Psychodermatology—A Personal Odyssey

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You are probably all well aware that in Europe certainly, and probably also in Asia, they are years, if no[1]t centuries, ahead of us, in the world of psychodermatology.

Most of the important papers are in the European literature — particularly the British Journal — and there is even a special Journal devoted to the topic, "Dermatology and Psychosomatics". There is evidently money available for research, and there are divisions of psych-derm within dermatology departments in Europe — indeed, I have a friend in such a department, whose enviable job is just to do psych-derm research, and treat patients. By contrast, interest here is luke-warm at best, and really only lip-service is given to the possibility of psychocutaneous interaction.

So — given this as a background, I thought that I would share with you the circumstances that nurtured my interest, in a climate that at the time was frankly hostile. Let me exemplify — on one occasion, at a very large meeting, a very senior and highly respected dermatologist got up, said "if you believe **that**, you're MAD !" and stalked out.

How it happened, was that I had presented a case of psychogenic purpura, in which we had demonstrated the development of a lesion in the fashion that was approved at the time, though it surely would not fly to-day ! We had injected a small amount of the patient's own blood intradermally, at three separate sites. We told the patient that the middle of the three was her blood, and that she should react to that, but as the other two were from controls, there should be no reaction. All areas were occluded overnight, and indeed, the following morning there was a nice purpuric lesion where the patient believed her own blood had been injected.

Clearly the demonstration had made my senior colleague very anxious, and so, in defense against that anxiety, he had to ridicule me.

But I should say that the climate here has not always been so hostile. You may remember that Freud wrote that the "ego is first and foremost a body ego", and in the latter part of the 19th.Century, early

psychoanalysts in Europe were greatly interested in mind-body interaction, an interest that was beautifully exemplified in Freud's "Studies in Hysteria".

In the mid-1930's, psychoanalytic and psychosomatic principles began to filter into the United States, and in 1935, Flanders Dunbar, from New York, published "Emotions and Bodily Change", a scholarly work in which she integrated psychological concepts into the various aspects of physical functioning. She suggested that "psychic" and "somatic" represent merely two angles of observation. "Our understanding of disease" she says, "rests on pictures taken from these two angles, viewed simultaneously, united stereoscopically".

In 1943, Dunbar published "Psychosomatic Diagnosis". This is a very impressive text, in which she applied **psychoanalytic** principles to clinical history-taking, and included those thoughts and feelings that the patient associated with the various events in the history. From this, she was able to develop a psychodynamic understanding of the emotional and physical components of the patient's disease.

Initially, dermatology was somewhat neglected in the U.S., but later Dunbar addressed the skin quite extensively. Stokes and his immediate followers, in Philadelphia, were convinced believers, as were Wittkower, Obermeyer and Becker, and up until the 1940's and 50's, psychosomatic medicine was a topic of some interest.

During this same time, a group of analysts had immigrated from Germany and Austria, and were trying to associate specific physical conditions with specific neuroses. This concept does not really hold water, and has been pretty much abandoned, although in dermatology there are some clear examples—for example, many of our "pickers" have obsessive-compulsive personality styles, as do some of our patients with body dysmorphic disorder. And, because the skin is so readily available for symbolic representation, hysterical-conversion symptoms do occur — for example, a young patient of mine, who developed a rash that was confined to her right leg. This occurred on the day of her grandmother's funeral — and grandmother had died of complications following amputation of her right leg ! Or — a colleague of mine, who developed lichen planus, confined to her right palm, and this occurred on the day after she had shaken hands, to say good-bye, to a much loved teacher !

But — at this point, I shall break off, and go back to my personal Odyssey. Much of this may at first seem un-related to my topic, but hopefully, it will come together, in the end.

I went to medical school in London, and — something quite unheard of at the time — married Peter in my Junior year. This created problems of its own, but they are unrelated to to-day's topic. I graduated in 1953, at the ripe old age of 23. That year was early in the history of the British National Health Service, which was a system that allowed of limited entry into the specialties. But it was a time when there was a long history of service in the colonies and the territories overseas, and this was held to be quite a prestigious career path.

