Gender Differences In Attitude To The Skin Disease-Atopic Dermatitis Among Adolescents:
The Role Of Cognitive Behavioral Therapy

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Abstract
This paper examines gender differences in attitude to the skin disease-atopic dermatitis among adolescents: The role of Cognitive- Behavioural Therapy. 83 adolescents aged between 13 and 15 and diagnosed with moderate (43) to grave (40) atopic dermatitis took part in the study. The groups were divided according to gender; group 1 was made up of 38 adolescent boys, and group 2 was made up of 45 adolescent girls. The control group included 80 adolescents (40 girls and 40 boys) matched for age. The psychodiagnostic complex used in the study were: Method for establishing the disease attitude type (DAT) and Male and Female Painting projective test. Data were analyzed using correlation and student’s t-test. The comparison of data yielded results that indicate gender-specific types of attitude to the disease among adolescents diagnosed with atopic dermatitis. A statistically significant difference between the groups was found in the anosognosic disease attitude type that is more typical of adolescent boys. This disease attitude type is characterized by active rejection of thoughts about the disease and its consequences which is explained by boy’s bravado, by their wish to demonstrate invulnerability and confidence, which is in effect an attempt to compensate for low self-appraisal.

Key words: Atopic dermatitis among Adolescents, Gender differences, attitude to Disease, CBT.

Introduction
The skin has many functions among which are protection, thermoregulation, water-salt exchange, excretion, blood pooling, as well as endocrine, metabolic, receptor, and immune functions. In addition to the above physiological skin functions, it also plays a psychological role – the skin is an expression and self-presentation organ. Skin diseases are therefore characterized by their external noticeability and concomitant skin itch. This characteristic
of skin diseases arises as a result of psychic problems which in turn adversely impact on the mental state of the patient, thus leading to a vicious circle. Atopic dermatitis is one of the most wide-spread skin diseases occurring in different age groups in both males and females in all countries. According to the WHO, the prevalence rate of atopic dermatitis is constantly rising and is 6% to 25% in different countries. It occurs significantly more frequently in women. Atopic dermatitis is more prevalent among the citizens of large cities than among rural population. Usually manifesting itself at an early age, atopic dermatitis soon acquires a chronic recurrent course. The discomfort related to severe itching leads to the disruption of sleep, every-day life and social activity which in turn requires the application of psychological intervention in order to change negative and unrealistic faulty emotional disturbances.

The adolescent stage of atopic dermatitis is diagnosed in children above 13 years of age. It affects the face and upper body parts and has a chronic recurrent course (Smirnova, 2006). Adolescence is usually characterized as a critical and transitional age. It is regarded as the most important and the most difficult period of life characterized by abrupt, rapid and critical events. Adolescence is perceived as the second birth, resulting in the emergence of a new “self” (Averin, 2003; Cle, 1997; Obukhova, 2003, & Polivanova, 1996).

Adolescence is accounted for by the presence of a major need to be “satisfied with one’s own appearance. (Mendelevich & Solovyeva, 2002). Accordingly, the adolescent thinks that other people are equally concerned with their appearance and behavior. This very belief was termed in Reana (2003) as "imaginary audience", and it is viewed as one of the main manifestations of egocentricity in adolescence. Adolescents persistently attempt to predict others’ reactions to themselves. However, these predictions depend on adolescents’ self-attitude. In their view, other people will treat them the same way they treat themselves. Due to these reasons, adolescents constantly construct the "imaginary audience" with themselves in the spotlight of attention.

