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Trauma and Psychological Experience in Hidradenitis Suppurativa: A Qualitative Study of 10 Patients

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Hidradenitis suppurativa (HS), is a chronic and painful dermatological condition, has significant psychological repercussions that remain underexplored. This exploratory qualitative study, conducted with ten affected women, aims to understand the link between prior traumas and the experience of the disease. Ten semi-structured interviews per participant were conducted over a one-year period, allowing for thematic analysis following Braun and Clarke (2006). Three main themes emerged: early familial traumas, traumatic relational and sexual experiences, and positive events and emotional support. The narratives reveal a connection between bodily experience, psychological suffering, and the reactivation of traumatic memories during flare-ups. These findings highlight the importance of an integrated approach, combining psychological support and dermatological care, to better understand the psychosomatic dynamics of this condition.

Keywords: *Hidradenitis suppurativa – Skin disease – Psychosomatic approach – Traumatic experiences*

Introduction

Hidradenitis suppurativa (HS), is a chronic inflammatory dermatological condition that primarily affects intertriginous areas such as the axillae, groin, genital, gluteal, and inframammary regions. It is characterized by painful inflammatory nodules that may progress to abscesses, sinus tracts, and purulent, often malodorous, discharge. The etiology of the disease is multifactorial and involves a complex interaction of genetic, hormonal, immunological, environmental, and psychological factors.

Beyond its physical manifestations, a growing body of research has demonstrated that HS has a profound impact on patients' quality of life, mental health, and social and intimate relationships. Chronic pain, lesions affecting intimate areas of the body, unpleasant odors, scarring, and the relational difficulties frequently reported by patients are often associated with experiences of shame, stigmatization, and social isolation.

Within this context, psychodermatological research has increasingly emphasized the importance of exploring the psychological, emotional, and relational dimensions involved in the experience of chronic dermatological diseases. Recent studies have particularly highlighted the role of traumatic experiences and relational contexts in shaping the subjective experience of chronic skin disorders.

It is within this framework that the present exploratory qualitative study was conducted. Its aim was to explore the psychological experiences of women living with hidradenitis suppurativa, the traumatic or emotionally significant experiences

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present in their life histories, and the relational and subjective contexts within which inflammatory flare-ups appear to emerge or intensify.

Literature Review

HS: Psychological Experience, Interpersonal Relationships, and Quality of Life

Several studies have shown that hidradenitis suppurativa (HS) affects women more frequently and has a substantial impact on quality of life, psychological functioning, and social and intimate relationships (Krajewski et al. 2021, Revankar et al. 2021). Physical symptoms, often located in intimate areas of the body, may be accompanied by feelings of shame, embarrassment, stigma, and difficulties in interpersonal relationships (Krajewski et al. 2021). HS affects not only patients at an individual level but also has repercussions on marital, family, and social relationships. Limitations in daily activities, sexual difficulties, chronic pain, and the feelings of shame and isolation reported by patients can affect their interactions with others and their participation in social life (Revankar et al. 2021). These findings highlight the profoundly relational and intersubjective nature of the experience of living with HS.

Comparable observations have been reported in other chronic dermatological conditions, particularly psoriasis and atopic dermatitis, for which several studies have also identified significant impairments in self-esteem, relational difficulties, experiences of stigmatization, and reduced quality of life (Dalgard et al. 2015, Zhang et al. 2021). These findings suggest that psychological and intersubjective consequences constitute a central dimension of the experience of chronic skin diseases, beyond their physical manifestations alone.

Other studies have also documented a high prevalence of anxiety and depressive symptoms among individuals with HS, as well as significant impairments in psychological and emotional well-being (Phan et al. 2020). Qualitative research further describes psychological suffering characterized by feelings of loneliness, misunderstanding, rejection, and social isolation among patients living with HS (Esmann et al. 2019).