So — being young, adventurous, and perhaps a little naïve, rather than a hum-drum life in family practice, we elected to join the Sudan Medical Service. At the time, Peter had had two years of medical residency, and I, all of six months in Ob-Gyn. Our medical school experience was very different from the U.S — it was really an apprenticeship. One learned by doing, most of the teaching was at the bedside, and lectures were minimal. So — without any extra training in tropical medicine, and **NO** knowledge of Arabic, we set off for Africa, believing ourselves to be adequately prepared.

I greatly wish that I had photographs to share with you, but unfortunately these have fallen victim to our numerous subsequent moves, so I shall have to rely on your imagination.

Our first posting was to Kassala, a small town in the Arab-speaking desert north of the Sudan, where Peter and one Sudanese doctor ran the Government Hospital. At the time our first child was two months old, so I stayed home, tried to absorb a little of the culture that I had adopted, and learn some rather primitive Arabic — this, from a charming gentleman, whose English was almost non-existent, and whose knowledge of medicine, and medical terminology was essentially nil.

After four months we were transferred to Juba, in the Southern sudan, close to the Ugandan border. The actual move may be hard for you to imagine. We, our 6 month-old son, our Arab cook, in his turban and galabea, our Eritrean nanny, and all our worldly possessions were deposited at the railway terminal, as we waited overnight, to board the Nile steamer that would take us south. It was somewhat reminiscent of a wagon-train, going out West ! We spent the night outdoors, in the

center of a circle formed by our furniture, and all our house-hold belongings, with a small fire to keep us warm.

Next day we boarded the steamer — a rather primitive affair to which were roped a series of large rafts, where the native travelers lived, together with the live-stock that would be their provisions for the journey. Cocks crowed, goats were slaughtered, fights broke out, and one evening Peter played chess with a priest, and the poor man was never seen again — quite literally — so it was all very colorful.

The actual steamer had three decks. The open top-deck was where we slept under mosquito nets, the middle was living space, and the lower, the toilets, showers, etc. It was reasonably comfortable, but if one had occasion to visit the bathroom during the night, one had to negotiate two narrow companionways in the dark, and then crunch across a sea of giant cockroaches, to reach the jon.

The 11 day journey in fact took three weeks, because the engineers went on strike. For many days one could see nothing but very tall rushes, on either side of the river, but Hippos were always playing around us, and there were many crocodiles. As a Brit, I took it all in stride, but for an American, it would have been a night-mare — there was minimal refrigeration, and the water for our son's formula was so-called "purified" in an earthenware contraption called a Berkfeldt Filter — this meant that that there was a deposit of about 3 inches of sand — or mud — in the bottom of each of his bottles.

In Juba, there was a small European settlement—a policeman, public works engineer, the Provincial Governor, and some missionaries. The Government Hospital, boasted a couple of English nurses, and a surgeon, but he went on leave soon after we arrived —so then there was just Peter and myself ! My share was pediatrics, women's medicine, Ob-Gyn, and the orphanage. All the rest fell to Peter, who fearlessly — and without extra training — opened heads and bellies, and anything else that came down the pike. Our patients were the Arab shop-keepers, and the local tribes-people. Dinka, and others that I can no longer remember, and of course no-one spoke English.

So — how was it for me—this wholly untried, now 24 year-old ?

We started the day with a clinic at 7.00 a.m., and what I most remember was a **long** line of half-naked mothers with tiny naked babies, standing or sitting on the ground, outside my office, the mothers wiping runny noses, and baby-diarrhea with their own clothing, so that

the experience had a distinct flavor of its own . We treated malaria, intestinal problems, skin infections, and so forth. What actual treatments were available, I no longer remember, but I remember well my distress, as I tried to communicate in a three-way conversation, through an Arab-speaking interpreter.

At 9.30, we went home for breakfast, and then worked till 2.00, when our work-day was over. In addition to my clinics and wards, one of my responsibilities was to train the local mid-wives. Since they were all illiterate, everything was identified by taste and smell, and much was accomplished by gesture. Many tribal customs had to be reversed, such as packing the vagina with camel dung, after delivery, and of course beliefs like this die hard, so this was by no means easy. The Arab women were all circumcised, episiotomies were immense, and third degree tears were not unusual, so a lot of repair-work had to be done. And, because of the mutilation, diaphragms were impossible, and vinegar-soaked sponges were the favored mode of contraception, among the more sophisticated. But the young midwives were eager to learn, and somehow we managed. What happened when they went out to the villages, I never found out, because, unfortunately there was no feed-back.

