

Psychodermatology across the lifespan: Case-based insights into cognitive decline, somatic preoccupations, and factitious dermatitis

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Abstract

Background: Psychodermatology examines the complex bidirectional relationship between the skin and the mind. This interaction becomes particularly significant in vulnerable populations such as older adults with cognitive decline and younger individuals with psychosocial or developmental vulnerabilities.

Aim: To illustrate the heterogeneity of psychodermatological presentations across the lifespan and highlight the role of cognition, insight, and psychosocial context in clinical manifestations.

Methods: We present a case-based analysis of three patients with distinct psychodermatological conditions: (1) delusional parasitosis associated with cognitive decline, (2) somatic preoccupation with mild neurocognitive impairment, and (3) factitious dermatitis in a young adult with intellectual disability. Clinical, neuropsychological, and contextual factors were analyzed comparatively.

Results: Older patients demonstrated dermatological symptoms linked to cognitive impairment and altered insight, including delusional infestation and psychosomatic skin complaints. In contrast, the younger patient exhibited self-inflicted lesions consistent with factitious disorder, driven by psychosocial stress and limited coping capacity. Insight varied across cases and was closely associated with cognitive status and psychosocial environment.

Conclusions: Psychodermatological conditions differ significantly across age groups but share a common biopsychosocial foundation. Early cognitive screening, careful psychiatric assessment, and interdisciplinary collaboration are essential for accurate diagnosis and effective management. **TCM-GMJ June 2026; 12 (2): P51-P54)**

Keywords: Psychodermatology; Delusional Parasitosis; Mild Neurocognitive Disorder; Dermatitis Artefacta; Somatic Symptoms; Cognitive Decline; Lifespan Psychiatry

Introduction

The human skin, the largest organ of the body, is not only a protective barrier but also a highly visible interface between the individual and the social world. Its condition can profoundly affect self-image, interpersonal relationships, and psychological well-being. With aging, structural and functional changes in the skin—including thinning of the epidermis, reduction of dermal collagen and elastin, impaired barrier function, and immune dysregulation—render older adults more vulnerable to dermatological diseases (Jafferany et al., 2012). These physical changes coincide with psychosocial vulnerabilities such as social isolation, bereavement, reduced occupational engagement, and cognitive decline, which amplify the impact of dermatological conditions on

mental health.

Psychodermatology, a discipline situated at the crossroads of dermatology, psychiatry, and psychology, provides a framework for understanding these complex interactions. Disorders in this field are commonly grouped into three categories: (1) primary psychiatric conditions with cutaneous manifestations, such as delusional parasitosis or trichotillomania; (2) dermatologic diseases influenced or exacerbated by psychological factors, such as atopic dermatitis and psoriasis; and (3) psychiatric sequelae of dermatological disease, where conditions like vitiligo or acne may trigger depression, anxiety, or social withdrawal (Yadav et al., 2013).

In older populations, psychodermatological disorders assume particular importance. Approximately 30–60% of dermatology patients are estimated to have a psychiatric or psychological component contributing to their presentation (Jafferany & Franca, 2016). Delusional parasitosis, for instance, has an estimated prevalence of 80 cases per million, with peak onset in individuals aged 50–70 years (Trabert, 1995). Up to 60% of these patients have underlying medical or psychiatric comorbidities, including de-

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mentia, depression, or substance use disorders (Freudenmann & Lepping, 2009).

Somatic preoccupations also frequently accompany mild cognitive impairment. Population studies suggest that 10–15% of older adults with cognitive decline exhibit psychotic or somatic misinterpretations before dementia is formally diagnosed (Fischer et al., 2012). Such early symptoms may be misattributed to dermatological or medical causes, delaying recognition of neurocognitive decline.

At the other end of the spectrum, psychodermatological phenomena are also observed in young adults. Factitious dermatoses, including dermatitis artefacta, are relatively rare but clinically significant, accounting for 0.2–4% of dermatological consultations (Rodríguez Pichardo & García Bravo, 2013). The condition often begins in adolescence or early adulthood and is associated with psychosocial stressors, personality vulnerability, or intellectual disability. Importantly, over half of patients may deny self-infliction of lesions, leading to repeated, often unnecessary medical investigations (Gupta et al., 2016).

