) (Hutchings, 2008).

Children can be particularly reactionary and children with a visible difference can experience bullying, social isolation and pity, as the following quote from one child demonstrates:

They'd call me names because of it, 'scabby fish cake', what they called me because my skin's quite scaly.

Quote from a child with eczema, cited in Thompson and Worthington, 2007

Experiencing social exclusion over a prolonged period of time during childhood is likely to have an effect on the development of personality, particularly in relation to vulnerability to experience shame (Kent and Thompson, 2002).

Psychological impact of skin conditions

Given the potential social and physical consequences, raised levels of psychological distress have been reported, with some studies indicating as many as 30% of patients may have clinically significant levels of distress (e.g. Gupta and Gupta, 2003). Psychological difficulties most commonly found have included: anxiety, particularly social anxiety; depression, including risk of suicide; lowered self-esteem; feelings of shame; and concerns with body image (Benrud-Larson et al, 2003; Salzer and Schallreuter, 1995).

Numerous reports suggest that such distress translates into actual disability in terms of reduced quality of life (Verhoeven et al, 2007), and people often engage in avoidance coping, i.e. avoiding situations where they anticipate they will either become distressed or experience negative reactions, or both.

Accounting for individual variation in the psychosocial impact

While the literature indicates that there are generally higher levels of psychological distress among people with skin conditions (Gupta and Gupta, 2003), there is considerable individual variation and many people cope well (Kalick et al, 1981).

As suggested earlier, there does not appear to be a simple relationship between single medical and demographic factors such as severity, type of condition, age, gender and psychological adjustment (see Thompson and Kent, 2001). Numerous studies have found only a weak association between disease severity and psychological functioning (see Kimball et al, 2005, for a review in psoriasis).

Accounting for the variation in individual distress and identifying the key factors that are involved in adjustment, will lead to the development of useful assessment guidance and measures, as well as appropriate interventions. Figure 2 is a heuristic model of the biopsychosocial factors likely to be involved in accounting for individual adjustment (for similar models see Kent, 2002; Kent and Thompson, 2002; Thompson, 2005).

Figure 2 shows how 'early experiences and cultural stereotypes' may play a



Figure 1. Steve McBean has been collaborating with Unite the Union to get disability rights for psoriasis patients. Photograph and quote first appeared in the 'United' Unite, The Union Magazine Issue 2, Winter 2008. Reproduced with permission.

role in adjustment. Children are likely to internalise stereotypes and consistent negative reactions received from others, particularly from carers. Such experience will shape cognitive structures associated with self-concept and personality and may lead in severe cases to shame-proneness. Further, Cash and Labarge (1996) have defined body image in terms of appearance-related mental representations developed in childhood. However, acquiring a skin condition in later life can also be distressing and may be related to either the confirmation of existing predisposing underlying negative beliefs, or to discrepancies arising between existing positive self-beliefs and actual self. Therefore, the personal value previously attributed to appearance may be a critical factor for some in predicting distress.

'Cognitive factors' do not just include dispositional traits but also processing styles such as jumping to conclusions, and scanning the environment for anticipated threat. Such processing biases are well acknowledged in social anxiety and have been hypothesised to play a role in guiding coping strategies in disfiguring conditions (Thompson and Kent, 2001). Consequently, they will influence not only mood and quality of life, but also engagement in treatment and the reactions of others, which, in turn, will influence adjustment.

'Coping strategies' refer to the many strategies (cognitive, behavioural and emotional) used to manage specific stressors. Lazarus and Folkman's (1984) transactional model is currently the predominant model of coping. This model suggests that through a process of primary and secondary appraisal, an individual will make use of a range of coping strategies. The available range can broadly be split into those that are aimed either at directly tackling the stressor itself, so-called problem-focused strategies (e.g. confronting someone who is staring), or those that are aimed at regulating the emotional impact, so-called emotion-focused strategies (e.g. wishful thinking). Avoidance behaviours, including the use of subtle safety behaviours (such as turning one's body so as to hide one's perceived worse side) are all commonly related to dispositional factors such as shame-proneness and fear of rejection (Gilbert, 2000).

