Global Skin Aging and its Management: Perception, Needs, Differences and Responses to Skin Aging

Psychosocial Implications

89 Psychological and Social Implications of Aging Skin: Normal Aging and the Effects of Cutaneous Disease

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Introduction

Aging, by definition, is a progressive deterioration of body structure and function [1, 2]. All organs, including the skin, age. The skin wrinkles, sags, and thins, becoming drier, rougher, and less elastic [1]. Successful aging transcends the inevitable physical decline and is characterized by adaptive psychosocial functioning that facilitates the maintenance of good mental health and satisfaction in daily life [3]. Although much of gerontological research in dermatology has focused on an aesthetic abeyance of the signs of aging, little real medical attention has been paid to the psychosocial effects of an aging integument [4]. The skin is the envelope of self and, therefore, the visible manifestation of personal identity [4]. It displays emotion, blanching, blushing, and sweating in response to internal feelings [5]. The "social" skin and its gerontological issues, then, must be contrasted to the merely biological skin [5].

Even in the absence of frank disease, the aged skin no longer looks or feels good; a subjective evaluation whose currency is not biology, but psychology [6]. Skin that does not look or feel good is emotionally burdensome [6]. Skin that is rough and itchy is uncomfortable and has the potential to cause considerable emotional distress [6]. Skin that becomes discolored, blemished, or loose, or is obviously oozing or crusting over is unappealing, eroding the self-esteem of its owner and causing anxiety, depression, and social withdrawal [7].

In addition, the prevalence of skin disease increases steadily throughout life [8]. Most people over 65 have at least two skin diseases worthy of treatment [5]; 10% of those over the age of 70 years have more than ten concurrent complaints [6]. Dry skin and pruritus virtually affect everybody by the eighth decade of life [6]. The view is widespread even among medical personnel that skin disorders in old age are trivial, with largely cosmetic ramifications [5]. In fact, skin disorders in the elderly are often the bane of their existence, the source of a significant amount of discomfort and distress [9] and having an adverse effect on almost every area of life [10].

The impact of cutaneous disorders in the elderly on the "social skin" has been largely ignored until recently [4]. Skin disease can be disfiguring, adding to the psychological burden of the already aged skin and causing further embarrassment and loss of self-confidence [7]. These diseases can repel physical contact by others, leading to social withdrawal and obstruction of interpersonal relationships [6]. These also can disrupt daily life activities and interfere with both work and leisure pursuits [11]. Decreasing quality of life (QoL) due to cutaneous disease in the elderly leads frequently to depression, anxiety, and other psychological dysfunction, robbing many older people of quality of life in their later years [11].

Beauty and the Aged Skin

An attractive appearance is a very valuable commodity [4]. Those deemed physically attractive by their fellow members of society have been shown to reap personal, educational, occupational, and social rewards [12]. Social reinforcement of physical attractiveness begins early: babies with a pleasing appearance receive more attention than more homely babies [13]. Aesthetically pleasing children get better grades and less punishment in school [14].

Those endowed with pleasing looks are believed to have equally appealing personalities [15], positive life experiences [15], and to be smarter, more successful, and more capable of emotional intimacy [16] The physically blessed draw higher salaries and more rapid promotions than their more homely colleagues [17].

Youthfulness is very much considered a component of attractiveness in twenty-first century Western society [4]. The elderly are dismissed as unimportant or even inconvenient [4], and inevitably judged as unattractive simply because they are aged [4]. Skin is a primary contributor to the evaluation of age [18], a fact instinctively appreciated

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by those with aged skin. People with photodamaged skin exhibited high anxiety and a high level of discomfort in interpersonal relationships, an issue which normalized after treatment ameliorated the cutaneous manifestations of photodamage [19].

Advanced age is increasingly viewed as a negative thing [20] and, interestingly no longer something which must be stoically endured; the social culture that has developed over the last few generations carries an expectation that signs of age must be staved off whenever possible [20], putting perhaps more psychological pressure on the aging individual. Ameliorating the physical signs of aging, when possible, however, is medically advisable. Attractive older people are more favorably perceived by others [6].