The affect often experienced by adolescents is “shame” as a reaction to constant attention on the part of the "imaginary audience". He or she view acceptance by others as very important. The acceptance of one’s own body acquires a major interest. In the adolescent’s view, “being attractive” means having successful personal relationships. Thus, the body becomes a hostage of romantic relationships rather than a value in itself. Sexual maturation increases inner tension. Bodily appearance and feelings become even more important enhancing the possibility of intimate relationship with a partner. Therefore, when an adolescent evaluates his or her body and detects physical defect, a conclusion is drawn about his/her own social inferiority. A desire may also arise to compensate drawbacks in another field or to try and improve them. Discomfort or insults by people around regarding the peculiarity of appearance can cause violent affect and pervert the behavior of the adolescent thereby causing traumatic experiences.
The Role of Cognitive-Behavioral Therapy (CBT) In Changing Thought Pattern

As opined in Takyun, (2009), the major challenge for mental health community is to learn how best to help people who are suffering from all forms of traumatic experiences including emotional trauma. Foa et al (1995), developed Brief Cognitive-Behavioural Treatments which include various forms of relaxation therapy and education. Cognitive restructuring is applied in CBT which involves techniques for replacing catastrophic, self-defeating thought patterns with more adaptive, self-reassuring statements. What sustains an individual through the disease process is the therapeutic alliance. Therapeutic interventions attempts to restore not only an individuals somatic and social balance but also the sense of coherence. The use of Cognitive Behavioral Therapy (CBT) is aimed at changing negative and unrealistic faulty reasoning because thinking determines feelings, emotions and behaviors.

Attitude to disease

The reflection of a disease in a person’s emotion is commonly called the internal disease pattern (IDP). This term encompasses everything “a patient feels and experiences, all the multitude of his/her feelings, the general sense of well-being, self-observation, ideas about the disease and its causes – the patient’s entire huge world consisting of complex combinations of perceptions and feelings, emotions, affects, conflicts, psychic experiences and traumas”. (Yeresko, Isurina, & Koydanovskaya 1994; Amon, 2000). The term was first introduced by the physician- Luria (1977) and is now broadly used in medical psychology. As a complex structural unit, the internal disease pattern consists of several levels: sensitive, emotional, intellectual, volitional, and rational.

The IDP is determined not only by the nosology, but also by the patient’s personality, it is as individual and dynamic as our internal world. There are a number of studies describing how the patient experiences his/her condition (Nikolaeva, 1987).

Mendelevich, (2005) states that the type of reaction to a particular disease is determined by two characteristics: objective gravity of the disease (defined by the mortality rate and disability likelihood) and its subjective gravity (the patient’s assessment of his/her condition).

Subjective gravity depends on social and constitutional features including the individual’s sex, age, and profession. Each age group has a distinct disease gravity register – a classification of diseases by their socio-psychological significance and gravity (Karvasarsky, 2002; Mendelevich, 2005). Thus, the most serious psychological reaction in adolescence may be caused by diseases that change the adolescent’s appearance making him/her unattractive. It is accounted for by the presence of a major need to be “satisfied with their own appearance” in adolescents’ consciousness (Mendelevich, 2005).

The typology of disease reactions includes 13 types of psychological disease reactions distinguished based on three factors: the nature of somatic condition, the type of personality with the character accentuation type being of major importance, and disease attitude in the referent (significant) group (Lichko, & Ivanov, 1980):
1. **Harmonic type.** This reaction type is characterized by sober evaluation of one’s condition without the inclination to overstate one’s burden, but also without underestimating the disease gravity. The patient is willing to actively contribute to the treatment. He or she does not want to burden others with the need for care. In case of an unfavorable disability forecast the individual shifts to the domains of life that remain available. In case of an unfavorable prognosis, attention, care and interests are centered on close relatives’ life and the patient’s own business.

2. **Ergopathic type.** This reaction type is characterized by “withdrawal from “disease to work”. Excessively responsible, sometimes obsessive, volitional attitude to work is typical, which is sometimes more pronounced than attitude to the disease. Selective attitude to treatment caused by the desire to continue work in spite of the disease gravity. The desire to maintain professional status and to continue work in the current position by any means.

3. **Anosognosic type.** This type is characterized by active rejection of thoughts about the disease, its potential consequences, denial of obvious disease signs, attributing them to random events or other transient conditions. Refusal of medical examinations and treatment, desire to do with one’s own means.

4. **Anxious type.** This reaction type is characterized by constant nervousness and distrust to unfavorable disease outcome, possible complication treatment inefficiency. The search for new treatment methods, craving for additional information about the disease, possible complications and treatment methods.

