Acta Derm Venereol (Stockh) 1994; Suppl. 186: 62–64

Psoriasis, Stress and Psychiatry: Psychodynamic Characteristics of Stressors

M. MAZZETTI, A. MOZZETTA, G. C. SOAVI, E. ANDREOLI, P. G. FOGLIO BONDA, P. PUDDU and F. DECAMINADA

Department of Psychosomatic Dermatology and Instituto Dermopatico dell'Immacolata, Rome, Italy

The aim of this investigation was to learn how a stressful event, often very mild, can determine a relapse of psoriasis. The research was carried out with clinical interviews and with the administration of Rorschach Psychoreactive, MMPI and H-T-P tests to 80 in-patients. Our data revealed a high prevalence of psychic disorders: 71.2% of patients showed symptoms which allowed a precise psychiatric diagnosis based on DSM-III-R criteria. 35% had personality disorders, 17,5% were moody, 12.5% were anxious and 6.25% had a schizophrenic trait. The analysis of the stressful events enabled us to determine the presence of a specific event in 88.7% of cases. For the majority of patients, the stressful event was felt as very mild: 67.6% of patients reported the existence of a low-impact stressful event according to the DSM-III-R classification. The average evaluation of the stressful event for all patients, based on a five-stage rating (ranging from 2 'light' to 6 'catastrophic') was 2.56. In conclusion, the analysis of the psychic conditions of in-patients showed that the importance in inducing an acute episode of psoriasis is the meaning of a stressful event as experienced by the patient, i.e. the questioning of his own identity, rather than the intensity of the aforementioned stressful event. In this case, the disease appears to be an attempt to express a defensive somatic response to a possible identity crisis. ***Key words: psoriasis; psychosomatic; stress; psychiatry.***

Acta Derm Venereol (Stockh) Suppl. 186: 62–64.

Marco Mazzetti, Dept. of Psychosomatic Dermatology, Istituto Dermopatico Dell'Immacolata, Via Dei Monti Di Creta I04, I-00167 Roma, Italy.

The influence of psychological factors in the etiology and pathogenesis of psoriasis has been long recognized in the literature. As early as the 1950s, a clear correlation between stressors and psoriasis was established (Ingram, Susskind, Wittkover). This fact led to several studies which were aimed both at identifying the frequency of stressors present at the onset of the disease and at verifying the influence by the stressor on the clinical course of the already established disease.

As to the onset of the pathology, several authors have succeeded in establishing the presence of stressors preceding its first manifestation. Their percentages are remarkedly varied: 32–44% (5, 6); 90% (16); 39% (17); 80% (11).

Other authors have specifically investigated the exacerbation of the disease following stressful conditions and they have found positive correlations (3, 12); the disease worsens within a month after the stressor and, in two-thirds of cases, during the first 2 weeks after its occurrence (19).

Under standardized experimental conditions, Arnetz et al. (2) found significantly more intense responses to stress in patients with psoriasis, compared with the control group.

Several studies have been conducted also to verify the existence of recurrent specific personality traits in the psoriatic patients, but the results are, by and large, not very significant (13, 3, 4, 15).

As to the specifically pathogenetic aspects, i.e., how the cutaneous damage develops from the stressor, the studies by Farber et al. (7, 8, 9) have underlined the role played by the psychoneuroimmune mechanisms, with particular attention paid to the function of neuropeptides.

Finally, all of the data collected in literature (10) point to the fact that an effective therapeutic program against this disease clearly benefits both from psychotherapeutic efforts aimed at controlling the stress and from the promotion of healthy physical conditions.

Following these studies, we have decided to carry out an investigation to learn how the stressors find a way to discharge psychological discomfort into the body. Our aim, therefore, was to accomplish an accurate assessment of the patients' psychiatric conditions, as well as of the recurrence and intensity of the stressors at the onset of the disease. This could prove to be important, as the history of many patients suggested that their psychiatric disease preceded the dermatological one. First and foremost, we wanted to analyse in depth the psychodynamic experiences of the subjects, in order to understand how the psyche reacts to the stressor, thus causing this specific somatic response.

MATERIALS AND METHOD

The sample consisted of 80 in-patients, aged 19–59 (mean: 34.65 SD: 11.79), 38 females (47.5%) and 42 males (52.5%).

The intervention protocol applied to each patient was structured as follows:

* administration of a socio-demographic questionnaire;
* three consecutive psychiatric interviews;
* administration of psychodiagnostic tests: Rorschach, MMPI, House-Tree-Person Test.

