

## Psychodermatology

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Psychodermatology covers all aspects of how the mind and body interact in relation to the onset and progression of various skin disorders. This book is the first text written by a multidisciplinary team of psychiatrists, psychologists, child specialists and dermatologists for all the health professionals who treat patients with skin problems. They cover a broad range of issues affecting these patients, including: stigma, coping, relationships, psychological treatments, the impact on children, psychosocial comorbidity, psychoneuroimmunology, quality of life and psychological treatments.

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# Psychological therapies for dermatological problems

Linda Papadopoulos

## Introduction

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The enormous growth in the last two decades in cosmetic surgery, dieting and the fashion industry are all the indicators of the huge investment that society puts into the 'appearance industry'. In the western world, people are subjected to the same message constantly: 'Attractive people are popular, happy, successful, interesting and are often loved and worshipped' (Papadopoulos & Walker, 2003). Of course, cosmetic and physical perfection are rarely associated with those experiencing cutaneous conditions. Consequently, people with dermatological illnesses are left feeling minimised as individuals, tend to be highly sensitive to the social significance of their actions and appearance, to anticipate rejection by others, and to experience embarrassment and/or shame (Kellett & Gilbert, 2001).

Therefore, it is not surprising that due to their visibility and appearance-altering quality, skin disorders have important psychological implications for the sufferer, making the long-established link between psychological factors and dermatology even stronger. Yet, little attention has been paid to them or to the ways in which to address them. Indeed, as the prevalence and aetiology of the majority of skin diseases are neither well known nor understood by the general public, dermatological ailments are often surrounded by misconceptions and stigma.

The link between dermatological and psychological problems has long been prominent in the published literature. Dermatology has a distinct relation with psychosomatics as the skin has strong psychological implications. The skin is a complex system made up of glands, blood vessels, nerves and muscle elements, many of which are controlled by the autonomic nervous system and can be influenced by psychological stimuli. These have the capacity to cause autonomic arousal and are capable of affecting the skin and the development of various skin disorders. Several theories postulate psychophysiological mechanisms underlying various dermatological disorders (Papadopoulos & Bor, 1999). Indeed, not only do

the skin and psyche share their embryonic origin but they are also closely intertwined functionally (Van Moffaert, 1992). There also appears to be a relationship between the skin and the immune system. Clinical studies have shown that psychological stress can cause suppression of killer T-cells and macrophages, both of which play important roles in skin-related immune reactions (Papadopoulos et al., 1999). Another important link between the dermis and the psyche is that skin diseases may signal internal pathogenic processes.

On a more practical level, dermatology deals with an organ that can be readily seen and touched. This has consequences for how a patient interacts with their lesions and also for the lack of privacy that so many complain about. From intrusive questions to rude comments, the visibility of cutaneous conditions has a devastating effect on the need for many to keep their condition private or personal. Consequently, a skin disease brings with it a variety of life changes and challenges for the patient, as our society places much emphasis on looks and appearance.

This chapter will aim to outline some of the core psychosocial issues faced by people living with skin diseases in the context of the use of counselling to address them and review the most frequently used psychological treatments. Their efficacy will be critically evaluated. Finally, recommendations for treatment will be made taking into account the potential challenges faced by people with skin problems.

## **Psychosocial impact of skin diseases**

Within the psychodermatological literature, there is a great degree of consensus that skin disorders have a negative impact upon the psychological and emotional functioning of some patients. Indeed, research has provided evidence that such appearance-altering diseases can have profound behavioural, emotional and cognitive impact upon sufferers (Griffiths & Richards, 2001; Thompson & Kent, 2001). A brief overview of the most commonly researched psychological implications is thus provided.