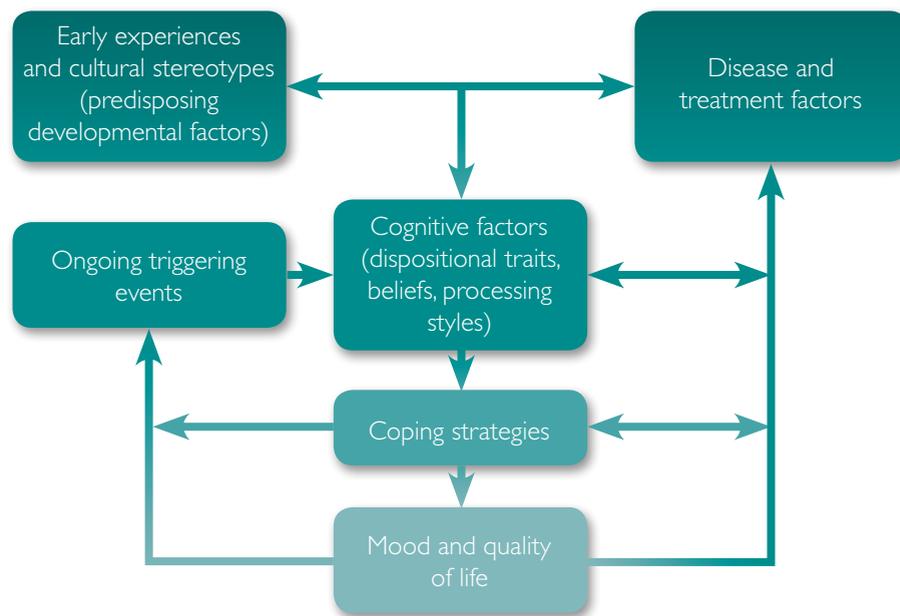


Figure 2. Model of the interacting factors implicated in the origin and maintenance of skin specific affect/distress.

Many skin conditions have a fluctuating course. Likewise the occurrence of anxiety being triggered by social events, such as meeting new people, varies over time. It has been argued that adjustment is likely to place an ongoing demand on psychological resources, and not be a discreet linear process (Thompson, 2005). This ongoing demand on psychological resources may also be influenced by factors such as general well-being (Thompson et al, 2002).

Implications for nursing assessment

Quality of life assessments have become commonly used in dermatology (Basra et al, 2008). However, while such measures have strengths it has also been commented that they have limitations, particularly in not measuring emotional distress (Chamlin et al, 2004). Consequently, verbal nursing assessment may be preferable, perhaps recording distress using simple scales (1–7 scales) of subjective distress across a range of domains during nursing consultations (Table 2).

In many ways the line separating assessment from intervention is somewhat blurred and an empathetic and sensitive nursing 'assessment' can provide patients with an important opportunity for emotional disclosure, normalisation of symptoms and provision of self-

help information. It is important when conducting an assessment, to be aware of how medical, social, and psychological factors can interact, as shown in Figure 2. Taking such a biopsychosocial perspective requires a sensitive assessment of a range of factors, as shown in Table 2, that cover behaviour, cognition, emotion, social circumstances, as well as biomedical signs.

As there is evidence that clinical severity is not a good guide of psychological functioning (Sampogna et al, 2004), it is much better to ask the patient about perceived severity rather than to rely on objective or professional measures. Exploring beliefs and expectations about treatment is also important in ascertaining psychological vulnerability should treatment be unsuccessful, and to provide an opportunity to improve treatment adherence. This line of questioning may provide an opening for psychological distress to be disclosed, which should always be followed up with more detailed questioning, including questions about risk of self-harm and suicide when necessary.

Implications for nursing intervention

There is much that can be done within the clinic to alleviate psychosocial distress once it has been identified. Figure 3 shows how a stepped care model might operate in this setting.

