

Acne

U. Gieler

Psychosomatic Dermatology, University of Giessen

Definition

Inflammatory disease of pilosebaceous glands.

Coding (ICD-10): Acne (L 70; F 54); acne vulgaris (L70.0); acne conglobata (L70.1); acne varioliformis, acne necroticans miliaris (L70.2); acne tropica (L70.3); acne infantum (L70.4); acne excoriée des jeunes filles (L70.5).

Epidemiology

Frequent disease, occurring especially in adolescents and young adults (manifestation age 14–35 years), caused by an impairment of the sebaceous gland follicles.

Dermatological Diagnostics

The dermatological diagnostics are limited to visual diagnosis and systematization depending on the presence of comedos, papules, pustules, cysts, or a conglobata form. Special forms, such as cosmetic or medication acne, or acne picealis, and forms with a particular course (acne fulminans) must be differentiated. With respect to psychosomatic dermatology, differential diagnosis is especially required in acne excoriée, in which there is maximum skin picking with minimal acne, so that this disease is assigned to the paraartificial disorders.

Psychiatric Diagnostics

Psychopathological aspects do not occur primarily in acne, combined occurrence with dermatophobia or tactile hallucinosis is rare.

Psychosomatic Diagnostics

Elicitation: Acne is not a disease in which psychogenesis must be assumed. In individual cases, the onset may occur after life-events, and the influence of stress as an exacerbating factor in acne has been demonstrated [Scholz, 1987].

Management: Management of acne is usually with regard to compliance with prescribed medicaments. The limitations caused by acne range from no limitations at all to suicidal crises in social phobia, including a broad spectrum of possible coping strategies [Motley and Finlay, 1989]. The majority of suicides among dermatological patients have been reported in male acne patients [Cotterill, 1997]! The occurrence of depressive phases with withdrawal from social life is among the usual coping strategies [Niemeier et al., 1998], problems in establishing social contacts and sexual relationships are also frequent [Koo, 1995]. Acne patients tend to experience their disease much more strongly than persons with healthy skin [Hünecke, 1976].

Diagnostic Measures

Obligatory: Discussion with doctor, whereby the acne patient usually suffers from the feeling that he and his disease are not taken seriously. The subjective suffering of acne is almost always underestimated, questions about the effects of acne in everyday social living absolutely must be asked in order to obtain hints of possible depressive coping and tendencies to social phobia. The question of stress factors as elicitors also belong to this discussion.

Optional: If the history shows evidence of depressive reactions or social-phobic tendencies, a discussion in the sense of psychosomatic primary care should be conducted. This should clarify suicidal thoughts and possible concrete plans, depres-

sive disorders or social phobia and also include the effects on sexuality. Acne is not infrequently a symbolic expression of impaired contact behavior. The use of psychometric test procedures, like the 'Marburger Hautfragebogen zur Krankheitsverarbeitung' (Marburg Questionnaire for Coping with Skin Diseases) [Stangier et al., 1997], the Stigmatization Questionnaire by Schmid-Ott [Schmid-Ott et al., 2000] or, where appropriate, the Life-Quality-Questionnaire (SF36) [Ware et al., 1998] may be helpful.

Additional Comments: Acne patients tend toward dissimulation, so specific questions are in order! Especially in obsessively structured patients, washing obsession may arise during the course of acne therapy.

Therapy

Dermatological Therapy

The dermatological therapy depends on the severity of the acne and is performed with local application of benzoylperoxide, vitamin-A-acid and its derivatives, and antibiotics (erythromycin, clindamycin) or systemic administration of tretinoin, antibiotics (tetracyclin, minocyclin) or hormones (antiandrogens). The intensity of therapy is not infrequently determined by the subjective suffering of the patient.

Psychosomatic Therapy

Psychosomatic Primary Care

Acne therapy should remain in the hands of the doctor who conducts the somatic therapy, as far as possible. He should pay attention to the aspects of coping strategies cited above and instruct the patient especially about the necessity of consequential treatment, since many patients expect to be healed rapidly [Gloor et al., 1978].

Indication for Psychotherapy/Psychopharmacology

Professional psychotherapy is always indicated if the patient presents with clear evidence of depressive reactions, artificial expression of normal acne (acne excoriée, paraartefacts), washing obsession or social phobia. No systematic studies have yet been performed on the success of psychotherapeutic measures in acne.

Relaxation

Other than general effects, no specific effects can be expected of relaxation techniques in acne.

Depth Psychological and Psychoanalytical Procedures

The secondary coping of acne patients (avoidance of contacts) can be worked out especially in the framework of depth psychological psychotherapy; even in association with personality disorders, this form of psychotherapy is helpful. This form of psychotherapy also appears particularly well-suited in cases with suicidal evidence.

Behavior Therapy

In social phobia and disfigurement problems, behavior-therapeutic measures have been found particularly beneficial [Stangier, 1996], especially video-feedback and self-confidence training. The treatment of acne excoriée with behavior-therapeutic procedures has also been frequently described [see Scholz and Luderschmidt, 1989].

Hypnosis

There are no current studies on the success of hypnosis in acne.

Psychopharmacology

Drug therapy with psychopharmaceuticals is only indicated in the cases of concurrent psychopathological disorders, such as phobias.

Training Programs and Combination Therapy

No current studies are available.

Self-Help

There is no self-help group for acne patients.

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