Damaged skin often carries the connotation of contagion or a lack of hygiene (Van Moffaert, 1992). Owing to a lack of health education and awareness in dermatology, some associate skin disease with such issues. This ignorance means that a skin disease patient may find that some people react negatively towards them or treat them differently because of the way they look. Consequently, the sufferer may experience distress, feel stigmatised and thus begin to avoid certain social activities that either involve the revealing of the lesions, such as swimming, or that involve potential intimacy with a third party, such as dating or physical displays of affection.

In their qualitative study with vitiligo patients, Thompson et al. (2002) found that the central recurring theme in their interviews concerned perceived differences from previous appearance and from others. Common behavioural strategies

used by these patients were concealment and avoidance, which were mostly utilised in order to avoid negative reactions from others. Moreover, acne patients have been shown to limit exposure through social avoidance and to conceal skin lesions (Kellett & Gilbert, 2001). Psoriasis patients have also been found to engage in anticipatory and avoidance coping behaviours, which are unrelated to the severity of their condition and this is hypothesised to relate to stigmatisation and rejection (Griffiths & Richards, 2001). Like previous work on disfigurement and social anxiety, skin disease patients use these dysfunctional behavioural strategies to manage the impression they make on others and their frequent use illustrates the overriding concerns about social exclusion (Thompson et al., 2002).

Cognitively appearance-altering, cutaneous conditions can have a profound effect on self-concept and on body image. Any minor deformity or disfigurement can contribute to the development of heightened body awareness. Cutaneous conditions can often have a progressive and episodic course making it necessary for the patient to adapt to changes in physical appearance. Hence, patients must not only learn to cope with the challenges of living with an appearance that deviates from the norm but also to adapt to a changing body image. That is, skin disease patients must develop and maintain a sense of self-esteem without relying upon physical attractiveness. This is an extremely difficult task given the fact that the robust relationship between self-esteem and body image has been underscored in numerous studies (Papadopoulos et al., 2002).

Feelings of anxiety, uncertainty and helplessness are often cited by dermatology patients as accompanying the diagnosis of their skin condition. Without the knowledge of when or how the condition will develop, the patient may be left wondering about what behaviours or actions might be contributing to its progression. Moreover, dermatology patients experience heightened self-consciousness, which, in turn, has negative implications for interpersonal interactions and relationships. Research has shown that self-consciousness is a common reaction amongst acne patients (Kellett & Gilbert, 2001). Papadopoulos et al. (1999b) found a significantly high frequency in irrational, negative thoughts among vitiligo patients.

Studies have also highlighted a higher prevalence of psychiatric disorder in dermatology patients (Hughes et al., 1983). Although it seems a little premature to make links between dermatological disorders and psychiatric conditions based solely on evidence from cross-sectional designs, research has certainly reported the increased prevalence of conditions, such as anxiety and depression in this population. Gupta et al. (1993) found that over 5% of their sample of psoriasis patients had active suicidal ideation and almost double this figure had expressed the wish to die. Similarly, Fortune et al. (2000) found that psoriasis patients had worry scores on standardised assessment indicative of pathological worrying, with 25% of the entire sample scoring above the mean for patients with a definite diagnosis

of generalised anxiety disorder. A linkage between obsessive–compulsive disorder (OCD) and dermatology has also recently been investigated. There is a specific clinical condition, *acne excoriee*, which is characterised by excessive picking and/or scratching of real or imagined lesions which is considered to be a dermatological variant of OCD (Kellett & Gilbert, 2001). Acne patients may also use too much soap or other vigorous cleaning methods in order to address the feelings of infection. Hence this type of behaviour may qualify as a compulsion.

As well as affecting psychosocial functioning, negative psychosocial experiences may also affect the onset and progression of cutaneous conditions. Clinical observations have suggested that stress often precedes the onset or exacerbation of many dermatological conditions that share both psychosomatic and immunological components, such as vitiligo, psoriasis and atopic dermatitis (Koblenzer, 1983; Al-Abadie et al., 1994). For example, emotional distress and stressful life events have been suggested as contributory factors in the onset of vitiligo (Papadopoulos et al., 1998).