5. **Hypochondriac type.** This type is characterized by an excessive focus on subjective disease-related and other negative feelings. An inclination to always share them with doctors, medical staff and people around. Exaggeration of the existing disease and the search for non-existent diseases and sufferings. Exaggeration of unpleasant sensations associated with side effects and diagnostic procedures. The combination of willingness to be treated and the disbelief in treatment success. Constant demand for thorough examination by superior specialists. Fear of the pain of procedures and possible harmful effects.

6. **Neurasthenic type.** This type is characterized by an “irritable weakness” behavior. Outbursts of irritation, especially when in pain or in case of painful sensations, treatment failures or unfavorable examination findings. Irritation often hits the nearest person and often ends in remorse and tears. Intolerance of pain sensations. Lack of general tolerance. Inability to wait for relief. Later, the feeling of
remorse for inconveniences and lack of restraint.

7. **Melancholic type.** This type is characterized by the feeling of depression because of the disease, disbelief in recovery, possible improvement, or treatment effect. Active depressive statements to suicidal thoughts. Pessimistic view of everything around, disbelief in the therapeutic success even in spite of positive evidence.

8. **Apathetic type.** This type is characterized by complete indifference to one's fate, disease outcome, and treatment results. Passive compliance with procedures and treatment when insistently induced from outside. Loss of interest to life and everything that arouse interest before. Inertness and apathy in behavior, activities and interpersonal relationships.

9. **Sensitive type.** This type is characterized by excessive concern with possible 'negative impression and information about the disease. Concerns that people around will start avoiding and considering inferior the person, treat with contempt or apprehension, spread gossip or unfavorable information about the causes and nature of the disease. Fear of becoming burdensome to relatives and resulting unfriendly relationships.

10. **Egocentric type.** This type is characterized by "withdrawal into disease", demonstration of the feeling of suffering to relatives and people around in order to capture their attention. The demand for exclusive care: everybody must forget and leave everything just to take care of the patient. Other people’s conversations are quickly turned to oneself. They require care and attention from others, they only see competitors and treat them in a hostile manner. Constant desire to show their particular condition and uniqueness of the disease.

11. **Paranoid type.** This type is characterized by the confidence that the disease is a result of somebody’s evil intention. Extreme suspiciousness towards drugs and procedures. Propensity to attribute possible complications and side effects of treatment to incompetence or evil intention of doctors and medical staff. Accusations and demand of punishment in this respect.

12. **Dysphoric type.** This attitude type is dominated by angry, dismal, and sullen mood and constantly gloomy and dissatisfied appearance. Envy and hatred towards the healthy, including friends and relatives. Fits of anger with an inclination to blame the disease on others. Demand for particular attention and suspiciousness against procedures and the therapy. Aggressive, sometimes despotic attitude to relatives, demand that everybody should please them.

13. **Obsessive-phobic type.** This type is characterized by fears that concern unreal, unlikely disease
complications, treatment failures, disease-related difficulties in life, work or family; objects (talismans) and rituals become protection from phobias.

Dubrovina, (2008) investigated disease attitude types in adolescents with neurodermatitis. The disease duration was between 10 and 17 years. The harmonic type of disease attitude was absent in this population, the euphoric type was observed in 40.7% of cases, sensitive type in 26.9%, anosognosic type also in 26.9%, and mixed psychological reaction was found in 51.9% of cases. Severe atopic dermatitis characterized by deteriorated of general condition, activity and mood, increased personal anxiety and intrapsychic behavioral patterns of mainly anxious type, in authors’ opinion, this demonstrate “withdrawal into disease” among adolescents with atopic dermatitis.