Psychodermatology and Psychological Issues in Hidradenitis Suppurativa

Research in psychodermatology conceptualizes chronic dermatological diseases as arising from a continuous interaction between inflammatory processes, psychological functioning, and the relational environment (Ghosh et al. 2013, Bewley 2017). This perspective is grounded in a biopsychosocial framework, which considers biological, psychological, and social dimensions as jointly contributing to the experience of illness. Several authors have highlighted the importance of emotional regulation difficulties, alexithymia, and mentalization processes in the experience of chronic somatic illnesses, particularly dermatological conditions (Giovannelli et al. 2016, Conversano & Di Giuseppe 2021).

Among chronic dermatological diseases, HS is distinguished by the severity of its psychological and psychosocial burden. Chronic pain, recurrent lesions, discharge,

unpleasant odors, and the frequent localization of symptoms in intimate areas of the body are associated with substantial impairments in quality of life, interpersonal relationships, and sexuality (Krajewski et al. 2021, Revankar et al. 2021, Alavi et al. 2018). Research has also demonstrated a high prevalence of anxiety and depressive symptoms among individuals with HS (Phan et al. 2020). Furthermore, several studies indicate that people living with HS are at increased risk of suicidality and suicide compared to the general population, reflecting the considerable psychological burden associated with this condition (Thorlacius et al. 2018, Patel et al. 2022).

Available studies also describe frequent experiences of stigma, shame, embarrassment, social isolation, and difficulties in intimate and sexual relationships (Krajewski et al. 2021, Revankar et al. 2021). However, although the psychological and psychosocial consequences of HS are now relatively well documented, research focusing on patients' psychological functioning remains limited. Most studies have concentrated on quality of life, psychological distress, sexuality, or symptoms of anxiety and depression, whereas relatively few have explored how individuals experience and psychologically process their illness, attribute meaning to their symptoms, or mobilize psychological resources in response to the challenges they face. Clinical psychology, psychodynamic, and psychosomatic perspectives remain underdeveloped within the field of HS research, leaving several questions unanswered regarding the psychological functioning associated with this condition.

Trauma and Dermatological Diseases

Within this context, several recent studies have examined the role of traumatic experiences in chronic dermatological conditions. Some findings suggest that patients with chronic dermatoses report a higher prevalence of traumatic experiences, dissociative manifestations, and significant difficulties in emotional regulation (Giovannelli et al. 2016).

With regard specifically to HS, some studies have reported a higher frequency of traumatic experiences among patients with the disease, while emphasizing the need for caution in interpreting these findings (Gielen et al. 2020). Several authors have also stressed that the experience of living with a chronic dermatological condition may itself be highly distressing, particularly when accompanied by persistent pain, unpleasant odors, sexual difficulties, social stigmatization, or a lasting sense of exposure to the gaze of others (Gupta et al. 2017, Szabó 2020).

Qualitative studies conducted with individuals living with HS describe significant psychological suffering characterized by feelings of loneliness, rejection, shame, and misunderstanding (Esmann et al., 2019). At the level of subjective experience, several patients report periods of relational tension, emotional insecurity, loss, or psychological vulnerability coinciding with the onset or worsening of cutaneous symptoms. These subjective associations do not establish a causal relationship between trauma and illness; rather, they highlight the importance of exploring the emotional and relational contexts in which inflammatory flare-ups emerge or recur.

Despite growing interest in the psychological dimensions of hidradenitis suppurativa, few qualitative studies have investigated how patients themselves

make sense of the onset and evolution of inflammatory flare-ups within the context of their relational and emotional histories.

Two main research questions guided the present study:

- In what specific or non-specific contexts did the first symptoms of hidradenitis suppurativa emerge?
- In what relational, emotional, or life-event contexts do inflammatory flare-ups appear to recur or intensify?

Method

Study Design

This study adopted an exploratory longitudinal qualitative design involving ten women diagnosed with hidradenitis suppurativa (HS). Each participant took part in ten semi-structured interviews conducted between 2023 and 2025, resulting in a total corpus of one hundred interviews.

The longitudinal design was chosen to explore the evolution of participants' psychological experiences, relational contexts, and perceptions of disease flare-ups over time. Repeated interviews provided access not only to significant life events and traumatic experiences but also to the ways participants progressively reflected upon, interpreted, and integrated these experiences into their understanding of the disease. This approach facilitated a deeper exploration of individual trajectories and enabled the identification of both stable and evolving patterns across the study period.

