Dermatology
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Commentary · Kommentar

Dermatol Psychosom 2000;1:53–55

Epistemological Aspects of Psychosomatic Dermatology

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Epistemology (or theory of knowledge, also called gnosiology) is defined in the Encyclopedia Britannica [1] as the study of the nature and validity of human knowledge. Epistemologists examine the degrees of certainty and probability in knowledge and the difference between knowing (with certainty) and believing (without being certain). This knowledge about knowledge can be used to provide a basis for wise action, security, and truth. Two competing epistemological orientations are Rationalism, which stresses the role of reason in providing certainty, and Empiricism, which stresses that of sensory perception.

Here we propose an epistemology of psychosomatic dermatology for the 21st century, based on a review of the epistemology of psychosomatics, psychosomatic medicine, and, in particular, psychosomatic dermatology. The term 'psychosomatic' was coined in the second decade of the 19th century as a reflection on knowledge, certainties and truths, as well as opinions, hypotheses and interpretations with rationalistic and/or empirical bases: an examination which dermatology first restricted and then enlarged, from the res expansa, the skin, to the whole human body, and then to the body and mind together. The term 'psychosomatic' was coined in 1818 by J. Heinroth (1778–1843), a psychiatrist 'ein *Psychicher*, nicht *Somatiker*', in Leipzig, Germany[1]. In his History of Psychiatry, E.H. Ackernecht reminds us that metaphysics, mysticism, 'morality', and poetry provided the cultural bases for the Psychicher, distinguishing him from the Somatiker. The former considered all disease to be a result of sin. And thus Heinroth, psychiatrist and poet (under the pseudonym of Treumund Wellentreter) concluded that the mentally ill (he classified 36 different categories) were responsible for their actions and acquired a new soul (not heredity, perhaps not even predisposition was considered) when God punished them with the loss of personal will. It seems absurd that Heinroth should have been the one to create the neologism 'psychosomatic'[2]. In fact, J. Taylor attributes the term to Coleridge, a poet, not a psychiatrist.

When Plato wrote: 'This is the great error of our times ... physicians see the body separate from the soul', it was the baptism, if not the birth, of psychosomatics, and the statement was used by Weiss and English as the epigraph for their book Psychosomatic Medicine [2]. The authors, both at Temple University, Philadelphia, mentioned the founding of the Journal of Psychosomatic Medicine in 1939, which was applauded by the Journal of the American Medical Association in a very favorable article on Freud and his work (when Freud had already fled to London and many of his colleagues to the United States). Historically, scientific psychosomatics has been supported by psychoanalysts, beginning with Freud. Weiss and English commented that 'no work could have been done in psychosomatic medicine without Freud's work on *biological* psychiatry'. They point out that Freud's discoveries were followed by the work of many others: Ferenczi, Abraham, Jones, Jelliffe, Deutsch, Wittkower, Menninger, Alexander, the group of the Chicago Psychoanalytic School, Flanders and Dunbar ('Emotions and Somatic Variations', published in 1935, reviews all the then existing literature on this subject), and the group of the Presbyterian Hospital in New York. The conclusion was that 'all medicine must become (meaning: is) psychosomatic medicine'. Up to now, experiences and opinions originating from many very different cultures have accumulated.

One of the fundamental problems is the hybrid status of psychosomatic epistemology. On the one hand, it is part of medicine with its empirical tradition; on the other hand, it refers to psychology with all related hermeneutic torments. The vari-

1 German psychiatry became dominant in the second half of the 19th century. In the first half of that century, instead, like all medicine, it was strongly influenced (dominated) by the romantic movement.

2 Heinroth has also been attributed to be author of the very successful romantic phrase: 'As man loves, so does he live.'