In addition, being deemed "attractive," and therefore successful, competent, and pleasant, is to some extent a self-fulfilling label [4, 21]. An "attractive" group of older people was observed to be actually happier, more satisfied with life, and socially more active than an age-matched group of more unattractive seniors [5, 18], a finding with long-term implications. In a longitudinal study, which evaluated 24 age-related functions, the most attractive 15% of a senior study population had better functional scores than did the most unattractive 15%. More importantly, the more attractive 15% had significantly longer lifespans [22].

Factors in Individual Adaption to Aging

There is a diversity in how people age. Some age more successfully than others [3, 4]. Individual physiological aging is determined by the effects of lifestyle choices on a genetic foundation [1, 2]. Personal psychosocial adaptation is also based on a genetically determined personality, modulated by early developmental influences as well as later life experiences [4].

There are numerous factors that move to the psychosocial burden that cutaneous disease in old age will represent any particular individual. The severity and location of the lesions, the nature of the lesions, and the nature and severity of pain or itching play a major role in determining the extent of psychological distress [23]. In studies of psoriasis patients, plaques on visible skin were, predictably, more disabling than plaques located only in occulted areas [24], although, surprisingly, even plaques in invisible areas could cause substantial psychosocial disturbance [25]. Indeed, resistant psoriasis, even in nonvisible areas, can be an indication to systemic treatment. Contagious diseases cause more social withdrawal than noncontagious [23], and life-threatening diseases more distress than nonthreatening disorders [23].

Whether the disease is self-limiting or chronic is also an important consideration. With chronic skin diseases, where alleviation of symptoms is not expected, physical and emotional symptoms can synergistically spiral downward. For example, intense itching will often disrupt sleep patterns, causing emotional distress. As the intensity of physical symptoms increases, the cycle may deteriorate until significant impairments in emotional health, social functioning, and sleep patterns are experienced, causing increasing fatigue and depression [26]. As attention to hygiene and grooming wane with waxing psychosocial dysfunction, an aversion and/or rejection of the subject may also occur, accelerating the downward spiral [25].

Existing psychological health is also an important component to cope with a debilitating skin disease. The strongest single predictor of later psychosocial adjustment is early psychiatric history – tranquilizer use before the age of 50 – predicts less favorable mental health in old age [27].

A foundational self-esteem is a critical determinant of psychological health, sowed largely in early months of life as the mother positively responds to her baby's needs. Self-esteem thus established in the early months of life lays down positive body image, emotional stability, a sense of personal security, and a conviction of personal ability to determine life events [4]. The person who develops self-esteem in childhood will, as an adult, find ways to reinforce that self-esteem [4]. Self-esteem, which endows these individuals with a basic belief that they can change negative circumstances, also helps a negative life circumstance to be eventually accepted, integrated, and used as springboard for personal growth [5]. People whose body image and self-esteem are less stable have been observed to exhibit dysmorphic tendencies, an obsession with personal appearance, and depression as a reaction to skin disease [28].

Many other personality characteristics have been associated with difficult in accepting and coping with a skin disease. Patient with high levels of perceived helplessness have demonstrably worse physical and psychological functioning [29]. A high need for approval, an elevated fear of negative evaluation, and difficulty in expressing anger also correlated to an increased psychological burden and an increased level of disability in psoriasis patients [30]. Individuals with narcissistic personalities have demonstrated more difficulty in handling signs of aging and/or cutaneous disease [31]. Finally, a high internal need for control (obsessive-compulsive personality) increases distress with regard to skin aging or disease [7].

In addition, the level of social support available plays a role in how an individual adapts to the psychosocial ramifications of skin disease. The perceived level of specific support as well as the size of the available social network influence psychosocial functioning [29].

Psychosocial Effects of Skin Disease in Old Age

It has been demonstrated that physical attractiveness influences social acceptance: more attractive individuals enjoy preferential treatment in social interactions [15]. Throughout history, those with skin disease have been social outcasts [4]. Skin diseases have been assumed to be contagious [23] or to be a punishment for some type of wrongdoing [6] and have been responded to by revulsion and aversive behaviors [5]. Today, caregivers in nursing homes and hospital have been shown to be more distant and less nurturing when patients are aged or otherwise unattractive [31].

