Atopic Dermatitis: Psychological Care

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Abstract: The number of adult atopic dermatitis patients have increased in recent years. Distrust of medical care arising from the abuse of topical steroids has given rise to a flourishing so-called “atopy business”, and this has imposed physical, mental, and financial burdens on the patients. The Japanese Dermatological Association has prepared diagnostic criteria and treatment guidelines to eliminate this situation, and in the process the psychosocial aspects of atopic dermatitis have been taken up as exacerbating factors. Scratching associated with emotions starts when the anger, anxiety, impatience, and tension that arises from the stress in daily life is released, and scratching behavior is established. This is characterized by the appearance of bilaterally symmetrical eczematous rash lesions over the areas of the body that the hands can reach. The first step in the clinical care of atopic dermatitis patients is making them aware of the fact that their idiosyncratic scratching is the greatest factor in prolonging the symptoms. Accordingly, it is important to listen attentively with a receptive and empathetic attitude to the stress the patient is experiencing. An integrated clinical strategy that combines “proper drug therapy” with “psychological care” is needed.

Key words: Atopic dermatitis; Psychological care; Psychosomatic medicine; Scratching behavior

Introduction

The atopic dermatitis that we have been encountering recently is highly intractable, and the number of patients in whom it persists into adulthood has been increasing. In addition to the problem of patients’ appearance, it is associated with lack of sleep because of intense itching, and there is also considerable loss of QOL in terms of patients’ going about their lives in society. For these reasons, atopic dermatitis is one of the skin diseases for which the establishment of an appropriate method of treatment is strongly desired.

Before the name “atopic dermatitis” was advocated by Sulzberger et al. in 1933, in Europe the disease was called constitutional eczema, neurodermatitis, and Besnier’s prurigo. The pathological elucidation of atopic dermatitis subsequently progressed in tandem with the
evolution of immunology and allergology. By contrast, although there was considerable debate concerning the psychological aspects of atopic dermatitis and psychosomatic approaches in the 1940s, it was later overshadowed by allergy research, and for all practical purposes hardly anything was ever done about it. Lately, however, the psychosomatic approach to atopic dermatitis has been taken up in large measure, and this trend has placed more weight on curing patients who have the disease than on elucidating its pathology.

Circumstances Surrounding Atopic Dermatitis

One of the reasons why the psychosomatic approach to atopic dermatitis has come to attract so much attention has been the public’s criticism of the abuse of topical steroids, which ironically have been the main pillar of the treatment of atopic dermatitis. Adverse reactions have been revealed as a result of long-term use of topical steroids, and this coupled with excessive reporting in the mass media, has led to the steroidophobia and intense distrust of medicine. This gap has been associated with the rampant growth of the so-called “atopy business”, and not knowing what to believe, the patients and their families have been at the mercy of dubious information and have been subjected to physical, psychological, and financial burdens.

To overcome this situation, the Japanese Dermatological Association has published the “Diagnostic Criteria for Atopic Dermatitis” and “Treatment Guidelines for Atopic Dermatitis”. The latter is published for specialists in dermatology, and one of the noteworthy features is that it takes up the psychological aspects of the disease. More specifically, numerous exacerbating factors are involved in prolonging atopic dermatitis. Despite avoiding allergens, such as certain foods and mites, and performing skin care that corrects abnormal barrier function, atopic dermatitis usually fails to respond to routine clinical care. This signifies that some other factor has been overlooked in the present clinical practice for atopic dermatitis.

Habitual Scratching

A psychosocial factor, idiosyncratic scratching behavior caused by the stress of everyday life, has been recognized as one of the answers. Kobayashi used diaries to analyze the scratching behavior of a large number of atopic dermatitis patients, and was the first to point to the contribution of habitual scratching in formation of the lesions of atopic dermatitis. The scratching is patterned, with the rash exhibiting a bilaterally symmetrical distribution over the back and normal skin remaining in the middle where the hands cannot reach, producing a “butterfly” sign (Fig. 1).

The scratching often begins automatically in association with emotions, and it is performed habitually every day. In addition to the psycho-
logical factors, such as anger, irritation, impatience, relief, anxiety, etc., many patients say that they somehow find themselves scratching even when they do not itch. The prominent red face in adult-type atopic dermatitis can also be explained by this scratching behavior.