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Table 1. Cutaneous affections reported to have high incidence of psycho-emotional factors

Hyperhydrosis	Telogen effluvium
Dyshydrosis	Alopecia areata
Pruritus	Psoriasis
Urticaria	Seborrheic dermatitis
Lichen simplex	Perioral dermatitis
Atopic dermatitis	Lichen planus
Acne	Herpes
Rosacea	Nummular eczema

Table 2. Examples of dermatological conditions with presumable (strong, frequent...) somatopsychic rebound

In infancy	In adolescence	In adulthood
Ichthyosis	Acne	Rosacea
Alopecia	Alopecia	Alopecia
Epidermolysis bullosa		Seborrheic dermatitis
Naevi		Psoriasis
Angioma		Skin aging

Table 3. Psychiatric syndromes with dermatological expression

Self-inflicted dermatological lesions
Dermatitis artefacta
Neurotic excoriations
Trichotillomania
Hypochondrias, the so-called phobias
Venereophobia
Dysmorphophobia
Bromhydrosiphobia
Glossodynia
Delusions of parasitosis (Ekbom's Syndrome)

ous current models of psychosomatics oscillate continually, but not explicitly, between these two poles. In collaboration with Jacqueline Amati-Mehler one of the authors (S.A.) proposed in a confrontation with the French School of Psychosomatics (Marty, de M'Uzan et al. – *pensée operatoire* or, for Sifneos, alexithymia) 'that the early levels implicated in psychosomatic diseases' (which is probably true for all physical diseases with varying incidence of emotional triggering factors) would refer to 'a pre-structural area, a level at which none of the elements of the two classical topics has been clearly differentiated. It is not yet possible to integrate psychically certain sensations, perceptions and affects into representations that are communicable to one's self and to others. We only have confused affective elements, primitive anguish that are not translatable as acquisitions of sense'. We must emphasize that there is general agreement among many psychoanalysts and psychiatrists that 'so called psychosomatic disease (and presumably any physical affection) has a defensive function' [3].

We agree with the premise of Weiss and English [2] that all medicine is (also) psychosomatic medicine. Obviously, there is no physical pathology that does not influence the mind and vice versa. But there is a category (affection and subject) where this repercussion is more important for understanding and treatment. For example, in dermatology as a modus vivendi of epistemological empiricism one of the authors (E.P.) classified dermatoses as: 'affections with high incidence of psychoemotional factors' (table 1), 'conditions with strong emotional repercussion' (table 2) and 'psychiatric diseases with cutaneous expression' (table 3).

If all medicine were like that, the term (and meaning of) 'psychosomatic' (ambiguous and risky) would be obvious and could be abolished. But we are convinced that there is no better term to make clear that this is what we are dealing with. Moreover, it is often useful to categorize rational and empirical observations (clinical observations regarding the individual subject) as psychosomatic.

Subtle resistance in the medical world is expressed by the continual risk of re-establishing the scission between body and mind, especially when referring to psycho-somatics (thus, instead of emphasizing the unity of mind and body with the term psycho-somatic, linguistic ambiguity led to scission). For example, emphasizing a one-way, linear path between cause (psychological) and effect (physical disease) rather than emphasizing the interactions of mental, emotional, and biological functions.

When a 'somatist', for example a dermatologist, reads the long, profound and precise descriptions of psychologists or psychotherapists, he may wonder how much these help in understanding (and treating) a patient, because a dermatologist's conversations with a patient are short in comparison, even in cases of well conducted, empathetic counseling. Individual ability and years of clinical experience, however, point out that we, too, are able to grasp and verify insurgence of understanding and reciprocal emotions between physician and patient, which are important in treatment.

One of us (S. Argentieri in collaboration with J. Amati-Mehler) [3] emphasized that 'body illness is the first elementary response, with the economic function of containing anguish related to the trauma of separation and detachment': this is the organization of the first nucleus of altered body function that remains like an island in the issue of the procedural structure of personality. This island does not integrate or evolve, but remains a vulnerable point that becomes progressively burdened with subsequent mental senses based on relationships with the environment, family, etc. These methods of functioning can begin in infancy (with the relationship to the mother) and then repeat throughout life. An exemplary prototype has been identified, specifically by E. Panconesi, since as far back as 1984, in atopic dermatitis with the hypothesis of the so-called 'eternal child' [4].