**Gender Differences in adolescents**

It is at early school age that children start interpreting contacts between girls and boys as romantic and sexual (Isaev & Kagan, 1979; Kagan, 1990, 1991). The emergence of sexuality in relationships between girls and boys is manifested under conditions of sexual segregation. Children of different genders have different attitudes to sex and related issues. Bendas, (2007) opined that, as a result of conversations with children of different sexes, it revealed gender differences in attitudes to sex. Girls talked willingly, used verbal constructions with multiple details, demonstrated serious reflection, whereas boys used short phrases, jargons, and sexual slangs. Girls draw information about sexual life from the family, while the source of sexual information for boys is their friends and the mass media. Girls were more interested in sexual relations between people; they are afraid of psychic pain from potential loss of a child and fear early pregnancy. Boys were more interested in the issues of contraception, abortions, sexual intercourse, and childbirth. Girls were more realistic concerning career and family, they were aware of the risks of alcohol consumption, drug abuse and violence, whereas boys demonstrated fearlessness and a humorous attitude to sex and violence.

When sexual maturation begins in adolescence, sexual segregation is ruined, and the same happens to gender confrontation. Boys and girls start building new relations (Ilyin 2002). Man’s role is traditionally instrumental and action-oriented, and the woman’s role is expressive and communicative. This is evidenced by experimental data showing that the masculine style is solution-oriented, whereas women have either expressive or mixed style. Mendelevich (2005) and Kocharyan (2010) point to women’s better tolerance of pain, long-lasting movement limitation or immobilization. In contrast to Bendas, (2007) with data on better pain tolerance in men and higher pain sensitivity in women. Studies dealing with individual diseases often contrast gender differences in the mental course of the disease. However, there is no comprehensive systematization or classification of gender differences in psychic reaction to a disease as of present. At the same time, there is a great amount of research dealing with gender differences and its analysis provides a solid foundation for studying and analyzing gender differences in disease reaction among adolescents.
diagnosed with atopic dermatitis (Golovneval, 2006; Kleitsina, 2004; Vorontsov, 2008). Thus, literature provides data on gender differences in visual system development registered in school age and adolescence. Males outperform females in spatial perception and chronometric indicators; females develop earlier visual acuity and visual estimation with the right eye. Attention studies also demonstrate gender differences. Thus, females outperform males in voluntary attention. Females focus more on the speed and males more on the precision of the task, Males are better at working with novel tasks and females with patterns; females also outdo males in communicative attention. Male’s general intelligence has a clear structure with predominant non-verbal component, whereas female’s intelligence is poorly integrated. 

Females are more emotional than males. It is evidenced by the following empirical facts: Females are more anxious; the link of emotions to interpersonal relations is more significant for girls and women than for boys and men; females more often talk about negative emotions, and positive emotions are experienced more vividly; females are more prone to depression; females are more sensitive to negative events experienced by their friends or relatives than male; females are not a shame of demonstrating their emotional reactions; females are more precise about the non-verbal expression of emotions; females are better at recognizing emotional signals from other people (Bendas, 2007; Heibrun, 1976; Ilyin, 2002).

Greater emotionality in females is evident by data about lower emotionality in males: males do not like to show their emotions, especially negative ones. They are emotionally reserved even with same-sex friends and are subject to strict social regulations with regard to emotionality demonstration. There are also male and female emotions. It is anger for males and sorrow and fear for females (Bendas, 2007). Males show an advantage in terms of the masculine aspect of self-evaluation, whereas females in terms of the feminine aspect. The shift of self-evaluation towards narcissism in female is associated with keenness on their appearance, and with physical conditions and social status in male. Females have less stable self-evaluation than males. These differences are influenced by the level of openness in relations, reaction to the feedback, stress caused by relations with relatives, and protective mechanisms (Ilyin, 2002). Boys and men outdo girls and women in open physical aggression, whereas girls and women are more prone to often resort to hidden verbal aggression (Bendas, 2007).

The aim of this article is therefore to assess gender differences in attitude to disease among adolescents diagnosed with the skin disease - Atopic Dermatitis and to explore the role of Cognitive Behavioral Therapy in changing thought pattern of individuals experiencing emotional disturbances.

