Dermatological Phobias

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Problems with skin phobias are not unusual in dermatological practice. The commonest dermatological phobias include steroid phobia, seen especially in mothers of children with atopic eczema. Dysmorphophobia may be seen in up to 12% of dermatological outpatients and its incidence is likely to be much higher in cosmetic dermatological and laser clinics. Germ phobia is easily overlooked as a cause of recalcitrant hand eczema. Patients with wart, mole and olfactory phobias are seen less often. It is important that the dermatologist is well acquainted with the myriad cutaneous presentations of patients with weight phobia (anorexia nervosa).
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Introduction

It has been estimated that up to 15% of patients attending dermatological outpatient clinics have an obsessional, compulsive disorder and it is thought that patients with this type of disorder are more likely to present to dermatologists than to psychiatrists (1).

Skin phobias take many forms. One of the commonest presentations is persistent hand eczema because of a compulsion to wash to rid the skin of germs. Mole phobia and wart phobia are less common, but steroid phobia, (2) especially in mothers of children with atopic eczema, is extremely common. Dysmorphophobia (dermatological non-disease, body dysmorphic disorder) can also be looked upon as a phobic disorder. The numerous cutaneous markers of anorexia nervosa should also be familiar to practising dermatologists.

Germ phobia

Germ phobia should be suspected in any patient with hand eczema when the condition is steadfastly refusing to improve, despite adequate and appropriate topical treatment. In this clinical situation the patient will often admit to washing the hands 30 or more times a day. Unfortunately the patient finds it very hard to stop the compulsive washing, which does bring some relief, albeit temporary, from the obsession about germs.

The dermatologist managing this clinical situation has to be patient. Management in a liaison clinic within a dermatological department is ideal. Such a clinic enables a joint approach between an interested dermatologist and a psychiatrist. In this situation adequate topical measures can be explored. Selective serotonin reuptake inhibitors are often useful in the overall management of this type of disorder.

Wart phobia

Wart phobia is a variant of germ phobia. In this condition the patient has a phobia about developing warts. The condition may follow a genuine wart infection, but in some patients a genuine infection with warts is never seen and the patient presents repeatedly with imagined wart infections. Strong reassurance may be necessary several times a month. The phobia always becomes worse during times of emotional stress and other family members may be dragged into the clinical situation and be brought to the dermatologist to be examined. Lovers and potential lovers of the index patient may also be brought to the dermatologist for a thorough examination to exclude warts and other dermatological problems.

The patient with wart phobia finds it very difficult to make any sort of lasting relationship because of a constant anxiety about acquiring the wart virus from other possibly affected members of the family or public.

Patients with wart phobia are constantly looking at other people, and their hands in particular, to make sure that all around them are wart free. Shopping becomes a nightmare and putting petrol in the car has to be done wearing gloves. Swimming and holidays are both off limits. One of my patients refused to wear knickers in case she transferred imagined wart virus from her feet to the genital area. The patient with wart phobia will usually only enter the consulting room if the door is opened and closed by the dermatologist rather than the

patient themselves. One of my patients brings disposal sterile dressings on which she stands during my examination, and leaves behind her popsox and the used dressings after the consultation.

Management

Management of patients with wart phobia is particularly difficult. Some patients require constant reassurance that they do not have problems with the wart virus. Unfortunately the condition does tend to disrupt holidays, families and marriages. General measures aimed at reducing emotional stress and strain will usually reduce the frequency of consultation. A minority of patients with wart phobia become suicidal because of their constant preoccupation and battle against the wart virus. In this group medication with selective serotonin reuptake inhibitors is helpful and management with an interested and empathetic psychiatrist is desirable.

Mole phobia

This condition seems to affect women more than men. An obsessional, premorbid personality seems to be important in pathogenesis. The obsessional ideas about moles and malignant change are usually triggered by reading an article in a magazine or seeing a programme on television. In some patients a chance remark is sufficient to trigger anxiety about moles.

Patients with mole phobia are more often seen in cosmetic and laser clinics than in general dermatological practice. The patient will usually say that they are very worried about the moles, not only in themselves but also in other family members. The index patient becomes so concerned that she may have to examine her children's moles every day. The children may be forbidden to go out and play on sunny days and the annual family holiday is cancelled. This type of behaviour puts intense pressure on the marriage and the husband often fails to understand his wife's anxieties and concerns.

Management

Management of this situation can be difficult, but laser assisted mole ablation gives very gratifying results. Ablation of moles, however, using, for instance, a Q-switched ruby laser or Alexandrite laser, should not be undertaken until fully informed consent has taken place. It is vital to explain to potential patients that the long-term effect of intense laser light is not known, although at the present time no malignant change has been observed in laser treated moles. Before I embark on treatment I insist that the patient must agree to regular follow-up after this type of treatment. Usually, once the moles have been ablated, the preoccupation about the moles disappears. Unfortunately, however, some patients then go on to develop other obsessional problems, such as eating disorders.

Steroid phobia

A recent study (2) has shown that 72% of 200 patients were concerned about the use of topical steroids and 24% of patients did not use topical steroids because of their concerns. The major concern was about skin thinning (34% of patients), whilst only 10% were worried about other possible complications, such as a deleterious effect on growth.

Steroid phobia is fanned by the lay and medical press and obsessional, rigid mothers of children with eczema are soon converted to the idea that topical steroids are dangerous. In individual cases this could have disastrous results on the quality of life of the child, who may be taken to one alternative medical practitioner after another to avoid the "dreadful steroids" on the skin. As a result of this type of parental phobia some children with very extensive eczema receive no effective treatment at all for their eczema – all because of some ill conceived and ill founded ideas that the topical steroids may have a deleterious effect in thinning the skin and will also delay the child's growth. As a result the child is taken to homeopathic practitioners, given potentially hepato and renal toxic herbs, assaulted by acupuncture and covered in topical medication of doubtful efficacy, usually containing constituents such as tea tree oil and aloe vera. The net result is a very unhappy child, unable to sleep, unable to play normally and unable to go to school.