Patients with skin disease are familiar with being asked to leave swimming pools, gyms, parties, beaches, and other public places because of their affliction [23]: for example, 40% of psoriasis patients have been asked to leave public swimming pools or hair salons [24]. Such stigmatization can understandably cause profound psychological distress [32], with sufferers feeling rejected, humiliated, embarrassed, and singled out [25, 33]. Many patients, particularly those who have been rejected previously, anticipate rejection and withdraw, avoiding parties, sports, meeting new people, being photographed, or unnecessarily exposing skin [34]. One survey of psoriasis sufferers found that 64% avoid short-sleeved clothes, 57% felt stared at, 55% felt that people believed psoriasis to be contagious, 55% felt untouchable, 50% felt sexual relationships affected, and 34% avoided hair salons; notably, 12% avoided public contact altogether [35].

Skin disease can also have a substantial effect on the sufferer's livelihood. The presence of a chronic skin disease can quite often limit the choice and the progression of a career [34], but even when established in a career, 20% of those with cutaneous disease reported interference with work performance. Indeed, 31% of psoriasis sufferers report some degree of financial difficulty related to the disease [24, 36].

Older people with skin disease in general feel less stigmatized than younger individuals [23], with anticipation of rejection, sensitivity to the opinion of others, and feelings of guilt and shame being less pronounced in older patients at the onset of psoriasis [37]. Older patients experience distress equal to their younger counterparts when manifestations of psoriasis and other disfiguring skin diseases are severe [29] The attitudes of the people closest to the patient proved to be the most important determinant of the impact that the disease had with regards to social functioning [23].

An important consideration in social interaction for skin-disease patients, particularly the aged, relates to the human emotional need for touch. It has been demonstrated that a broad area of tactile stimulation increases self-esteem in children [4]; the benefits of touch are at least as important in the aged [38]. However, as a human being ages, the skin becomes rougher, less attractive, and less pleasant to touch [5], while at the same time the pool of potential touchers typically becomes smaller [4]. Less attractive residents of nursing homes have been observed to be less likely to elicit touching by caregivers than more attractive residents [38].

Touching interventions, however, in nursing home populations have demonstrated that residents who receive regular touch through massages, hugs, and hand squeezes are more alert and less confused than those who are not touched [38]. Conversely, 26% of psoriasis patients in one study had experienced in the previous month an event in which someone made a conscious effort to avoid touching them, thus setting the stage for psychological distress. The Carroll Rating Scale for depression correlates depression with a lack of recent touch [39].

Psychological Effects

Skin imperfections have a negative influence on self-esteem [6], often in dramatic disproportion to the physical severity of the disease. A survey of 236 dermatology patients by a general health questionnaire found a higher prevalence of psychiatric disorder in patients with skin disease (i.e., acne, eczema, psoriasis, alopecia); patients severely affected with psoriasis exhibited the highest level of depression scores (using the Carroll Rating Scale for Depression), equivalent to clinical depression [40]. Psychological effects related to depression are displayed in *Table 89.1*.

Certain diseases (e.g., vitiligo) that involve a change in skin pigmentation, but no health consequences whatsoever, have the potential to create a significant psychosocial burden [41]. As the skin represents the interface between the internal self and the external world, patients take skin disease personally. Skin disease makes the patient feel anomalous and out of control [23]. Even modern patients often attribute their own skin disease to some personal

Table 89.1

The prevalence of psychological effects in psoriasis and atopic dermatitis

	Depression	Anxiety	Despair	Suicidal ideation	Distress
Psoriasis	46%[a] [29]	33%[a] [29]	26% [33]	2.5% [29]in outpatients	21% [33]
	20%[b] [29]	13%[b] [29]		7.5% (in inpatients) [29]	
Atopic dermatitis	45%[a] [29]	30%[a] [29]		2.1% [29]	

[a]Identified as depressed or anxious by virtue of scoring equal to or higher than the mean average of psychiatric outpatients on the Depressed Mood and Anxiety scale

[b]Identified as depressed or anxious by virtue of scoring equal to or higher than patients with a diagnosis of clinical depression or clinical anxiety

wrongdoing [6]. There is, therefore, often an inherent sense of guilt; the patient feels that he or she must have done something to deserve the affliction [23], and the disease engenders feelings of helplessness, anger, shame, embarrassment, and frustration [42].