Dermatologists cannot propose consultation in liaison with psychologists/psychiatrists in all cases, and many do not have the time or background for personalized psychotherapy. Furthermore we must acknowledge that with liaison there is a risk that the patient may again be divided into two parts, one for the physician and one for the psychologist.

Knowledge of specific factors (regarding, for example, quality of life) related to individual somatic affections (internal or other non-skin problems) provides information of great value. For example, clinical examination for a real or presumed sexually transmitted disease can tell a lot about the patient's sexual habits, especially if the physician is adequately experienced in the field of those particular infections.

Textbooks published by presumably eminent psychiatrists and psychologists tend to avoid or ignore such important topics as dermato-venereology. In 'Psychosomatic Medicine', Stanley Cheren dedicates only 5 pages to the dermatologic discipline, limited to cutaneous thermal biofeedback and galvanic skin response. The word 'dermatology' does not appear in the large subject index [5].

Furthermore, we wonder how American psychiatrists refer to patients with 'psychosomatic' problems, given that the word itself appears to be almost banned from the DSM-IV. We support the criticism of Maj, who wrote a 'Critique of the DSM-IV operational diagnostic criteria for schizophrenia' [6].

In their student 'Handbook of Psychiatry' [7], H. Kaplan and B. Sadock of New York University support the DSM-IV, but then solve the problem in a rather – psychiatrists permitting – schizophrenic way. The title of chapter 17 is 'Psychosomatic Disorders', followed by a sort of sub-title in parentheses 'Psychological factors affecting medical condition'. And the authors list 316 synonyms of those 'psychological factors':

– mental disorders,
– psychological symptoms,
– personality traits or coping styles,
– maladaptative health behaviors,
– stress-related physiological response,
– other or unspecified.

Kaplan and Sadock by-pass the orthodox DSM-IV and ad usum Delphini present first of all a definition for students: 'The term psychosomatic disorder refers to a physical condition (we would prefer pathological) caused or aggravated by psychological factors' (it would be more precise to add the word psychopathological to psychological). And they specify that 'while many disorders are influenced by stress, conflicts or generalized anxiety, some are more influenced than others'. The list corresponds precisely with table 1, the affections with high incidence of psychoemotional factors, that we have been presenting as such for the last 20 years [4].

Regarding pathogenetic theories, Kaplan and Sadock barely refer to Dunbar's specific theories ('coronary' personality, for example) and Alexander's idea that certain unconscious conflicts produce a specific anxiety mechanism in the autonomous nervous system, leading to the formation of ulcers. The problem of the lasting (and in our view wrong) idea or theory about specificity in psychosomatics (that system = that personality = that psychic trauma and, even, that drug) presents a risk of diagnostic and therapeutic oversimplification.

Like Kaplan and Sadock, we propose a more acceptable non-specific theory: Any prolonged stress (or even particularly strong emotion) causes (can cause) physiological changes (and pathophysiological changes) that provoke physical disorder(s) (pathological alterations). Every person has a 'shock organ' (or even more than one) that is genetically (or merely due to some post-natal action or stimulus) vulnerable (the 'meiopragia' of the old masters) to stress (and the somatic effects of stress). Some subjects are 'cardiac reactors' (they react with cardiac damage), others are 'gastric reactors', and still others are 'skin reactors'. And some react with one or more organs simultaneously or alternately, such as atopic subjects: skin/dermatitis – bronchi/asthma – nasal mucosae/rhinitis. Perhaps to the idea of individual predisposition (perhaps genetic and/or acquired) of precise organs and systems we should add functional trends in response ('psychosomatic') to stress and trauma: spasms, ranging from vascular, arterio-capillary to muscle spasms, gastric spasms, and so on.

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