Despite such overriding evidence concerning the impact of skin disease on the sufferer and its implicated role in aetiology, cutaneous conditions are not generally recognised as a handicap and people with such conditions often face trivialisation of their distress (Papadopoulos & Walker, 2003). Until recently, little attention was given to the psychological effects of skin conditions and the challenges faced by those who suffer from them, not only by family and/or friends but by health professionals. Since skin diseases are rarely life threatening, their impact is often minimised by health professionals. Some doctors tend to make judgements about the seriousness of a medical condition in terms of pathological severity rather than quality of life. They consequently deem many skin conditions trivial or unimportant. Patients are left feeling misunderstood or embarrassed for having taken up their doctor's time. They may also feel that they are not taken seriously or are upset by being trivialised. Hence, consultations with professionals can become quite problematic (Papadopoulos & Walker, 2003).

Of course, individual variation exists with regard to adjustment to skin disease and some people cope well with their condition. However, there exists a proportion of this population that finds it particularly difficult to cope (Papadopoulos & Bor, 1999). Clearly then, psychodermatological research has only recently begun to identify the factors that might account for successful adjustment to disfigurement. Variables, such as coping, social support and cognitive representations of illness are being investigated in order to account for psychological impact (Fortune et al., 2000; Papadopoulos et al., 2002; Thompson et al., 2002). Such research has obvious theoretical and therapeutic implications. Theoretically, any model designed to explain psychological adjustment to skin conditions will need to provide explanations for the relationship between disease and psychological distress. Therapeutically, an

understanding of patients' adjustment to disease will firstly help professionals to understand patients' attitudes towards treatment and care, and improve the chances of benefiting from them. Secondly, it will elucidate patients' attitudes and representations of their illness as well as their seeking, and adherence to, treatment (Papadopoulos et al., 2002).

### **Psychological approaches to treatment for dermatological conditions**

Increasingly then, within the dermatological literature, attention was given to the therapeutic benefits that might derive from psychological interventions beyond those of standard medical care. Given the close and clear associations between psychological factors and cutaneous conditions, it is not surprising that the effects of such treatment have been investigated. The literature has documented psychological interventions for a number of cutaneous conditions, such as vitiligo, psoriasis, acne and atopic dermatitis, which have been suggested to be as effective for each of these types of disorders as classical medical procedures (Van Moffaert, 1992; Papadopoulos & Bor, 1999). For example, in their review of psychological therapies for the treatment of psoriasis, Winchell and Watts (1998) describe a case in which two psychiatric patients with psoriasis were given a suggestion that imipramine would have beneficial effects on their skin condition. Following this suggestion one of the patients experienced complete remission while the other improved significantly.

The methodological rigour of trials in this field has improved over time. Specifically, early research must be viewed as tentative in view of certain methodological shortcomings. It often used single-case experimental designs with few attempts to evaluate the progress of patients after the termination of therapy or to compare results with those of other patients or matched controls (Papadopoulos & Bor, 1999). Studies were also based on small samples with no control groups. Outcome measures were unsophisticated and were usually given by a single observer. Furthermore, outcome was measured by changes to either psychological or dermatological health but rarely by both. Since the early 1980s, psychocutaneous research investigating the efficacy of psychological interventions has started to employ controlled trials with large samples and quantitative cross-sectional designs, and to examine outcome from both psychological and dermatological perspectives (Papadopoulos & Bor, 1999).