These are all very well-known instruments, which can very accurately single out psychopathological signs and symptoms. They were administered and analyzed by psychologists who were unaware of the clinical diagnosis made by the psychiatrists. Only subsequently were the clinical and test data compared in order to make a definitive diagnosis. The detailed analysis of the results obtained through these tests will be reported in other works.

Both the psychiatric diagnosis and the assessment of the stressor intensity were based on the DSM-III-R diagnostic criteria.

RESULTS

The patients' symptoms evidenced in the psychiatric interviews and by the psychodiagnostic tests allowed of an accurate psychiatric diagnosis of 57 subjects (71.2%), based on the DSM-III-R

 ISSN 0365-8341

Table I

Diagnosis		No.	%
Personality disorders		28	35
	Dependent	12	15
	NOS	12	15
	Histrionic	2	2.5
	Ossessive, compulsive	2	2.5
Mood disorders		14	17.5
	Dysthymia	8	10
	Major depression	2	2.5
	Cyclothymia	2	2.5
	Bipolar disorder, manic	1	1.25
	Bipolar disorder, mixed	1	1.25
Anxiety disorders		10	12.5
	Generalized	6	7.5
	Simple phobia	3	3.75
	NOS	1	1.25
Psychotic disorders		5	6.25
	Delusional (persec. type)	2	2.5
	Chronic schizophrenia, disorganized	1	1.25
	Schizof., residual type	1	1.25
	Schizoaffective disorder	1	1.25

diagnostic criteria. Table I shows the frequency of the various diagnoses.

Each patient's history allowed for the individuation of a triggering stressor in 71 cases (88.75%). Table II shows the patients' distribution according to the presence or absence of stressors as indicated in the DSM-III-R. Table III classifies patients on the basis of the stressor intensity, which was generally very low.

When the means of the stressors' intensity were compared for the two sexes, no significant difference emerged. The same result was obtained by comparing psychiatric and non-psychiatric patients (Tables IV, V).

DISCUSSION

The above results are, in a way, only a premise to our observations. The data relating to our patients' psychiatric disorders indicate the remarkable presence of personality disorders. This is a rather new result in the current literature, and it shows the existence of chronic disorders, as far as the patients' identity is concerned. Their onset is rather early, around adolescence or pre-adolescence.

Moreover, the analysis of the stressors indicates that their intensity is generally very low: our patients reported what to an outsider may appear as very mild stressors, such as quarreling with a sister-in-law or the possibility that one's brother might separate from his wife.

No statistical significance existed in the relationship between stressor intensity and patients' psychic health conditions. One could, therefore, suppose that equal intensity stressors might variously affect the patients according to their basic psychic conditions, i.e., that the subject's psychiatric pathology may render him/her more susceptible to stress. This is potentially the case in personality disorders, which generally precede the onset of psoriasis. This hypothesis, however, was not supported by solid data.

In any case, the presence of stressors was among the most comprehensive ever reported in the literature. This was probably due to the modalities used in data gathering. Indeed, we collected elements of psychologically significant episodes in the patients' history rather than verifying how aware the patients were of a more or less accidental connection between something that had upset them and the onset of the disease. Only later did we investigate the possibility of a temporal connection between these episodes and the onset of the dermopathic event. This probably allowed us to identify events that would have otherwise escaped the anamnesis.

In fact, our interviews have indicated that, in itself, the stressor intensity is not important: what counts is the meaning that said stressor takes on within the patients' way of 'viewing themselves' in the world, i.e., with respect to their psychological identity.

For these patients the stressor does indeed become so mea-

Table II

Code	Stressor	No. of pats	%
0.	Insufficient Info	5	6.25
1.	None	4	5
2.–6.	Present	71	88.75

Table III

Stressor intensity		No. of pats	%
2.	Low	48	67.6
3.	Moderate	10	14.1
4.	High	11	15.5
5.	Extreme	–	–
6.	Catastrophic	2	2.8
	Total	71	100
	Mean	2.56	
	SD	0.95	

Table IV

	Male	Females	Difference
Mean	2.703	2.412	0.291
SD	1.127	0.701	

$p = 0.411$

Table V

Psychiatric Pathology	Present	Absent	Difference
Mean	2.640	2.381	0.259
SD	1.051	0.584	

$p = 0.322$

ningful as to undermine their self-image. The phenomenon occurs in the most varied fashions, but in all cases the consequence is the same: the patient feels 'undermined' as a person, and thus the disease becomes a compensatory response capable of holding at bay the anxiety that the subject experiences when confronted with a crisis of identity.