The authors declare that artificial intelligence was used solely to improve the clarity and quality of the English language and did not contribute to the generation of scientific content, data analysis, interpretation, or conclusions.

Participants and Inclusion Criteria

The sample consisted of ten adult women aged between 18 and 40 years with a confirmed diagnosis of HS and a reported history of physical, sexual, or psychological trauma. Participants presented varying levels of disease severity, ranging from mild to severe forms.

The decision to include only women was based on the higher prevalence of HS among females and aimed to ensure greater homogeneity within the sample.

Exclusion Criteria
Male sex.
Recruitment

Participants were recruited through a Facebook group associated with patient support organizations. A study announcement described the aims of the research, participation procedures, confidentiality measures, and informed consent requirements. Individuals

who expressed interest were contacted individually to verify eligibility and discuss participation.

Data Collection

Data were collected through semi-structured interviews conducted via videoconference. Each interview lasted approximately 45 to 60 minutes and was audio-recorded and transcribed verbatim. All transcripts were anonymized using participant codes (P1–P10).

The interview guide explored four main domains:

1. Personal history and disease trajectory;
2. Traumatic and emotionally significant experiences;
3. Perceived relationships between life events and HS flare-ups;
4. Psychological, emotional, relational, and social consequences of the disease.

Participants were also invited to discuss positive life events and sources of emotional support in order to explore potential protective or moderating factors.

Data Analysis

Thematic analysis was conducted following the framework developed by Braun and Clarke (2006). Analysis was performed on the complete corpus of one hundred interview transcripts.

The coding process was conducted manually. Each transcript was reviewed multiple times to allow for thorough familiarization with the collected material and to identify meaning units related to traumatic experiences, emotional experiences, interpersonal relationships, and the subjective experience of living with hidradenitis suppurativa.

Initial codes were progressively grouped into broader categories and subsequently refined into themes and subthemes through an iterative analytical process.

Given the longitudinal nature of the study, the analysis was conducted at two complementary levels. First, interviews were examined within each participant's individual trajectory in order to identify continuities, changes, and transformations in the meaning attributed to experiences over time. Second, a cross-sectional analysis was performed to identify recurring patterns, shared experiences, and points of divergence across participants.

The identified themes were regularly compared against the original transcripts to ensure consistency with the participants' narratives and with the final thematic structure. Particular attention was paid to preserving the complexity and uniqueness of individual experiences while also allowing for the identification of themes common to the corpus as a whole.

To ensure participant confidentiality, all data were anonymized. Each participant was assigned an alphanumeric identifier (P1, P2, P3, etc.), which was used throughout the analytical process and in the presentation of findings. Any

information that could potentially allow for the direct or indirect identification of participants was removed or modified.

In keeping with the clinical and interpretative nature of the study, the analysis aimed not only to identify recurrent themes but also to preserve the subjective meaning of participants' experiences and the singularity of their narratives.

The coding process was conducted manually. Each transcript was read repeatedly to ensure familiarity with the material and to identify meaningful units related to trauma, emotional experiences, interpersonal relationships, and the lived experience of HS. Initial codes were progressively grouped into broader categories and subsequently refined into themes and subthemes through an iterative analytical process.

Because of the longitudinal nature of the study, analysis was conducted at two complementary levels. First, interviews were examined within each participant's trajectory in order to identify changes, continuities, and evolving meanings over time. Second, data were analyzed across participants to identify recurring patterns, shared experiences, and points of divergence.

Themes were repeatedly reviewed against the original transcripts to ensure coherence between participants' narratives and the final thematic structure. Particular attention was paid to preserving the complexity of individual experiences while identifying common themes across the sample.

Given the clinical and qualitative orientation of the study, reflexivity was maintained throughout the research process. As a clinical psychologist, the researcher continuously reflected on her theoretical assumptions, clinical sensitivity to trauma-related material, and potential influence on interpretation. Regular returns to the original data were used to minimize overinterpretation and maintain close adherence to participants' accounts.