Psychological approaches, such as psychoanalysis and hypnosis (Gray & Lawlis, 1982) as well as behavioural (Wolpe, 1980) and cognitive-behavioural therapy (Papadopoulos et al., 1999b) have been used to treat people affected by skin disorders (see Table 8.1). Indeed, such interventions have been shown to produce clinically significant improvements in cutaneous conditions, such as atopic dermatitis

**Table 8.1.** Approaches to treatment of dermatological conditions

|            | Behaviour therapy   | Cognitive-behaviour therapy   | Group therapy  | Psychodynamic psychotherapy                                 |
|------------|---|---|--|---|
| Time frame | Here-and-now  | Here-and-now  | Here-and-now   | Understanding the past, focuses on current relationships    |
| Cost       | Cost-effective  | Cost-effective  | Cost-effective   | Expensive   |
| Techniques | Systematic desensitisation, modelling, relaxation, habit-reversal training, assertiveness and social skills training, imagery | Problem-solving, cognitive restructuring, guided imagery, modelling | Psychoeducation, social and assertiveness skills training, role-play | Analysis of transference and counter-transference, hypnosis |
| Time       | Short-term  | Short-term  | Short-term   | Long-term   |
| Efficacy   | Psoriasis, eczema, vitiligo, acne   | Psoriasis, eczema, vitiligo, acne                                   | Psoriasis, eczema, vitiligo  | Eczema  |

(eczema), psoriasis, vitiligo and virus-mediated diseases (Van Moffaert, 1992) and have helped patients to improve their psychological well-being and quality of life (Cole et al., 1988; Papadopoulos et al., 1999a). Outlined below are the main therapeutic techniques used in dermatology settings.

**Behaviour therapy**

Behaviour therapy incorporates applications derived from learning theory (classical and operant conditioning) and employs them to the treatment of persistent, maladaptive, learned habits. Among behaviour therapy techniques are systematic desensitisation, assertiveness and social skills training, behaviour analysis, relaxation training (e.g. autogenic and progressive muscle relaxation, biofeedback) habit-reversal training and imagery. The aim of these techniques is to progressively diminish maladaptive behavioural responses by repeatedly inhibiting the anxiety by means of competing responses (Wolpe, 1980). A behaviour analysis is conducted where the clinician collects information about the relationship between stimuli and behavioural responses in order to understand the role of anxiety.

Diverse behavioural therapeutic strategies have been applied, either separately or in combination with other psychological techniques to dermatological conditions.

*Systematic desensitisation* is an appropriate technique for the treatment of dermatoses which feature anticipatory anxiety (Van Moffaert, 1992). The fear and apprehension that patients with skin disease may feel about themselves may be challenged by this technique. Through graded exposure, the patient enters situations that they may fear and avoid. The *habit-reversal technique* is a common strategy used to inhibit scratching and it has been reported to have some success with skin disorders, such as eczema and psoriasis (Ginsburg, 1995). It involves self-monitoring for early signs and situational cues of scratching and practising alternative responses, such as clenching the fists (Ehlers et al., 1995). *Relaxation* has beneficial effects on skin disorders because it reduces stress levels. It is a useful way to help patients prepare for anxiety-provoking situations or to cope with stressful social predicaments. Relaxation can be used on its own as a means to reduce anxiety or tension or can be paired with imagery. There are various different techniques, such as progressive muscle relaxation or autogenic relaxation training.

*Imagery* with skin disease patients is employed in order to help them cope with anxiety relating to their condition. Imagery is a useful technique for helping the patient to visualise the feared situation while in a relaxed state (Papadopoulos & Bor, 1999). *Assertiveness and social skills training* is appropriate for patients with cutaneous conditions that attract attention from others, such as staring or personal questions. Interventions focus on improving social skills and ways of expressing emotions, thus helping patients deal more effectively with the reactions of others and learn a more positive mode of social functioning (Robinson et al., 1996).

Weinstein (1984) found that compared with patients receiving only medical treatment (psorafen plus ultraviolet light A, PUVA), both psychological treatment groups, one receiving progressive relaxation and guided imagery and the other meeting to discuss psychosocial concerns about psoriasis, were effective in reducing the signs and symptoms of psoriasis. Robinson et al. (1996) found a significant decrease in anxiety and an increase in confidence of facially disfigured people (among whom were people with acne and vitiligo) after a social skills workshop that aimed at improving social interaction skills. Additionally, Ehlers et al. (1995), in their controlled trial, used relaxation therapy with patients with atopic dermatitis and found significant improvement in the skin condition.