**METHOD**

**Participant’s characteristics**

Participant’s characteristics include 83 adolescents aged between 13 and 15 and diagnosed with moderate (43) to grave (40) atopic dermatitis took part in the study. The groups were divided according to gender – group one (1) included 45 adolescent girls, and 38 adolescent boys.
were in group two (2). The control group included 80 adolescents (40 girls and 40 boys) matched for age. The participants did not have complaints about the psychological condition. However, the patients showed irritability, aggressiveness, tearfulness, low mood, sub-depressive conditions, increased anxiety, feeling of inferiority, disbelief in treatment success, suspiciousness, sleep disorders, asthenic conditions, unwillingness to meet with peers; on the contrary, they prefer to retreat into themselves or a close circle of people. These conditions did not reach a clinical level so adolescent patients were not examined by a psychiatrist.

**Instruments & Procedure**

The psychodiagnostic complex used include the following methods:

*Method for establishing the disease attitude type (DAT)* Male and Female Painting projective test.

*Method for establishing the disease attitude type (DAT)* (Wassermann L.I. et al (2003) was developed at the Laboratory of Clinical Psychology at V.M. Bekhterev Institute. The method distinguishes between 12 types of disease attitudes grouped into 3 blocks. There were two blocking criteria: “adaptivity-disadaptation” (influence of disease attitude on personality adaptation) and “intrapsychic orientation” of disadaptation (in case of disadaptive relationships). This technique took the form of a questionnaire consisting of 12 tables with sets of statements each containing from 10 to 16 statements. The patient is asked to select two most suitable statements. In addition to “Yes” and “No” answers, each table with statements also had the “Not applicable” option, which allows for more precise classification of disease attitudes.

*Male and Female Painting projective test by Romanova N.M. (2004).* The Male and Female Painting (MFP) studies personal gender attitudes. The author of the method defines gender attitudes as a certain gestalt, a figure against the background of a person’s individual gender concept. Gender attitudes point to the person’s main socio-sexual dominance.

The participant is supposed to paint male and female figures. The analysis of the painting (size of the figure, their mutual positioning, graphic features of same-sex and opposite-sex figures, completeness of the painting) help determine the nature of relationship between man and woman, single out gender attitudes reflecting the main aspects of gender identity.

The author of the method distinguishes between the following types of gender:

- **mindsets:** support, isolation, cooperation, independence, attraction, indifference;

- **attitudes:** super valuable object, blame object, romantic object, functional object, object of contempt, sexual object, dangerous object, incomprehensible object, low-value object.
Results

Table 1: Prevalence of subclinical psychopathological symptoms in adolescent patients with atopic dermatitis

<table>
<thead>
<tr>
<th>Subclinical Psychopathological Symptoms</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability</td>
<td>48.12</td>
</tr>
<tr>
<td>Aggressiveness</td>
<td>38.55</td>
</tr>
<tr>
<td>Tearfulness</td>
<td>40.96</td>
</tr>
<tr>
<td>Subdepressive conditions</td>
<td>36.14</td>
</tr>
<tr>
<td>Increased anxiety</td>
<td>69.88</td>
</tr>
<tr>
<td>Feeling of inferiority</td>
<td>54.22</td>
</tr>
<tr>
<td>Disbelief in treatment success</td>
<td>46.99</td>
</tr>
<tr>
<td>Suspiciousness</td>
<td>34.94</td>
</tr>
<tr>
<td>Sleep disorders</td>
<td>61.44</td>
</tr>
<tr>
<td>Asthenic conditions</td>
<td>57.83</td>
</tr>
<tr>
<td>Unwillingness to meet with peers</td>
<td>43.94</td>
</tr>
</tbody>
</table>

Table 2: Prevalence (abs. values and %) and reliability of variance (φ-criterion) of disease attitude types between groups