Given the demographic shift toward aging societies and the persistence of psychodermatological conditions across the lifespan, clinicians increasingly require an integrated, multidisciplinary approach. Dermatologists, psychiatrists, neurologists, and primary care providers must collaborate to identify early cognitive decline, explore psychosocial contributors, and manage skin conditions in a manner that respects both biological and psychological dimensions of health. Recent literature further underscores the growing clinical and conceptual relevance of psychodermatology, highlighting its evolution into a structured interdisciplinary field bridging dermatology and mental health (Langan & Millington, 2022; Latheef & Hafi, 2023). In parallel, accumulating evidence emphasizes the substantial psychiatric burden associated with chronic skin diseases, reinforcing the importance of integrated care models (Silverberg et al., 2023). Moreover, geriatric-focused research draws attention to the specific vulnerabilities of community-dwelling older adults, where skin health intersects with functional status, cognition, and quality of life (Rossi et al., 2024). Together, these findings support a lifespan-oriented, biopsychosocial understanding of psychodermatological conditions.

This article presents three clinical cases that exemplify the heterogeneity of psychodermatological presentations: two aging women with early cognitive impairment and skin-related symptoms, and one young man with factitious dermatitis. By analyzing these cases comparatively, we aim to highlight the role of cognition, insight, and psychosocial context in shaping clinical presentation, and to emphasize the importance of holistic, patient-centered care.

Methods

Study design: This study employed a qualitative, case-based design to explore the clinical and psychopathological features of psychodermatological conditions across the lifespan. A comparative approach was used to analyze patterns of symptom formation, cognitive involvement, and psychosocial context in patients presenting with skin-related complaints of psychiatric origin.

Participants

Three patients were selected from routine clinical practice in a multidisciplinary setting involving psychiatry, dermatology, and neurology services in Tbilisi, Georgia.

Inclusion criteria were:

- presence of dermatological symptoms with suspected or confirmed psychological or psychiatric contribution
- availability of clinical, neuropsychological, and (where applicable) neuroimaging data
- sufficient clinical detail to allow case-based comparative analysis

The selected cases represent distinct age groups and diagnostic categories:

- an elderly patient with delusional parasitosis and cognitive decline
- an older adult with mild neurocognitive disorder and somatic preoccupation
- a young adult with factitious dermatitis and intellectual vulnerability

These cases were chosen to illustrate variability in presentation and underlying mechanisms across the lifespan.

Data collection: Data were collected retrospectively from clinical records and supplemented by direct clinical observation. The following sources of information were included:

- **Clinical psychiatric interviews**, focusing on symptom history, insight, affective state, and behavioral patterns
- **Dermatological examination findings**, including lesion morphology, distribution, and evolution over time
- **Neuropsychological assessments**, evaluating memory, executive functioning, attention, and cognitive decline
- **Neuroimaging data** (where available), including structural findings relevant to neurocognitive status
- **Collateral information** from family members or caregivers, particularly in cases involving cognitive impairment

Special attention was given to the relationship between subjective symptom interpretation and objective dermatological findings.

Data analysis: A qualitative comparative analysis was conducted across cases. Each case was examined along the following dimensions: cognitive status, level of insight, nature of dermatological manifestations, psychiatric features and psychosocial context

Cross-case comparison was used to identify common patterns and distinguishing features, with particular focus on the role of cognitive impairment in symptom misinterpretation, differences in mechanisms (delusional, psychosomatic, factitious) and the influence of social environment and interpersonal stressors

Ethical considerations: All cases were anonymized to ensure patient confidentiality. Clinical information was used in accordance with ethical standards for case-based research. Identifying details were removed or modified to prevent recognition. Informed consent was obtained from

patients or, where appropriate, from caregivers for the use of clinical data in academic publication.

Methodological limitations: As a case-based qualitative study, the findings are not intended to be generalizable but rather to provide in-depth clinical insight. The retrospective nature of data collection may limit completeness of information in some domains. However, the richness of multidisciplinary clinical data enhances the interpretative value of the analysis.

Results and discussion

Case 1. Delusional Parasitosis with Underlying Cognitive Decline

A 73-year-old retired botany teacher developed a fixed belief of skin infestation after a gardening incident. Despite negative dermatological evaluations, she remained convinced of parasitic movement beneath her skin and began using sewing needles to “extract” the organisms, causing multiple self-inflicted wounds. Neuropsychological testing showed mild cognitive impairment, and neuroimaging revealed cortical atrophy. With no prior psychiatric history, she demonstrated poor insight and significant functional decline.