### **Cognitive-behavioural therapy**

Cognitive-behaviour therapy (CBT) is a treatment approach that aims to change maladaptive ways of thinking, feeling and behaving through the use of cognitive and behavioural interventions. This model takes the view that it is not situations in and of themselves that are stressful, but rather the perception that one takes of them that makes them so. According to the cognitive model, the beliefs that patients hold about their condition often influence how they cope with and adapt

to it. A common feature in the beliefs of people with emotional difficulties is that they have negative and irrational content. These perceptions are often the result of distortions in processing, such as 'cognitive errors' (Beck, 1976, 1993).

CBT focuses on examining and trying to challenge dysfunctional beliefs and appraisals, which may be implicated in a person's low mood or avoidance of certain situations or behaviours. Consequently, targeting cognitions and maladaptive behaviour are the key areas of CBT interventions for facilitating change. According to this approach, beliefs are considered as hypotheses to be tested rather than assertions to be uncritically accepted. Therapist and client take the role of 'investigators' and develop ways to test beliefs, such as 'Others do not like me because of my eczema' or 'I won't be happy anymore because of my vitiligo'. Success at challenging these beliefs involves providing evidence that they are erroneous, and underscored by anxiety and depression (Beck, 1993).

CBT has been successfully applied to various skin conditions. For example, Horne et al. (1989) used cognitive-behavioural therapy along with standard medical treatment in treating three patients suffering with atopic eczema. All three showed a post-treatment reduction in symptom severity, an increase in their ability to control the disorder and a decrease in their reliance on medication. Four controlled studies have also used a cognitive-behavioural approach with psoriasis patients (Price et al., 1991; Zacharie et al., 1996; Fortune et al., 2002; Fortune et al., 2004). Findings have shown adjunctive cognitive-behavioural interventions result in a reduction of psychological distress and in the clinical severity of the condition. Additionally, Papadopoulos et al. (1999b) compared two matched groups of vitiligo patients, one of which received CBT while the other received standard medical treatment alone. Results suggested that patients could benefit from CBT in terms of coping and living with vitiligo. There was also preliminary evidence to suggest that gains made through CBT influences the progression of the condition. Finally, Ehlers et al. (1995) employed CBT with patients with atopic dermatitis and found significant reductions in anxiety, frequency of scratching and itching as well as cortisone use.

### **Psychoanalytic psychotherapy and hypnosis**

Psychoanalytic psychotherapeutic approaches place emphasis in psychodynamics and in particular to unconscious processes. Transference and counter-transference phenomena as well as patients' resistance are all dynamic aspects of the therapeutic relationship and important clinical concepts for this model. The basic goal of this type of therapy is to make the unconscious conscious and to create meaning where there is anxiety or confusion.

The integration of the psychoanalytic approach in dermatology has been realised in some examples of dermatological conditions where patients (such as

patients with urticaria or eczema) are not yet aware of a psychogenic factor in their dermatosis. There are case reports in the literature where the use of psychoanalytic psychotherapy led to marked improvements in skin conditions (Van Moffaert, 1992).

Early researchers in psychodermatology experimented with the use of hypnosis (Van Moffaert, 1992). Hypnosis brings about changes in physiological parameters, such as skin conductance, skin temperature and vasomotor reactions all of which can be decisive in the aetiology of skin diseases (Van Moffaert, 1992). Neurodermatitis, chronic urticaria and viral warts are skin diseases with which hypnosis has been successfully used (Barber, 1978).

### Group therapy

Group therapy is a mode of intervention that helps individuals with a common problem enhance their social functioning through group exercises. Group members are given the opportunity to share their experiences, feelings and difficulties in a safe atmosphere under the auspices of a group facilitator. Using a combination of instruction, modelling, role-play, feedback and open discussion, members of the group are encouraged to discover more about the interaction process. In most cases 6–12 clients meet with their therapist at least once a week for about 2 hours. Usually groups are organised around one type of problem (such as coping) or type of client (such as psoriasis patients).