<table>
<thead>
<tr>
<th>Disease attitude types</th>
<th>Group 1 (n=45)</th>
<th>Group 2 (n=38)</th>
<th>φ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anosognosic</td>
<td>2 (4.4%)</td>
<td>10 (26.3%)</td>
<td>2.97**</td>
</tr>
<tr>
<td>Ergopathic</td>
<td>3 (6.7%)</td>
<td>8 (21.1%)</td>
<td>1.96**</td>
</tr>
<tr>
<td>Anxious</td>
<td>5 (11.1%)</td>
<td>3 (7.9%)</td>
<td>0.49</td>
</tr>
<tr>
<td>Sensitive</td>
<td>10 (22.2%)</td>
<td>2 (5.3%)</td>
<td>2.34**</td>
</tr>
<tr>
<td>Mixed</td>
<td>14 (31.2%)</td>
<td>14 (36.8%)</td>
<td>0.55</td>
</tr>
<tr>
<td>Diffuse</td>
<td>21 (44.4%)</td>
<td>1 (2.6%)</td>
<td>3.22**</td>
</tr>
</tbody>
</table>

Note: ** – p<0.01
Discussion of findings

Table 1 shows the prevalence of the conditions in the group of adolescent patients suffering from atopic dermatitis. The fact that more than 60% of adolescents with atopic dermatitis reported sleep disorders caused by itching and unpleasant thoughts is the basis for asthenic manifestations.

Table 2 shows comparison of data obtained in two samples yielded results that indicate gender-specific types of disease attitudes in adolescents diagnosed with atopic dermatitis.

A statistically significant difference between the groups was found in the anosognosic disease attitude type that is more typical of adolescent boys. This disease attitude type is characterized by active rejection of thoughts about the disease and its consequences.

Male adolescents have unreasonably uplifted spirits, are light-minded about the disease, they try to ignore the disease and tend to break the regime and not to abide by recommendations. Lack of this disease attitude type among females can be explained by boys’ bravado, by their wish to demonstrate their invulnerability and confidence, which is in effect an attempt to compensate for low self-appraisal.

Boys tend to maintain the existing gender stereotypes attributed to males, such as power and stamina, whereas they think that the recognition of problems, fears and anxiety is a sign of weakness.

It was noted by Bendas, (2007) that boys and men have to resort to a more powerful protection of their self-esteem than women, i.e. this disease attitude type works as a falsifier and amplifier of self-esteem. Besides, it should be noted that boys are more reserved than girls: the latter more readily share their experiences and trust adults. This gender difference may also mean that, when giving answers, boys are more inclined to stay reserved and to demonstrate their invulnerability. Girls, who are “allowed” to be weak, uncertain, and expressive, do not resort to this self-description of the disease because they do not have to employ such self-protection methods.

Boys also differ from girls in terms of the ergopathic disease attitude type, which is characterized by a “retreat into studies”, preoccupation with their activities, over-responsibility, and volitional attitude; despite the disease, boys try to maintain their status at school and remain active. This gender difference may be explained by the fact that boys have more pronounced motivation to be a success in the fields that suggest activity, encouragement or discouragement (Ilyin, 2002). Purposefulness and result-orientedness, which is characteristic of males, make boys determined and firm in their hard work and the desire to overcome obstacles posed by the disease. The achievement of goals is very important for males because it is in this way that they can prove their success and not fall in their own eyes. Many authors Averin (2003) emphasize that females prioritize interpersonal relations which is evidenced by greater significance of communication for women. Males are more task-oriented so the men’s style is described as analytical and manipulative.

The sensitive disease attitude type is typical of teenage girls. This type is characterized by interpsychic personal reactions, which explains girls' social maladaptation. Girls’ major concern in
relation to the disease is the unfavorable impression that the disease symptoms may produce on people around, and this makes girls overly vulnerable and shy. It leads to a restricted behavior and the narrowing of the range of interpersonal contacts. Mood fluctuations are influenced by interpersonal contacts that are more significant for girls than for boys. Girls are more oriented towards relationships that are disrupted as a result of the disease, whereas boys are more task-oriented. Boys and girls are motivated by different needs: the need for affiliation is more important for girls than the need for achievements, which is more important for males. In addition to the affiliative vector of females’ motivation accounting for the sensitive disease attitude, another factor is the females’ attitude to their appearance. Attractive appearance is one of the central life values; it is females that tend to be highly dissatisfied with their appearance (Rumsey, 2009). Attractive appearance is of great social value, it raises female’s self-appraisal and value for people around. The symptoms of atopic dermatitis negatively affect the appearance of a teenage girl, which is a reason for the sensitive disease attitude. Females are under a greater social and cultural influence related to the appearance, and the teenagers’ environment is a “merciless appearance judge”, which is evidenced by the phenomenon of lookism – discrimination by looks.