Certainly the experience sharpened my powers of observation, and made me more alert to facial expression and body-language, and impressed on me the need to search beyond the obvious. It improved my communication skills, made me more tolerant and respectful of others, and opened my eyes to ways of life, and standards of living that were wholly unknown to me.

After two years in the Sudan, and a brief stay in the U.K., we went out to British North Borneo. As young and very junior Docs, we were stationed in a small port town called Kudat. The local shop-keepers and business-men were Chinese, and the indigenous population Malay. Malay was the lingua franca, and I found it a little easier to master than Arabic, though I must confess that my Malay was strictly of the "kitchen" variety. Because Kudat was a small Station , the government would support only one doctor to man the Hospital, and eager to work, I set up a private general practice in the town.

The first job was to find an assistant who could speak both Malay and Chinese, and I was fortunate that one of the shop-keepers had an aunt, Mrs Chong, who had retired from working as an Aid at the hospital. Mrs Chong was delightful, with a wonderful sense of humor, a

fund of knowledge about the town and pretty much everyone who lived there, and a lot of rather strong opinions. She was delighted to come and be my “amah”.

I rented a room above a coffee-shop on the dirt-road that formed the main drag, in the center of town. We had no running water, so Mrs Chong would run up and down our outside stair, carrying buckets of water from the hand-pump in the court-yard below. This we used to sterilize our instruments—in those days we had re-usable syringes — in a cooking pot, over a primus-stove. Medication was more difficult as everything had to be imported from Singapore, and was, for me, very expensive. Fortunately I date from a generation that still had to learn the rudiments of pharmacy, so we would order the basic ingredients, and Peter and I would spend our evenings mixing up some stock medicines—cough mixture, stomach mixture, mist.pot.cit. for urinary symptoms, and so-forth, in our kitchen sink,. Antibiotics were few at that time, but we did have penicillin and sulfa, and of course aspirin, and antimalarials. Penicillin was such a “wonder drug” that, rumour had it, if one visited one of the local Chinese physicians, everyone received a penicillin shot, before ever even seeing the doctor !

My practice grew remarkably quickly, with most of my patients being Chinese. I learned of interesting customs, and interesting complaints. It was customary, for example for the patient, in addition to paying my fee, to leave a “red pocket”. This was a small package wrapped in red crepe paper, which contained a few dollars, and would ensure that the Gods would favor the transaction, and make the patient well. One might think of this as a bribe, but rather, I think, it was a kind of magic, and something that I treated with the greatest respect

My office was directly across the road from the Chinese Temple, and I learned from Mrs Chong that many patients would visit the temple and consult with the Gods, before coming to see me. They would balancing a special triangular piece of wood on its pointed end. If it fell one way, the answer was “yes”, and the opposite way was “no”. Fortunately the Gods seemed to be on my side, because quite a lot of patients came.

Many of the complaints of my female patients seemed to be psychosomatic — for example tao lau vin, what I understood to be a kind of light-headedness, was very common. Mrs Chong would describe for me the circumstances of the families of my patients, which often were very stressful, as the people tried to eke out a living. Deaths

of childeren, lack of money, drunken and violent husbands, gamblers, all took their toll on these frazzled and hard-working women. Their homes were literally huts with earthen floors, but they were always clean, and their clothing immaculately ironed.

I learned to read the unspoken signs, and intuit the unasked questions. And I learned that even if there were no physical findings, the symptoms were very real—something that has stood me in good stead working with psych-derm patients.Having done my best to understand and to empathize, I would tell Mrs Chong what I wanted her to relay to the patient. There would follow a long discussion in either Chinese or Malay, of which I could follow only the barest minimum, and it was always my suspicion that my faithful amah was telling the patient what **she** thought, which was not necessarily what **I** thought — that it was in fact **she** who was practicing medicine — but whichever the case, most of my patients did well.

I did, however, have one major failure, when I was called to the house of a man in the town. Unfortunately when I arrived the man had already died, and I had to confess that raising the dead was beyond my competence — and even the competence of Mrs Chong ! But I did receive a "red pocket" nevertheless — designed to safeguard the rest of the family, I dare say.