Through group interaction, ineffective and immature ways of coping are discouraged, positive attitudes are fostered and feelings, such as loneliness and isolation, that many patients experience, diminish. Moreover, group members can bolster one another's self-confidence and self-acceptance, as they come to trust and value one another, and develop group cohesiveness. Group therapy allows participants to try out new skills in a supportive environment and members learn from one another. Thus this offers features not found in individual treatment.

Various approaches, such as social skills training to group therapy have been tried with patients with skin disorders (Robinson et al., 1996). Patients with chronic skin conditions, such as psoriasis or eczema are known to benefit from group therapy and such therapy has increased their confidence in coping with the disease (Ehlers et al., 1995; Seng & Nee, 1997; Fortune et al., 2002).

Overall, research suggests that psychological treatments lead to improvements in clinical severity of skin condition and reductions in psychological distress. This idea corroborates reports that psychological interventions are useful adjuncts to dermatological treatment in such cutaneous disorders and, when combined, can be considered an effective way of managing patients with such conditions. Skin disease appears to be a complex interplay of biological, psychological and social factors, and treatment should exist within the context of this interplay.

Specifically, CBT is gaining credibility as a psychological treatment in the management of skin condition. Data from the studies reviewed are generally supportive of its efficacy as an approach, which can be used as an adjunct to medical care (Ehlers et al., 1995; Papadopoulos et al., 1999; Fortune et al., 2002, 2004). Findings have shown that cognitive techniques produced reductions in the frequency of cognitions concerning itching, catastrophizing cognitions (Ehlers et al., 1995), and in beliefs about the consequences and the emotional causes of disease, and were maintained at 6 month and at 1-year follow-up. Research has also shown that relaxation is an important component of CBT and it has proved most effective in decreasing anxiety levels among dermatology patients (Ehlers et al., 1995; Zacharie et al., 1996). These data suggest that high anxiety levels often observed in these patients can be reduced with treatment and that treatment effects can be maintained even after a 1-year follow-up.

### **Recommendations for treatment**

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The present review has certain treatment implications for the management of people with skin conditions. It underscores the fact that the effects of dermatological conditions permeate much deeper than the skin (Papadopoulos et al., 1999b). Consequently, when treating dermatology patients one needs to take into account the impact that their conditions have on their emotional well-being and quality of life and we should seek to develop therapies that would address these factors.

The recognition that cognition, emotion, behaviour and motives have an impact on skin disorders opens new possibilities regarding assessment and treatment in the field of psychodermatology (Papadopoulos & Bor, 1999). A biopsychosocial model of skin disease enables us to go further than simply acknowledging that multiple systems (psychological, physiological, social, environmental factors) interact to produce states of health and illness by providing evidence for the reciprocity between the body and the mind. In order to understand the psychological consequences of dermatological conditions and to treat them effectively, we need to view the patient holistically. Psychological therapies or counselling can be considered an effective adjunct to medical treatment for various skin disorders.

The use of counselling or therapy in the field of dermatology encompasses the idea that people have the capacity to cope with their difficulties and to grow emotionally. Through this process the patient is encouraged to move towards openness and self-trust as opposed to feeling stuck or invalidated (Papadopoulos & Bor, 1999). Therefore, it is useful firstly to explain the way that counselling can help and secondly to distinguish between the different levels of counselling in order to illustrate the range of activities carried out by clinicians.

## How can therapy help in the treatment and management of dermatology patients?

Therapy such as CBT can help dermatology patients to:

- come to terms with their conditions;
- explore treatment options and facilitate decision-making;
- examine difficulties they are experiencing with their condition and gain insight into what factors maintain those difficulties;
- explore and challenge dysfunctional appraisals, beliefs and assumptions;
- identify useful coping strategies;
- facilitate social interaction skills;
- examine issues that may be indirectly linked to the skin condition;
- challenge and cope with anticipatory anxiety and depression.