The diffuse disease attitude type is also characteristic of adolescent girls with atopic dermatitis. Non-differentiation indicates the vagueness of the disease pattern, which apparently seizes the whole personality leaving no zones free from conflict. It should be noted that an indispensable part of the undifferentiated disease attitude type in girls is its sensitized component (100%). Lower pronouncedness of the diffuse disease attitude in boys may be explained by lower vulnerability of males to this disease and greater vulnerability and involvement of females.

Irrespective of gender, the mixed disease attitude of intra- and inter-psychic type is the most common disease attitude type. Thus, ergopathic disease attitude type is more common among boys. It is characterized by absorption into an activity, ethnicity, and general activity. Sensitive and diffuse disease attitude types are more common among girls. Their major concern in relation to the disease is the unfavorable impression that the disease symptoms may produce on people around, and this makes girls overly vulnerable and shy. It leads to a restricted behavior and the narrowing of the range of interpersonal contacts. Mood fluctuations are influenced by interpersonal contacts that are more significant for girls than for boys. Girls are more oriented towards relationships that are disrupted as a result of the disease. The symptoms of atopic dermatitis negatively affect the appearance of a teenage girl, which is a reason for the sensitive disease attitude. People around are treated as condemning and discriminating based on appearance.

Diffuse disease attitude type is a combination of types into two blocks: 1) intrapsychic, including anxious, hypochondriac, neurotic, melancholic, and apathetic types; 2) interpsychic, including sensitive, dysphoric, and paranoid types. The diffuseness means that the disease pattern is unshaped, underarticulated and vague.
Male-specific disease attitude types among adolescents with atopic dermatitis are the types that do not considerably disrupt social adaptation (ergopathic, anosognosic). Female-specific disease attitude types among adolescents with atopic dermatitis are the types (sensitive, diffuse) that disrupt psychic adaptation, mainly of interpsychic orientation. The adaptivity-disadaptivity poles are set by gender mechanisms: in boys, it is “false self-evaluation” and task-orientedness (adaptation pole), while in girls it is motivation of affiliation and high significance of appearance for females (disadaptivity pole). Irrespective of gender, the most common disease attitude type is the mixed disease attitude of intra- and inter-psychic type. Harmonic disease attitude type was not diagnosed. The study has serious implication for youths in Africa most especially where families have been undermined, truncated and displaced due to multi-faceted and complex issues exposing them to all kinds of skin diseases. Youths who are most passionate about their look are often the most vulnerable: emotionally, physically and psychological. As stated earlier, the most serious psychological reaction in adolescence may be caused by diseases that change the adolescent’s appearance, making him or her feel unattractive thereby the need for Cognitive Behavioral treatment that changes the adolescents thought pattern from maladaptive to adaptive.

Conclusion & Suggestions
The quality of life in girls with atopic dermatitis is significantly decreased – the disease influences all spheres of their life and does not leave any “lucid windows”. The most significant component disrupted among the girls is the sphere of personal relationships. The decrease in the quality of males with atopic dermatitis is due to two factors: 1) disturbance of the general sense of well-being, which affects adolescents’ day-to-day activity and learning; 2) “disrupted leisure”, which is related to the limitation of personal relationships and the need to follow the therapeutic regimen.

Adolescents with atopic dermatitis have decreased self-esteem. Boys have higher self-esteem than girls. In the subjective world image of the girls with AD, “attractive appearance ensures success and is the basis for self-confidence”; girls with atopic dermatitis demonstrate the “phenomenon of scissors” – a large gap between the system of actual self-evaluation and demands (ideal images of the self), which creates inner tension and incongruence which inform the need for behavioral treatment.

Suggestions for further studies include the investigation of adolescent’s personal traits that account for the predisposition to certain disease attitude types and to determine how the adolescence crisis affects the shaping of the disease attitude type.

References