During that time, one of my jobs was as Medical Officer to a rubber plantation. The infirmary was manned by a medical assistant, and once a month I would visit to help with any difficult cases that he might have.

My visit started at dawn, when I would board a ferry — a rather small and leaky motor boat — to travel for four hours across a bay. During the trip we sat on the floor-boards of the deck, while a member of the crew constantly baled large quantities of bilge-water, with an old coffee can. The boat was surrounded by Portuguese man-of-war jelly-fish, and each time I was absolutely terrified that we would not make it. But I felt that I must keep my cool lest my fellow-travelers, local natives, become alarmed, and panic. This clearly was a projection of my own fear, and perhaps also a rather arrogant British concept. On arriving at the other side of the bay, I would find a bicycle propped against a tree. This was my transportation to the plantation, and I would ride through the jungle for about half-an-hour to reach the infirmary. After seeing the patients, and enjoying a substantial lunch with the

plantation manager, I would mount the bicycle again, for the return trip home.

Usually the cases were fairly run-of-the-mill, but once I was called to an emergency — a woman had gone into premature labor at a timber camp several miles up-river. This time I rated for the Government launch, which was somewhat more comfortable than the ferry.

I was the only medical person for hundreds of miles, apart from the wife of an employee, who serendipitously happened to be a physical therapist. I found the patient, a Eurasian Catholic, lying in bed, clearly in labor, but also bleeding quite profusely. The only light in the darkened bed-room, came from a single candle, on an altar in the corner of the room, at which the patient's mother was praying — this was something that she continued to do, without ceasing, throughout what seemed to be a **very** long night.

It as all so long ago now, that I don't remember the details, but I imagine that I must have given the patient some pitocin. I then remember sitting in the camp manager's house, as though nothing was happening, and making "drawing-room" conversation, with occasional breaks to examine the patient, until she was ready to deliver. The delivery of a healthy baby accomplished, with the help of my assistant the physical therapist, the bleeding continued, and the placenta failed to separate. This required manual removal, and bimanual compression of the uterus, until more pitocin could be given, and a dextrose I.V. set up. Finally, we were ready, as dawn broke, to load mother, father, baby and I.V. onto the launch, for the trip to the Government hospital several hours down-stream, feeling gratified, but exhausted.

So — what did I learn from this experience ?

I think again that it sharpened my powers of observation, and increased both my empathic understanding, and my tolerance for the needs of others. Though myself feeling that I needed all the help I could get, I could also recognize and empathize with the anxiety of the patient's mother and husband, and **their** need to keep praying throughout the whole event. Of course it exercised resourcefulness too, as I had to make do with what was there, and I think also, that this was the first time that I was aware of the use of dissociation as a defense against anxiety — throughout the whole adventure, it was as though I was acting automatically, and without emotional involvement.

So, with this as a background, let me return to dermatology.

In 1964, after a few other minor diversions, we were established here, with our kids in school, and I was ready to get back into medicine. Peter was already established as a pediatric dermatologist, so it seemed that the logical thing for me to do, was to join him in derm. I had had no special interest in dermatology, indeed I had always seen myself as an internist, but I thought that if we both had to go to meetings, they might as well be the **same** meetings!

I was fortunate to get a residency with Scotty Burgoon, and somewhat to my surprise, I found that I really loved it. Scotty had been a student of John Stokes, and was very open to psychosomatic concepts, which , as I said, had been kept alive throughout the 1950's and 60's by a number of texts. I read all of these, and was particularly excited by Herman Musaph's "Itching and Scratching". But actual understanding was rather primitive in my program, Chlorpromazine was the magic bullet, and we were taught that if a patient failed to improve with chlorpromazine, then clearly, the psyche was not involved. No attempt was made to try to understand what was going on in the patient's mind, or what purpose the rash served in the patient's psychic economy.

And then followed the tremendous advances in cellular biology, during the 70's and 80's, that allowed us to indulge in the pipe-dream that **there** lay the answer to everything, and interest in psychosomatics flagged.

But, once in residency, I think because of my overseas experiences, it did not take long for me to recognize that conventional dermatology was missing a **lot** of what goes on in the skin. I felt that the right questions were not being asked, and that non-verbal signs were being ignored. I began to realize that dermatology is primarily a visual and tactile field, and that many of my colleagues really didn't want to know what was going on beneath the surface.