Higaki et al. conducted a questionnaire survey and found that psychosocial factors contributed to exacerbating atopic dermatitis in 83% of patients 16 years of age and older. In our study as well psychosocial factors contributed in the form of exacerbating factors in 29 (93.5%) of the 31 adult atopic dermatitis patients who required hospitalization.

The most common psychosocial factors identified were attributable to excessive demands on the patient’s time at work, at school, at home, etc., taking examinations, and mother-child relations. However, no contribution by psychosocial factors was identified in about 10% of the patients, and another approximately 10% had obvious mental disorders, such as panic disorder or depression. We therefore concluded that approximately 80% of atopic dermatitis patients form a group that is capable of responding to psychosomatic care, more specifically, to attentive listening. It appears that these psychosocial factors may prolong atopic dermatitis through habitual or idiosyncratic scratching.

Psychological Characteristics of Atopic Dermatitis Patients

In this way psychosocial factors have been found to have a major influence in inducing and prolonging scratching, but do atopic dermatitis patients display any special psychological characteristics? Several studies have assessed this question, and the results are summarized that the patients display severe anxiety and depression, and they tend to have a high level of anger. It remains unresolved whether these psychological characteristics are truly specific to atopic dermatitis, or whether the presence of atopic dermatitis itself produces this sort of psychological state. In any event, telling patients, “You have these psychological tendencies”, probably does not help. Of course, psychotherapy or psychiatric treatment does not need to be considered at the very beginning. What is most important is to make the patient aware that the habitual scratching is the greatest causative factor in prolonging the symptoms. The first thing required to be able to achieve this is attentive listening.

Holistic Understanding of the Patient Centered on Attentive Listening

While attentive listening is important, examinations start with careful identification of the physical manifestations. If possible, with curtain drawn, etc., inspect the patient’s entire body, check the distribution and severity of the skin rashes, and even in areas where there are no obvious skin lesions actually touch the skin to determine whether it tends to be even slightly dry, or whether any moist normal skin remains at all. Conversations that encourage the patient to a complete cure, for example by saying something like, “Since you still have this really clear skin, if we treat it properly, all of your skin should clear up”, are useful especially during palpation of the normal skin. Palpation allows the physician to determine the state of the patient’s skin and at the same time send a message to the patient through the physician’s touch.

Checking for rashes caused by scratching, which are considered characteristics of atopic dermatitis, such as the “butterfly sign” described above, glossy nails, referred to as “pearly nails” (fingernails made shiny by scratching), pigmentation and thickening of the dorsal aspects of the finger joints (evidence of using those areas to scratch other sites), bilateral pityriatic erythema of the neck (having simultaneously rubbed it with the thumb and middle finger), pityriatic erythema in the midline of the neck (pinching with the thumb and the index finger), Hertoghe’s sign (thinning of approximately the
lateral 1/3 of the eyebrows) provides objective evidence when attempting to convince the patient of habitual scratching later.

Sitting at a 90 degree angle from the patient creates better conditions for talking during the medical interview than sitting directly opposite the patient. Have the patient talk about the course of the atopic dermatitis thus far, if possible, describing it in chronological order, asking when it began, and when it grew worse. Ask about treatment during that period and whether anything seemed to aggravate it, however, it is essential to express an empathetic attitude, by saying something like, “That must have been terrible”.

Inquire about psychological conditions at home (husband-wife, parent-child, wife-mother in law relations), schoolwork (friends, examinations, cram school, clubs), work-related stress (job-hunting, overtime, sleeplessness, qualitatively difficult work) as psychosocial factors that are often involved in exacerbations. While touch on a variety of matters during the conversation, find out whether the patients have had a so-to-speak “exhausting” time of it, and whether the patient has been put in a position of “being unable to be convinced”. Check on family composition and others living in the home by starting out by asking whether anyone has had any eczematosus rashes, and then casually broadening the conversation. Since it is sometimes difficult for the patients themselves to mention, for example, that they are divorced, or that their parents are living separately, it is better to ask about the family situation after the conversation has progressed somewhat. If the patient is employed, it is easier for the patient to accept when the conversation starts with work.