The use of repeated interviews constituted a central methodological choice of this study. Rather than relying on a single retrospective account, the longitudinal design enabled the exploration of how participants' narratives evolved over time and allowed the researcher to capture the dynamic relationship between traumatic experiences, emotional states, interpersonal contexts, and disease flare-ups. This approach provided a richer understanding of subjective meaning-making processes than would have been possible through a single interview.

Ethical Considerations

The study was conducted in accordance with the principles of the Declaration of Helsinki. Written informed consent was obtained from all participants prior to participation, and all collected data were anonymized.

Given that the interviews involved the discussion of potentially traumatic experiences, particular attention was paid to participants' emotional well-being throughout the study. Participants were informed of their right to temporarily pause or terminate the interview at any time without having to provide a reason.

Whenever emotional distress emerged during an interview, time was provided to facilitate emotional soothing and affect regulation before continuing the discussion. Information regarding psychological support resources and services was also made available whenever deemed necessary.

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Table 1. *Interview Guide: Main Themes and Open-ended Questions*

Main theme	Open-ended questions
1. Personal background and HS trajectory	1. Can you tell me how the disease first appeared in your life? 2. How would you describe the evolution of your symptoms over time? 3. Which moments have been particularly significant in your experience with HS? 4. What situations or events have influenced the intensity or frequency of your flare-ups? 5. Can you share positive or meaningful moments in your life, whether or not they are related to the disease? 6. How did you experience your first flare-ups and initial treatments?
2. Past traumatic experiences	1. Have you experienced difficult or painful events in your life? 2. How have these experiences influenced the way you perceive yourself and the world? 3. Are there particular moments or memories that you feel are connected to your current emotional experience? 4. How did you experience your body and your emotions during these events? 5. What forms of support or resources were available to you in dealing with these traumas?
3. Perceived link between trauma and HS flare-ups	1. In your view, are there moments or situations that tend to trigger your flare-ups? 2. How do you experience the connection between your past experiences and the disease exacerbations? 3. Can you describe what you feel before, during, and after a flare-up? 4. Are there any warning signs that, in your opinion, announce an upcoming flare-up?

	5. How do these flare-ups affect your emotions or your relationships with others?
4. Psychological and emotional impact of HS	1. What emotions do you most often experience in relation to your disease? 2. How has the disease influenced your relationship with your body? 3. How do you experience periods when your symptoms subside? 4. How do you cope with difficult moments related to the disease? 5. In what ways does the disease influence your relationships with others (family, friends, partner, work)?

Table 2. *Table 2. Life Trajectories of Participants: Significant Events and Symptomatic Manifestations*

Participant	Nature of Event	Category	Event	Age	Symptom Present
P1	Negative	Family	Announcement of sister's death before her birth	7 years	No
P1	Negative	Assault	Sexual assault and humiliation	18 years	No
P1	Negative	Social	Loss of best friend / accomplice in the assault	18 years	No
P1	Negative	Professional	Toxic supervisor	20 years	No
P1	Negative	Family	Rejection / humiliation by her sister	33 years	Yes
P1	Positive	Professional	New professional training	33 years	Yes
P2	Negative	Assault	Sexual touching	6 years	No
P2	Negative	Relational	Forced marriage	26 years	No
P2	Negative	Relational	Separation from her children	28 years	No
P2	Negative	Relational	Divorce	29 years	No
P2	Negative	Relational	Toxic relationship with an alcoholic partner	29 years	No
P2	Negative	Family	Conflict with her mother	31 years	Yes
P2	Positive	Relational	Marriage	30 years	Yes
P3	Negative	Family	Physical and psychological abuse by her mother	Childhood	No
P3	Negative	Relational	Forced sexual relations within the couple	21 years	No