Group therapy, especially social and assertiveness skills training can help dermatology patients:

- encounter difficulties in social situations;
- discuss their problems with others who can empathise;
- develop a better understanding through the others' experiences of their condition;
- allow members to acquire and develop a variety of skills and put them in practice with other members;
- serve as a means of emotional and social support for skin patients.

## Levels of counselling

### Information giving (education)

This concerns the provision of factual information and advice about medical conditions, treatments, drug trials, disease prevention and health promotion among others.

### Implications counselling

This concerns the discussion with the patient and/or others about the implications of the information received regarding the illness for the individual or his/her family and his/her personal circumstance.

### Supportive counselling

In supportive counselling, the emotional consequences of the information and its implications can be identified and addressed in a supportive and caring environment.

**Psychotherapeutic counselling: therapy**

This focuses on healing, psychological adjustment, coping and problem resolution. Different theoretical approaches involve CBT, psychoanalytic therapy, behaviour therapy, humanistic therapy and others.

**Conclusion**

This chapter examined the close and complex relationship between psychology and skin disease in an attempt to demonstrate the need for psychological interventions in the treatment of dermatological conditions. Indeed, it has been shown that there is a real need to address psychosocial issues surrounding disfiguring dermatological conditions. The impact skin disease has on the patients' well-being as well as his/her relationship to the outer world can be great and varied. Hence, a major aim of the present chapter was to conceptualise skin disorders as a biopsychosocial phenomenon, which have the ability to exert negative pressures on sufferers and therefore their management calls for a holistic approach.

Although evidence was provided that psychological treatments can be efficacious in addressing them, still much of the research in this area is methodologically flawed. Some studies often have small numbers of patients and some lack appropriate controlled groups. Additionally, as the majority of the research has employed quantitative designs, much of the depth of information regarding patients' beliefs about psychotherapeutic approaches, such as relevance, motivation and expectations is lost. Finally, studies have failed to examine variables, such as length of treatment and treatment at different stages of illness, which can provide more data on the benefits accrued from such approaches.

Therefore, there is a great need for systematic evaluation to determine the treatment efficacy of different approaches to counselling and the development of psychological treatments, which will focus on the unique issues pertaining to dermatology patients. Future research should seek to examine the utility of different modalities for various skin conditions by employing designs that will compare them. Thus, controlled studies should be devised to compare differences between the effectiveness of different psychological treatments as well as varying time and stage of illness. Moreover, future research should seek to address factors, such as motivation, adherence to treatment and treatment expectations. On the whole, it appears that the positive outcome of therapy is dependent on non-specific variables, such as motivation and expectations rather than on specific treatment variables per se (Van Moffaert, 1992). Hence, investigations with less motivated and committed samples need to be considered in order to establish precisely the types of individuals that are likely to benefit from therapeutic services.

In conclusion, the fact that psychological interventions can have important effects on the severity of chronic dermatological disorders offers an exciting prospect for the management of skin patients. Certainly, we have come a long way in our understanding of the relationship between psychological factors and dermatological conditions. More knowledge and education of the public around issues concerning counselling and its effectiveness in dermatological conditions is needed. Prejudicial beliefs about psychological services as well as patients' own psychological difficulties, particularly perceptions of stigmatisation, may impede them from attending such treatments. However, as health professionals we can begin to overcome these obstacles by providing patients with comprehensive information about psychological approaches and helping them to make more effective use of and derive benefits from the psychological interventions available to them. Ultimately, dermatological conditions, like other illnesses, need to be addressed not only in terms of the objective effects of the illness but also in terms of the subjective experience of the patient; it is only through well-researched, methodologically sound psychological techniques that we can ever hope to address that.

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