In a group of patients with a variety of skin diseases, specific contributors to psychological stress were identified as fatigue, a perceived lack of control, feelings of alienation, and a perceived lack of social support [29]. In a study focused on patients with atopic dermatitis, itching was the biggest component to psychological distress, with 63.2% stating that it was very or extremely bothersome, followed by occasional sleep disturbances (57%), dryness (52.3%), rashes (47.2%), and open sores (21.2%) [26]. One percent of the patients reported continual sleep disruption [26]. In atopic dermatitis, severe itching was also strongly related to psychological distress [29]. Itching is far less tolerable than pain, as well as more intractable to treatment [6]. Generalized, intractable pruritus is the most common dermatological cause of suicide [6]. In an evaluation of the psychosocial burden of venous ulcers using the *Skindex-29* index, older patients displayed worse quality of life scores than younger patients [43]. In venous ulcer patients, 80.5% reported pain, 69.4% reported itching, 66.7% reported altered appearance, 66.6% reported sleep deficit, and 58.3% reported functional limitations [43]. Venous ulcers have also been shown to produce embarrassment [44] and social isolation [45]. (*Tables 89.2* and *89.3*).

The effects of psychological stress include an increased risk of destructive behaviors such as alcohol and tobacco abuse, the use of tranquilizers, sleeping medications, and the use of antidepressants [46], particularly in men [47]. Patients with acne, psoriasis, and facial conditions are more likely to have reactive depression and be at risk of suicide [48].

Elderly patients were found to suffer at least as much psychological distress as younger patients as the result of both psoriasis and atopic dermatitis [29]. Severe psychological distress suffered by victims of vitiligo was also determined to be as pronounced in the aged as in younger patients [49]. In general, suicide is attempted less often, but is successful more often in older patients, and suicide rates rise significantly after the age of 75 [50]. It is not unlikely that the psychosocial ramifications of aged skin and its attendant disfiguring and disabling disorders contribute to the increased risk of suicide in the aged population [7].

Quality of Life

Numerous indices have been validated for measuring quality of life (QoL) in skin conditions: *Dermatology Life Quality Index*, *Dermatology Quality of Life Scales*, *Dermatology Specific Quality of Life*, *Psoriasis Disability Index*, and *Skindex-29*. Studies using these indices routinely demonstrate that skin diseases have a profound effect on the patient's quality of life. QoL indices attempt to measure the various ways in which skin disease impacts the patient's life: psychological stress, social function, and functional limitations with regard to work, daily life, or leisure activities.

Many patients feel that they have been discriminated against socially and economically, and by medical insurers [34]. They report intense psychological upheaval and strong feelings of alienation and rejection, using words like *mortified*, *unspeakable*, *hideous*, *gruesome*, and *hateful* [23]. In a study of 100 patients (diseases represented included eczema, psoriasis, and acne), 40% reported social isolation, 74% reported interference with work, 80% reported shame, 60% reported anxiety, and 30% reported experiencing depression [51].

Several studies have compared the quality of life for skin-disease patients with that of other serious diseases. The impact of psoriasis on QoL was found to be as pronounced as that of cancer, heart attacks, or chronic pulmonary diseases [52]. Forty-six percent of psoriasis

Table 89.2

Common disorders in the aged and their psychosocial implications

Disorder	Prevalence	Sources of psychosocial suffering	Reference
Xerosis	Nearly 100% by eighth decade of life [6]	Skin becomes dry, itchy, cracks	[64]
Pruritus	Up to 29% [65]	Intense itching, sleep disturbances, can be significant psychosocial stress	[65]
Fungal infections, primarily of feet	38% [67]	Unsightly, discomfort, may be disabling	[66]
Seborrheic dermatitis	6% [67]	Unsightly, itchy	[68]
Benign neoplasms	12.8% [67]	Unsightly	[67]
Pigment disorders	4.4% [67]	Unsightly	[67]
Malignant tumors	2.1% [67]	Unsightly, anxiety	[67]

Table 89.3

Less common dermatological complaints of the aged with a high psychosocial burden