Table 2**Areas to explore during assessment****Behavioural:**

- ▶ Avoidance
- ▶ Agression
- ▶ Irritability
- ▶ Scratching

Cognitive:

- ▶ Worries
- ▶ Self-criticism
- ▶ Expectations

Emotional:

- ▶ Nervousness
- ▶ Low mood
- ▶ Shame
- ▶ Anger

Social:

- ▶ Current stresses
- ▶ Support
- ▶ Reaction of others
- ▶ Discrimination

Medical:

- ▶ Patient perception of change
- ▶ Severity
- ▶ Side-effects

The model shown in *Figure 3* suggests how different interventions might be required. Where there are well-established cognitive factors operating or clear early experiences playing a role, in-depth or complex psychotherapy interventions such as cognitive behavioural psychotherapy, cognitive analytic psychotherapy, or psychoanalytic psychotherapy may be required and this would necessitate a referral on (Chida et al, 2007) ideally to a clinical psychologist or other suitable psychotherapist connected to the extended clinic team. This is important as many patients find the idea of referral to a mental health practitioner a further stigma and there is likely to be greater adherence and less anxiety if there is access to tertiary care as part of the dermatology service. It is important to acknowledge that there are relatively few evaluations of psychotherapy with dermatology patients and further research is needed.

Figure 3 shows how coping strategies play a key role and how there can be the ongoing stress of managing reactions of others. Dermatology nurses with additional training can greatly assist patients in developing coping strategies either to manage the reactions of others, or to manage their own stress. Established relaxation and stress management techniques can quickly be learnt (by healthcare professional and patients), and the development of counselling skills can help facilitate supportive emotional disclosure. In addition, relatively simple behavioural techniques can also be readily learnt and be useful in reducing itching and unhelpful scratching or picking behaviour. For example, Long et al (2006) have described a simple four-session intervention for habitual scratching. They suggest that following assessment, which should include behavioural analysis of the triggers for scratching, patients are taught to use competing response behaviours (including adopting body postures which are antagonistic to scratching postures). While the intervention is simple, for it to work patients must first gain awareness of the habitual nature of their scratching, which can be achieved through record keeping and discussion. There is emerging evidence to support the use of many of these techniques which, as shown in the second level of *Figure 3*, could be provided by core specialist dermatology nurses, although some additional training would be required (Ersser et al, 2007).

Lastly, *Figure 3* describes how simple psychosocial interventions, such as advising patients on their rights if they face discrimination in the work place, advising patients of national and local support groups and internet resources, listening to distress and normalising experiences, and signposting towards self-help, could be provided by all staff working with dermatology patients. Indeed, there is a wealth of self-help material provided by a range of organisations including Changing Faces (www.changingfaces.co.uk/), the Psoriasis Association and the Vitiligo Society (www.vitiligosociety.org.uk/).

The future of psychodermatology

Clearly, the role that psychosocial factors play in skin conditions is undeniable and yet services to address such

issues are scarce and underdeveloped. Psychodermatology must be included as a routine part of training in dermatology for both specialist nurses and doctors, to enable confident psychosocial assessment and implementation of a variety of primary psychosocial interventions. Models of service delivery need to be established that provide patients with an opportunity to receive low intensity psychosocial intervention in the clinic, and the establishment of clear pathways into linked secondary specialist psychological services is required. Further research is needed to establish psychosocial need, develop explanatory theories that can account for individual variation and to develop and evaluate interventions. **DN**