As the topic of conversation gets closer to the core, the patients’ hands automatically begin to touch their arms and neck. If you restrain their hand and say “This is the problem”, most patients look surprised and suddenly become aware of their unconscious scratching. At the first meeting, it takes the patients about 20 minutes before they begin to talk about what is troubling them most, yet that is the most important part in terms of obtaining their “awareness”, and it forms the foundation for physician-patient relations and a trusting relationship.

This attentive listening is also meaningful as a form of counseling. Its most important aspect is the caregivers’ attitude being receptive and empathetic, and striving not to judge the patients according to their own personal values. Physicians usually occupy a high position in society and have a tendency to brand patients as psychologically weak from their superior position, as though they were judges, however, they must be strictly admonished against speech that might invite the patients to react in that manner.

Mothers of children with atopic dermatitis often lose confidence in their childrearing ability and are bewildered. Inadvertently speaking in a manner that blames the mother in such situations only adds iatrogenic stress. On the other hand, interviewing the patient in a more leisurely manner than necessary, in an attempt to completely understand the patient’s psychological status, will not yield good results. At times temperaments seem to be incompatible regardless of what one does. When that happens, it is sometimes better to bring matters to a close in an appropriate manner and refer the patient to another caregiver.

The most important point is that getting the patients to recognize their unconscious scratching in reaction to stress is all that is necessary, and when re-examining the patient it is best either not to touch on such topics at all, or else lightly touch on them and devote one’s efforts toward correcting inappropriate responses to stress. To repeat, the important thing is to make the patients aware of the close association between stress and scratching.

Many medical caregivers complain that they wish to talk with patients in a relaxed manner, but that they don’t have time, and there do seem to be circumstances in which practicing physicians, in particular, cannot very well spend
sufficient time with each individual patient. In such situations, it is necessary to make some adjustments, such as by gradually deepening the attentive listening over several sessions or taking some other time to listen to the patient in a more relaxed manner.

In terms of medical fees for these clinical services, while there is a notion that it might be all right to apply special additions, e.g., when more than 30 minutes are required, for psychosomatic therapy (70 points) in the outpatient clinic, psychosomatic therapy should essentially be performed by physicians who have been especially trained for it. The attentive listening described here should be included in the basic medical service, and I should like to think that it is covered by the dermatology specially-designated-disease guidance and management fee (III) (50 points). Moreover, medical care that includes psychosomatic medicine has become routine, and I hope that the number of points for the dermatology specially-designated-disease guidance and management fee (III) for atopic dermatitis will be raised to a generally acceptable level not only for guidance regarding topical care but as compensation for the time spent providing psychosomatic care.

This sort of practical backup may also be needed to make psychosomatic care generally available, but the process of providing psychosomatic care before that, perceiving the patient holistically, and considering the optimal treatment methods together with the patient, provides a deep feeling of satisfaction not only to the patients, but also to their physicians as well. Although there are quite a few difficult patients, a different form of growth as a physician as a human being is to be found in not just explaining the disease in the routine way and writing out prescriptions.

**Therapeutic Strategy for Atopic Dermatitis**

Several vicious cycles, including “itching and scratching”, “barrier destruction by scratching and inflammation”, and “stress and scratching” must be broken by the two wheels of “appropriate drug therapy” and “psychological care”. More specifically, I think that breaking these cycles can be achieved by both appropriately using topical steroids and immunosuppressive drugs to control the itching caused by existing rashes and identifying the psychosocial exacerbating factors the patient harbors by empathetic and receptive attentive listening and applying appropriate measures, i.e., stress coping to deal with them. Doing so results in completely cure of the habitual scratching in a short time in the majority of patients. Moreover, just by becoming aware of the habitual scratching, even patients who have severe psychosocial factors begin to feel that they can improve their condition themselves, and at least the “wild fluctuations” described in relation to stock prices is no longer seen in the patient’s skin.

We have encountered many cases in which after becoming aware the patient soon escaped from these multiple troublesome vicious cycles and recovered. It is often difficult to explain how something behaved in leading to a remission, but there is no doubt as to what the first step is. The “psychological care” that had been abandoned up to now may become the greatest task in the medical care of atopic dermatitis in the future.

**REFERENCES**


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