	Visible manifestations	Sensory manifestations	Natural history	Impact on QoL	Prognosis	Reference
Psoriasis	Typically, thick keratin salmon-colored plaques covered with silvery scales of dead skin	Severe itching, irritation	Chronic, relapsing	Self-image, discomfort, high cost in time and money to treat, social withdrawal	Idiosyncratic	[29]
Eczema	Erythema, can excoriate, crust, ooze	Itching, pain if scratching produces excoriation	Chronic	Unsightly, causes discomfort, causes self-image disturbances, social withdrawal	Tends to be chronic, some forms increase with old age	[69]
Atopic dermatitis	Cycle of itching and scratching results in erythema, exudation, excoriation, dryness, cracking, lichenification	Pain, itching	Chronic	Unsightly, causes discomfort	Improves throughout lifespan but can persists into old age	[26]
Leg ulcers	Ulcerated open wound	Pain, itching	Chronic	Unsightly, requires bulky dressings, exudes embarrassing odor	Onset typically in old age, some resolve but many chronic	[44]
Rosacea	Reddened, inflamed cheeks with or without presence of papules or pustules	Irritation, burning	Chronic	Unsightly, negative effect on self-image, social withdrawal, occupational effects	Onset in early maturity, persists	[70]
Urticaria	Erythema, cutaneous swellings accompanied by pruritus	Pain, itching	Less than 48 h	Self- image, discomfort, activity limitation, social withdrawal		[71]
Contact dermatitis	Erythema, possible exudation, excoriation	Pain, itching	Related to exposure	Unsightly, causes discomfort	Possible at any life stage	[70]

patients felt it at least as bad to have psoriasis as diabetes [47]. In addition, patients with psoriasis were observed to have both physical and mental functions reduced to a level comparable to arthritis, cancer, depression, and heart disease [52]. The only group with higher risk of mental illness than psoriasis was those who experience major depression [52]. A large British survey found the disability impact of skin diseases to be equivalent to that of angina, asthma, bronchitis, arthritis, diabetes, hypertension, and back pain [34].

In a comparison of QoL between younger and older psoriasis patients, those younger than 54 had more difficulty with psychosocial issues, while those who are at the age of 55 and above had more disability and limitation on life activities. Older patients had more trouble in sleeping (22%), using hands (19%), walking (14%), and sitting (15%) or standing (15%) for long periods of time [24].

Studies Which Have Evaluated Psychosocial Burden of Skin Disease in Older People

Studies that specifically focused on the psychosocial effects of skin disease on older patients have been very limited.

One study observed that older people with rashes had significantly poorer quality of life than patients with lesions (including skin cancer), with the extent of disease inversely associated with the QoL [53]. Patients enrolled in the study had a variety of cutaneous diseases, including basal cell carcinoma (BCC), squamous cell carcinoma (SCC), malignant melanoma (MM), actinic keratoses, Bowen's disease, basal cell papillomas, granuloma annulare, eczema, xerosis, psoriasis, venous ulceration, lichenoid eruptions, extensive actinic damage, and urticarial reactions [53].

Older psoriasis patients have been observed to have relatively fewer issues with socialization than younger psoriasis patients [46]. Nevertheless, QoL in older patients suffers. A hospital-based, cross-sectional study evaluated the effect of age on QoL in psoriasis patients, using *Skindex 29*, the *Dermatology Life Quality Index (DLQI)*, the *Psoriasis Disability Index*, the *General Health Questionnaire*, and the *Psoriasis Life-Stress Inventory*. QoL was observed to be significantly worse in older patients and the psychological distress was higher. Older women suffering from anxiety or depression had greatest impairment of quality of life [54]. In another study on psoriasis in ambulatory psoriasis patients, psychological distress was higher in the aged [55]. Psychological stress in the elderly patient is largely the result of pruritis and functional limitation [24].

Quality of life was also evaluated in vitiligo patients using the *Skindex-29* index. QoL impairment was very pronounced, with 39% of all patients probably with depression. QoL effects were equally pronounced in aged patients as in younger ones [56].

Pemphigus, an autoimmune blistering disease, related to QoL was also evaluated in older patients. Pemphigus was observed to induce a markedly impaired QoL, with decreases in positive emotions and functioning. Depression and/or anxiety was observed in 39.7% of patients. Older patients were more significantly affected than younger patients [57].

Therapeutic Options

First of all the dermatologists must consciously monitor their elderly patients for indications of psychiatric pathology related to dermatological disease, which was often missed in the past [11]. It was observed that dermatologists consistently underestimated the level of psychological suffering related to dermatological disorders, often assuming the severity of psychosocial suffering to be determined by the clinical severity of disease [11]. Once the emotional ramifications of skin disease are recognized, there should be a plan of intervention [58].