References

- Al'Abadie MS, Kent GG, Gawkrodger DJ (1994) The relationship between stress and the onset and exacerbation of psoriasis and other skin conditions. *Br J Derm* 130: 199–203
- All Party Parliamentary Group on Skin (2003) *Report on the enquiry into the impact of skin diseases on people's lives*. HMSO, London
- Basra MKA, Fenech R, Gatt RM, et al (2008) The dermatology life quality index 1994–2007: a comprehensive review of validation data and clinical results. *Br J Derm* 159: 997–1035
- Benrud-Larson LM, Heinberg LJ, Boling C, et al (2003) Body image dissatisfaction among women with scleroderma: extent and relationship to psychosocial function. *Health Psychol* 22: 130–9
- Cash TF, Labarge AS (1996) Development of the Appearance Schemas Inventory: A new cognitive body-image assessment. *Cog Ther Res* 20: 37–50
- Chamlin SL, Frieden IJ, Williams ML, Chren MM (2004) Effects of atopic dermatitis on young American children and their families. *Pediatrics* 114: 607–11
- Chida Y, Steptoe A, Hatakawa N, et al (2007) The effects of psychological intervention on atopic dermatitis — a systematic review and meta-analysis. *Int Arch All Immun* 144: 1–9
- Ersser SJ, Latter S, Sibley A, Satherley P, Welbourne S (2007) Psychological and educational interventions for atopic eczema in children. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD004054. DOI: 10.1002/14651858.CD004054.pub2. Available online at: www.cochrane.org/reviews/en/ab004054.html
- Gilbert P (2000) The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clin Psychol Psychother* 7: 174–89

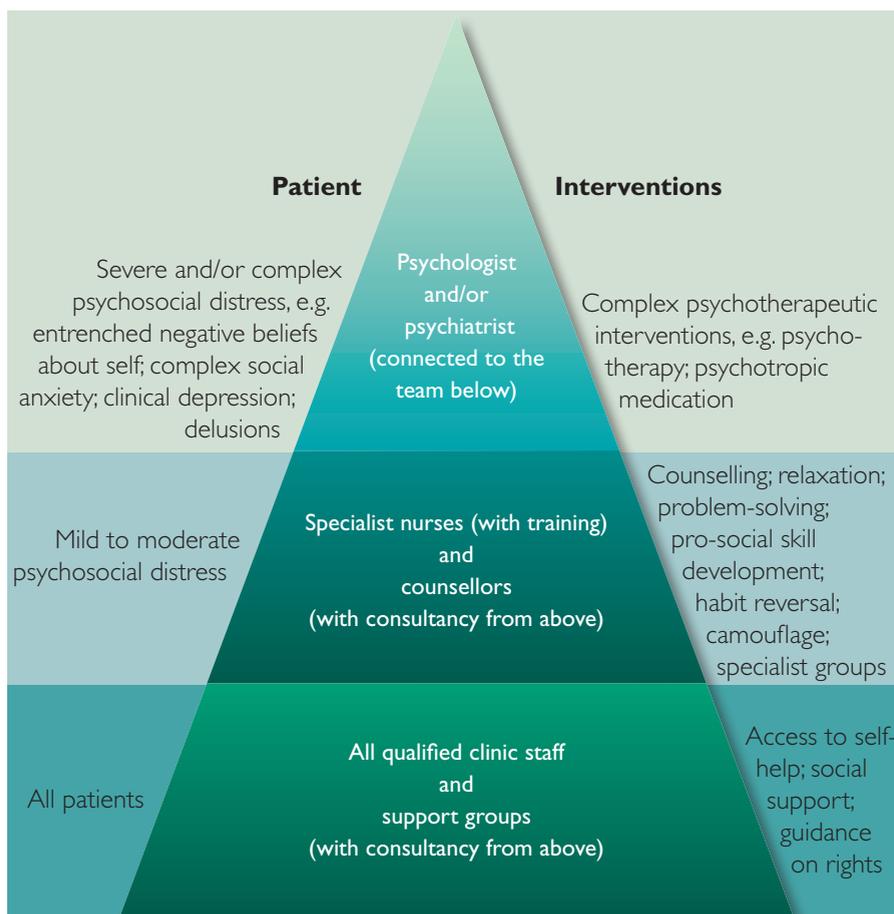


Figure 3. Stepped care model to providing psychosocial interventions.