Diagnosis: Delusional parasitosis (Ekbom’s syndrome) with mild neurocognitive disorder.

6A24 Delusional disorder (with somatic type / delusional parasitosis presentation)

6D70 Mild neurocognitive disorder (probable neurodegenerative etiology)

Case 2. Subtle Cognitive Decline and Somatic Preoccupation in a Retired Artist

A 69-year-old retired musician was referred due to her husband’s observations of forgetfulness, impaired decision-making, and name-recall difficulties. While she denied major memory issues, neuroimaging confirmed mild cortical atrophy. Psychologically, she expressed anxiety, depressive thoughts related to family separation, and recurrent hand scratching, attributed to presumed pimples or allergy. These excoriations were linked to stress and self-critical ideation. Despite these issues, she remained socially engaged through music and artistic pursuits.

Diagnosis: Mild neurocognitive disorder (early Alzheimer-type) with adjustment disorder and psychosomatic skin complaints. 6C20 Hypochondriasis (Illness anxiety disorder / hypochondriacal disorder), 6D70 Mild neurocognitive disorder

Case 3. Factitious Dermatitis in a Young Adult Man

A 28-year-old man, single, with secondary education and mild intellectual impairment, worked in church selling candles. He presented with recurrent skin lesions, reportedly appearing “mysteriously” overnight. Examination revealed linear excoriations and superficial ulcers, often in cross-like

shapes, located on accessible forearm areas with varying stages of healing. He denied self-infliction and showed limited insight. The onset coincided with interpersonal stress within the church community, triggering anxiety, humiliation, and dependency struggles.

Diagnosis: Dermatitis artefacta (factitious dermatitis). 6D50 Factitious disorder imposed on self (dermatitis artefacta subtype), 6A00.0 Mild intellectual developmental disorder

Comparative analyses (see box 1)

Together, these three cases trace the spectrum of psychodermatological presentations across the lifespan. In elderly patients, cognitive decline may predispose to delusional misinterpretations (Case 1) or somatic preoccupations (Case 2). These findings align with prior literature suggesting that neurodegenerative processes can alter insight, somatic perception, and coping strategies (Rossi et al., 2024). The interface between cognitive impairment and psychodermatology underscores the need for early cognitive screening in older adults presenting with new dermatological complaints.

In contrast, the younger patient (Case 3) exemplifies dermatitis artefacta, a factitious disorder where self-inflicted lesions serve as maladaptive expressions of psychological distress. As Rodríguez Pichardo and García Bravo (2013) describe, such cases often involve individuals with limited coping skills, intellectual disability, or interpersonal dependency, highlighting a distinct psychosocial mechanism compared to late-life presentations.

Taken together, these cases reveal:

- The role of cognition in shaping somatic misinterpretations and dermatological behaviors.
- The variation in insight across age groups and disorders.
- The importance of psychosocial context, from isolation in elderly women to interpersonal dependency in younger men.

The clinical imperative of interdisciplinary collaboration between psychiatry, dermatology, and primary care.

Conclusion

Psychodermatology offers a unique lens for understanding the intersection of skin and mind across the lifespan. While elderly patients often present with delusional or psychosomatic manifestations linked to cognitive decline, younger individuals may exhibit factitious disorders rooted in psychosocial conflict or intellectual disability. These cases demonstrate the need for integrated, patient-centered approaches to diagnosis and management, emphasizing both the biological and psychosocial dimensions of skin disease.

Comparative analyses (see box 1)

Feature	Case 1 – Teacher	Case 2 – Artist	Case 3 – Young Man
Age / Gender	73 / Female	69 / Female	28 / Male
Primary Complaint	Parasites in skin	Forgetfulness, eczema	Spontaneous lesions
Insight	Poor	Fair	Limited
Skin Findings	Self-inflicted excoriations	Stress-related scratching	Linear artefactual ulcers
Cognitive Status	Mild impairment	Mild impairment	Mild intellectual disability
Psychiatric Features	Delusional disorder	Anxiety, adjustment difficulties	Anxiety, dependency, denial
Social Context	Isolated, retired	Socially active, supportive spouse	Church community, conflict
Diagnosis	Delusional parasitosis + neurocognitive d/o	Mild neurocognitive d/o + psychosomatic skin complaints	Dermatitis artefacta

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