At first I tried to make referrals to psychiatry, but I learned that patients who somatize are either not consciously aware of the problems that are deep to the surface, or have a defensive need to deny them. These patients are either incensed by the suggestion of psychiatric problems, and leave in disgust, or simply fail to follow through. The psychiatrists also were not much help to me, because they are generally not eager to engage in dialogue about their patients, so that either I got no useful feed-back, or I lost the patient to psychiatry, and the skin was neglected.

Frustrated by an inability to find the answers that I was looking for, or the help that I needed with these fascinating but difficult patients, I realized that I would have to take on the challenge myself, and, since a part-time psychiatry residency was not an option, I took training in psychoanalysis.

That behind me, in the summer of 1983, Peter and I went on a pilgrimage to some of the centers in Europe, to try to understand how best to incorporate what I had learned, into my practice. We visited Ghent, Amsterdam, and Florence, amongst other places, and were very graciously received. We were amazed to see the wonderful co-operation between psych. and derm. and we found everyone both enthusiastic and helpful about our venture.

In 1979, Bill Gould and Tom Gragg had published their landmark paper describing the liaison clinic at Stanford, and this too had given me some encouragement, so I approached Jerry Lazarus about establishing a clinic at Penn, and for many years I spent a half-day a week with a resident, in the derm clinic, where we would see referrals.

My next step was to bring some kind of order to the general confusion, by evolving a classification. The first one which I published in 1982, was a little cumbersome, but over the years it has become progressively simplified, and currently I find this version useful:

Psychocutaneous disease.

1] Psychiatric Syndromes that present to dermatologists:

a) Cutaneous Delusions.
- Parasitosis
- Infection
- Toxic Damage
- Dysmorphic

Delusions. (Delusional B.D.D.)

b) Chronic Cutaneous Dysesthesia syndrome. (M.H.P. or B.D.D.)

i) focal

ii) generalized
- Itching
- Burning
- Stinging
- Pricking
- Something "drawn" across the skin

Glossodynia (B.M.S.)
Dysesthetic
Vulvodynia, etc.

c) Obsessive-Compulsive symptoms
i) obsessional worries
Parasitosis
Infection
Toxic Damage
Dysmorphic
Obsessions
ii) compulsive habits
Neurotic
Excoriations
Trichotillomania
Onychotillomania,
etc.

d) Dermatitis Artefacta

2] Primary dermatoses precipitated or exacerbated by stress
i) Depression
Chronic Urticaria
Alopecia Areata
Psoriasis
Idiopathic Pruritis
ii) Anxiety
Atopic Dermatitis
Nummular Eczema
Dyshidrotic Eczema
Seborrhoeic
Dermatitis
Acne Vulgaris
Rosacea
Recurrent H.
Simplex

3] Somatopsychic Effect

In an attempt to learn what it is that determines which patients, given the right genetic background and physical environment, will use the skin to express conflict, I turned to the work of some of the earlier psychoanalysts who had studied early child development, through longitudinal child-observation. These workers included Anna Freud, Renee Spitz, Phyllis Greenacre, and Edith Jacobson, among others, and their work taught me the importance of very early development in determining the integrity of the body image, the quality of self-esteem, and the capacity to modulate tension, all of which play a part in aspects of psychocutaneous disease.

Little has changed in my understanding of the **psychodynamics** of psychocutaneous disease, since my publications in 1982, and 1988, but of course there have been tremendous advances in psychobiology, and in psychopharmacology, that have brought changes in the way we practice, and relief to a lot of patients.

In 1991, a small group of the faithful formed the Association for Psychocutaneous Medicine of North America the A.P.M.N.A.— we are still a rather small group, and we would be delighted to welcome anyone who is here to-day, but unfortunately our annual meeting coincides with your own. We have a somewhat loose affiliation with the European group, which is significantly more active — but I believe that there are a number of things that will keep us alive and well. One is the rapidly expanding information about the effects of stress on immunologic and neurohormonal mechanisms, and on neuropeptide release, another is the widening interest in the impact of severe chronic dermatosis on the quality of life of our patients, and a third is the tremendous increase in cosmetic procedures that are being undertaken, and the need to understand the emotional health and motivation of patients who seek such procedures.

So — we will keep the flag flying!