Goffman E (1968) *Stigma*. Penguin, London

Grandfield T, Thompson AR, Turpin G (2005) An attitudinal study of responses to dermatitis using the Implicit Association Test. *J Health Psychol* 10(6): 821–9

Gupta MA, Gupta AK (2003) Psychiatric and psychological co-morbidity in patients with dermatologic disorders — epidemiology and management. *Am J Clin Derm* 4: 833–42

Hutchings D (2008) More than skin deep: One member's fight to get disability rights for psoriasis sufferers. *United: The Union Magazine* 2: 41

Jobling R (1976) Psoriasis: a preliminary questionnaire study of sufferers' subjective experience. *Clin Exp Derm* 1: 233

Kalick S, Goldwyn R, Hoe J (1981) Social issues and body image concerns of port wine stain patients undergoing laser therapy. *Lasers Surg Med* 1: 205–13

Kent G (2002) Testing a model of disfigurement: Effects of a skin camouflage service on well-being and appearance anxiety. *Psychol Health* 17: 377–86

Kent G, Thompson AR (2002) Models of disfigurement: Implications for treatment. In: Gilbert P, Miles J, eds. *Understanding*

body shame. Brunner-Routledge, Hove, UK: 106–16

Kent G, Keohane S (2001) Social anxiety and disfigurement: the moderating effects of fear of negative evaluation and past experience. *Br J Clin Psychol* 40(Pt 1): 23–34

Kimball, AB, Jacobson, C, Weiss, S, Vreeland, MG, Wu, Y (2005) The psychosocial burden of psoriasis. *Am J Clin Derm* 6(6): 382–92

Lazarus R, Folkman S (1984) *Stress, appraisal and coping*. Springer, New York

Long D, Long RA, Grillo MP, et al (2006) Development of a psychological treatment service for pruritic skin conditions. *Aust J Derm* 47: 237–41

Misery L, Alexandre S, Dutray S, et al (2007) Functional itch disorder or psychogenic pruritus: suggested diagnosis criteria from the French psychodermatology group. *Acta Derm Venereol* 87: 341–4

Sampogna F, Sera F, Abeni D (2004) Measures of clinical severity, quality of life, and psychological distress in patients with psoriasis: a cluster analysis. *J Invest Derm* 122: 602–07

Rumsey N, Bull R (1986) The effects of facial disfigurement on social interaction. *Hum Learning* 5: 203–8

Key points

- ▶▶ Dermatology patients can face intrusive reactions and, in some cases, real discrimination and may need support on how to deal with this.
- ▶▶ The psychological impact for some people can be the most disabling aspect of the condition and a range of psychological interventions can be effective.
- ▶▶ Access to psychological assessments and interventions is variable and clarity is needed around care pathways.
- ▶▶ Much can be done in the clinic to alleviate distress and dermatology staff require support and additional training to be able to deliver psychosocial interventions.

Salzer B, Schallreuter K (1995) Investigation of personality structure in patients with vitiligo and a possible association with catecholamine metabolism. *Derm* 190: 109–15

Thompson AR (2005) Coping with chronic skin conditions: Factors important in explaining individual variation in adjustment. In: Papadopoulos L, Walker C, eds. *Psychodermatology: the impact of skin disorders*. Cambridge University Press, Cambridge, UK: 57–66

Thompson AR, Kent G (2001) Adjusting to disfigurement: processes involved in dealing with being visibly different. *Clin Psychol Rev* 21: 663–82

Thompson AR, Kent G, Smith JA (2002) Living with vitiligo: Dealing with difference. *Br J Health Psychol* 7: 213–25

Thompson AR, Worthington J (2007) Living with visible eczema — young people's experiences. Oral presentation at The British Health Psychology Conference, 12/09/2007, Nottingham, UK

Verhoeven EWM, Kraaimaat FW, de Kerkhof PCMV, et al (2007) Psychosocial well-being of patients with skin diseases in general practice. *J Euro Acad Derm Ven* 21(5): 662–8