Management is difficult and the phobia will often persist despite adequate information designed to neutralise all concerns.

Dysmorphophobia (dermatological non-disease, body dysmorphic disorder)

This skin phobia, characterised either by overvalued ideas or true delusions of ugliness associated with compulsive mirror-checking, is common and may be seen in up to 12% of patients seen in a dermatological outpatient clinic (3). The incidence of this phobic disorder may be much higher in patients seeking advice in cosmetic and laser clinics.

Patients with dysmorphophobia are rich in symptoms in important body image areas, such as the face, scalp and genital area, but there are no significant or very positive physical signs on examination. Depression is the commonest psychiatric illness present and is coupled with a narcissistic type of personality disorder.

Management of patients with this phobic disorder is extremely difficult and suicidal ideation and attempts at suicide, sometimes successful, are a relatively common feature, especially in women rich in facial symptoms.

Treatment with selective serotonin reuptake inhibitors is helpful and the dose required is very much higher than that necessary for treating a conventional patient with depression (4).

Acne excorieé

Acne excorieé is a dermatological ragbag. Some patients may be atopic, some patients may have acne, some skin pickers are depressed and some are dysmorphophobic. Skin picking is common in patients with dysmorphophobia and management with selective serotonin reuptake inhibitors may be helpful in this difficult clinical situation.

Anorexia nervosa and bulimia

Patients with eating disorders are often phobic about their weight. Anorexia nervosa/bulimia often develops at the same age, i.e. in the early to mid-teens, as patients with dermatological non-disease. The condition may be just as refractory to treatment as dysmorphophobia and unfortunately suicide is one recognised clinical outcome.

There is a very wide range of dermatological presentations seen in patients with anorexia nervosa. These include increased lanugo body hair, diffuse non-scarring alopecia involving scalp hair, brittle nails and dry skin. Pseudo-jaundice associated with a raised blood carotene is also characteristic. Callouses may be seen on the fingers as a result of repetitive self-induced vomiting. Generalised pruritus and acne are both features of anorexia nervosa, particularly in the re-feeding period. Some patients may also suffer from compulsive hand washing and pathological hair pulling (trichotillomania). Severe perniosis is very characteristic of the condition and, when seen in thin young women, should always raise the possibility of anorexia nervosa. Drenching night sweats may also be a feature of the re-feeding stage of this disorder (4, 5).

Blushing and erythrophobia

Blushing is a normal physiological response and some individuals, especially those with Celtic skin, seem to blush more readily than darker skinned individuals. In women especially the blushing may extend on to the neck, and even the upper chest, and some women become self-conscious about this.

A commoner clinical situation in the writer's experience is the presentation in a dermatological outpatient clinic of rather serious, introspective young men with pale, normal skin who complain bitterly of blushing. These patients will often say that the changes in their skin become highlighted when they move, for instance, from a cold environment to a warm environment. In some of these individuals there is a true erythrophobia, i.e. a compulsive state related to fear of blushing. This fear comes to impinge on the quality of the patient's life and may even affect college education and work.

Management of individuals who are actually blushing

Treatment of any underlying anxiety with an anxiolytic drug or manage-

ment by a clinical psychologist can be helpful. Betablockers and clonidine have a limited place in the management of this condition. For those who are truly frightened of blushing hypnosis may be a valid option.

Needle phobia

There are no studies to establish the frequency of this disorder, but the writer's impression is that it is reasonably common. On a personal note, one of my patients with needle phobia broke a consultant anaesthetist's arm as he tried to anaesthetise her via the intravenous route.

Up to 50% of women in their 50s develop thread veins in their legs and for most of these patients sclerotherapy may be the treatment of choice. However, sclerotherapy becomes very difficult in needle phobic patients and in these individuals treatment with a combination of the pulsed dye laser for the finer, red veins and the long pulsed Nd:YAG laser for the larger blue/purple thread veins up to 4 mm in diameter, may be well tolerated.

Olfactory phobias

Many people have a concern that they may suffer from an undesirable body odour and from time to time soaps and deodorants are marketed at this type of individual. True olfactory phobia, however, is rare and affected patients are compelled to change articles of clothing, wash and use copious fragrance and deodorants on a regular basis. One of the writer's patients, for instance, could only holiday in Majorca if he was able to change his socks and footwear on three occasions during the flight.

This type of behaviour may respond to selective serotonin reuptake inhibitors but is best managed in a liaison clinic or in conjunction with an interested psychiatrist.

Sometimes patients with this disorder also complain of excessively smelly flatus and usually consult gastroenterologists where they are investigated with negative results for steatorrhoea.

Cancer phobia

Cancer phobia is a relatively common symptom of depressive illness. This may be a marked clinical feature in some patients with orodynia (glossodynia) and responds to antidepressant medication with a selective serotonin reuptake inhibitor rather than a tricyclic antidepressant, which leads inevitably to a dry mouth.

True cancer phobia related to dermatological lesions is, in the writer's experience, rare.

Claustrophobia

It is interesting that about 2% of patients who undergo a laser assisted skin resurfacing procedure, followed by the use of closed dressings, develop claustrophobia to these dressings.

Phobic anxiety

Anxiety is common in our patients and some patients will suffer from varying degrees of a phobic anxiety disorder. Those most affected will find it impossible to come to the clinic and may have to be seen on a domiciliary basis at home. Fluctuating levels of phobic anxiety may lead to patients cancelling their appointments in dermatological clinics.

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