All of our cases dealt with delicate subjects whose identity structure was rather defective and precariously balanced due to the most varied factors. For example, a particularly intense and symbiotic relationship with one's mother, the sense of family's unity, a stable and reassuring job, the school environment, one's bedroom walls, etc.

When the stressor endangers the protective factor to which the patient connects his/her identity, then the subject may face a crisis even though the stressor intensity is very low, because what really counts is the meaning that he/she attributes to it. In consequence, a family quarrel or a family member's potential marital separation can be experienced as an actual blow to the solidity of the group to which the patient is bound. The same can occur following changes in one's work environment (maybe just a change of room or of duties within the same organisation), in the school environment or a house move: clearly, subjects who are sufficiently sound at the psychological level can easily cope with events of this nature.

Such identity crises are not a rare event in psychopathology and they have no specific evolution pattern. In fact, in other types of patients they can develop into a variety of symptomatologic pictures: other psychosomatic diseases, hypochondriasis, psychic disorders of a different nature. We believe that this peculiar type of response in the psoriatic patients is determined by a widely recognized genetic predisposition.

Even the localization of the cutaneous lesions does not present characteristics that may somehow be correlated to specific problems. The disease seems rather to constitute a sort of generalized response: its para-hyperkeratosis apparently emphasizes and demarcates the boundaries of one's bodily and psychic self in a compensatory manner. Indeed, the disease allows these patients to shift their attention from their inner to their outer world, thus providing the double benefit of defending them against the anxiety about internal disintegration and of clearly marking their body boundaries.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders – 3rd edition, Revised (DSM-III-R). Washington DC: APA, 1987.
2. Arnetz BB, Fjellner B, Eneroth P, et al. Stress and psoriasis: psychoendocrine and metabolic reactions in psoriatic patients during standardized stressor exposure. Psychosom Med 1985; 47: 528–541.
3. Baughman R, Sobel R. Psoriasis, stress and strain. Arch Dermatol 1971; 103: 599–605.
4. de la Brassine M, Neys C. Psychosomatics and Psoriasis. In: Psoriasis, Proceedings of the Fourth International Symposium, Stanford University, 1986. New York: Elsevier, 1987.
5. Farber EM, Bright RD, Nall ML. Psoriasis: a questionnaire survey of 2144 patients. Arch Dermatol 1968; 98: 248–257.
6. Farber EM, Nall ML. The natural history of psoriasis in 5600 patients. Dermatologica 1974; 148: 1–18.
7. Farber EM, Nickoloff BJ, Recht B et al. Stress, symmetry and psoriasis: possible role of neuropeptides. J Am Acad Dermatol 1986; 14: 305–311.
8. Farber EM, Lanigan SW, Rein G. The role of psychoneuroimmunology in the pathogenesis of psoriasis. Cutis 1990; 46: 314–316.
9. Farber EM, Rein G, Lanigan SW. Stress and psoriasis: psychoneuroimmunologic mechanisms. Int J Dermatol 1991; 30: 8–12.
10. Farber EM, Nall L. Psoriasis: a stress-related disease. Cutis 1993; 51: 322–326.
11. Fava, GA, Perini GI, Santonastaso P, Fornasa CV. Life events and psychological distress in dermatologic disorders: psoriasis, chronic urticaria and fungal infections. Br J Med Psychol 1980; 53: 277–282.
12. Gaston L, Lassonde M, Bernier-Buzzanga J, et al. Psoriasis and stress: a prospective study. J Am Acad Dermatol 1987; 17: 82–86.
13. Goldsmith LA, Fisher M, Wacks J. Psychological characteristics of psoriatics. Arch Dermatol 1969; 100: 674–676.
14. Ingram JT. The significance and management of psoriasis. BMJ 1954; 24: 823–828.
15. McEnvoy MT, Roenigk RK. Psychological aspects of psoriasis. In: Roenigk HH, Maibach HI, eds Psoriatis. 2nd ed. New York: Marcel Dekker Inc, 1990.
16. Nyfors A, Lemholt K. Psoriasis in children: a short review and a survey of 245 cases. Br J Dermatol 1975; 92: 437–442.
17. Seville RH. Psoriasis and stress. Br J Dermatol 1977; 97: 297–302.
18. Seville RH. Psoriasis and stress. II. Br J Dermatol 1978; 98: 151–153.
19. Seville RH. Stress and psoriasis: the importance of insight and empathy in prognosis. J Am Acad Dermatol 1989; 20: 97–100.
20. Susskind W, McGuire RJ. The emotional factor in psoriasis. Scottish Medical J 1959; 4: 503–507.
21. Wittkower ED, Russel B. Emotional factors in skin disease. New York: Hoeber, 1953.