Physicians must work to optimize doctor–patient relationship [23]. This is critical for the patient with skin disease to overcome overwhelming feelings of alienation and isolation. The physician must acknowledge the feelings of their patients with skin issues, remove embarrassment as much as possible, and provide complete and appropriate information [4], because a well-educated patient feels more in control and appropriately emotionally distanced from the disorder [23, 59].

The health-care provider must also be cognizant of the deep need for touch in these patients [4] and encourage the use of sunscreening agents, retinoids, alpha-hydroxy acids, adequate moisturizers, and emollients to improve the appearance and texture of skin [4]. For example, appropriate use of commercial cosmetics and dermatological concealers is to be encouraged; use of the dermatological covering makeup (Unifiance® [La Roche-Posay]) to conceal discolorations, lesions, rosacea, vitiligo, and acne, improved the mean DLQI score from 9.2 to 5.5. Maximizing physical attractiveness is to be encouraged in order to reduce stereotypical responses to elderly [4]. Tumors and other blemishes should be destroyed or removed, as well as wrinkles, scars, and pigmentation

issues in order to optimize appearance [6]. More involved procedures should be pursued as appropriate, keeping in mind the very real psychological and physical benefits of improved appearance [4, 6]. Aesthetic procedures often are viewed as vain or frivolous: the patient may need to be convinced of the very real medical benefits to be gained from optimizing appearance [6]. The physician should encourage participation in support groups [23], which increases confidence, decreases the sense of isolation, provides a relief from embarrassment, and provides a safe haven to share the emotional burden of the disease [58]. Significant improvements in healing rates have been observed in support group for leg ulcers [44]. Education of patients earlier in life will help put them on paths to a healthy and successful old age [4].

Beyond patient care, there is a need for social change. Physicians wherever possible should act to change societal dehumanization of elderly [4]. In addition, third-party insurers currently do not typically recognize the psychosocial ramifications of skin disease in the elderly. Because relatively inexpensive procedures could potentially avert much more serious psychological illness [4], the fact that these procedures are often disallowed by insurers responsible [5] is a false economy [4]. Patients who feel attractive and comfortable in their skin and socially at ease will seek more interaction and are more active; this will boost to overall health [60], which is ultimately the goal of every patient-provider encounter.

Conclusion

Patients with skin disease, including elderly patients, have a substantial burden of psychosocial suffering. The high visibility of skin diseases, particularly when superimposed on the already compromised aged skin, induces both unconscious and intentional stigmatization of the patient. The awareness of one's compromised appearance makes interpersonal relationships uncomfortable and promotes social withdrawal. Having a rough, itchy, aged skin is associated with a significant level of both physical and psychological discomfort.

Dermatologists and patients differ in their assessment of the psychosocial impact of dermatological conditions: dermatologists consistently underestimate the degree of psychological distress that their patients suffer, a misconception that may impede the recognition of psychiatric disorders in their patients [61]. Dermatologists tend to estimate the psychological burden by the severity of the physical disease, while in fact, it is not uncommon (particularly with psoriasis) for a patient with less severe disease to have impairment in psychosocial function equivalent to that in a patient with much more severe physical symptoms [62]. The psychosocial effect of skin disease on patients' lives, in fact, has been shown to be comparable with the impact of several diseases considered much more serious [42]. The effect of skin disease on psychosocial functioning, therefore, is underappreciated [42].

Patient health should be measured not only by physical symptoms, but also by the likely psychological and social sequelae. Patients should be asked how they are coping and how much burden their disease is posing on them [63]. Health policy should be aimed not only at the management of symptoms of skin disease but also at QoL issues [34]. The high rate of clinical depression and suicidal ideation among patients with disfiguring and disabling dermatological diseases highlight the importance of evaluating the presence of psychosocial morbidity associated with these disorders [40]. No one dies of old skin [5]; skin diseases in the elderly will not generally end life or even shorten it, but can certainly greatly reduce quality of life in the last years [5]. Physicians who seek to treat both the biological and the social skins will improve their patients' lives as well as earn their gratitude [42].

Cross-references

- Aging Skin: Some Psychosomatic Aspects
- Assessing Quality of Life in Older Adult Patients with Skin Disorders

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