P3	Positive	Academic	Degree attainment	22 years	Yes
P3	Negative	Relational	Toxic relationship	37 years	Yes
P3	Negative	Family	Separation from her family	35 years	Yes
P4	Negative	Family	Loss of adoptive brother	7 years	No
P4	Negative	Relational	Relationship breakup	25 years	No
P4	Positive	Travel	Significant travel experience	27 years	No
P5	Negative	Family	Death of grandmother	14 years	No
P5	Negative	Family	Conflicts with her mother	15 years	Yes
P5	Negative	Family	Death of cousin	15 years	Yes
P5	Negative	Family	Relocation and change of city	16 years	Yes
P5	Negative	Health	Period of obesity	Adolescence	Yes
P5	Negative	Relational	Difficulty refusing sexual relations	16 years	Yes
P5	Positive	Professional	Professional promotion	33 years	Yes
P6	Negative	Assault	Sexual touching by a stranger	7 years	No
P6	Negative	Family	Death of a close relative	13 years	No
P6	Positive	Family	Birth of her son	13 years	No
P6	Negative	Relational	First sexual experience perceived as negative	Adolescence	No
P6	Negative	Relational	Forced sexual relations with current husband	30 years	Yes
P6	Negative	Family	Conflicts with her mother	30 years	Yes
P7	Negative	Family	Conflictual relationships with parents	Childhood–adolescence	No
P7	Negative	Family	Raised by grandparents	Childhood–adolescence	No
P7	Negative	Family	Conflicts with older brother	Adolescence	No
P7	Negative	Assault	Sexual touching by brother of first boyfriend	17 years	No
P7	Positive	Medical	Surgeon who saved her life	26 years	Yes
P8	Negative	Family	Father in a coma	17 years	Yes
P8	Negative	Academic	Regret over discontinuing schooling	17 years	Yes

P8	Negative	Relational	Attempted non-consensual sexual relationship (first boyfriend)	17 years	Yes
P8	Positive	Travel	Cultural travel experience	32 years	Yes
P9	Negative	Family	Physical and psychological abuse	Childhood–adolescence	No
P9	Negative	Relational	Toxic relationship and forced sexual relations with an alcoholic partner	20 years	No
P9	Negative	Family	Repeated ruptures with parents	Adulthood	Yes
P10	Negative	Health	Difficulty conceiving a child	24 years	No
P10	Negative	Professional	Employment instability	24–34 years	Yes
P10	Negative	Professional/Relational	Contact with abused children and difficulties in relationship with parents (aggressiveness)	34 years	Yes
P10	Negative	Relational	Repeated separations from partner due to difficulty conceiving	Adulthood	

Results

In line with the objective stated in the Introduction, the thematic analysis of the narratives collected from the ten participants identified three main thematic axes:

1. early trauma and the family environment;
2. the relational, sexual, and emotional dimension of trauma;
3. positive events and emotional support as modulating factors.

Early Trauma and Family Environment

The majority of participants (7 out of 10, 70%) reported negative experiences within the family environment during childhood or adolescence, including physical or psychological violence, repeated conflicts, and significant losses. These experiences were often associated with a persistent sense of emotional insecurity.

Violence and Familial Control

Three participants (30%) described a family climate marked by violence or excessive control:

> P3: "As a child, I faced words and attitudes from my mother that constantly belittled me… always imbued with control and humiliation."
> P5: "I had many conflicts with my mother, and these relational difficulties persisted throughout my life."
> P9: "I experienced physical and psychological violence during my childhood and adolescence."

Parental Conflict and Rejection

Three other participants (30%) reported an atmosphere of rejection or persistent tension:

> P1: "At the age of 33, I felt deep rejection and humiliation from my mother, which coincided with a flare-up of my disease."
> P2: "At 31, I was still experiencing conflicts with my mother, and the family climate remained very difficult."
> P7: "During my childhood and adolescence, my relationships with my parents and my older brother were constantly conflictual."

Bereavement and Significant Losses

All participants (100%) experienced at least one real or symbolic loss (death, separation, or family rupture). These events often appeared to be temporally linked to the onset or intensification of symptoms. Examples include the loss of a loved one (P4, P5, P6), rupture with the family (P3, P9), or repeated separations (P2, P10).

Theme 1 Summary

Type of Experience	Number of Participants	Percentage
Physical/psychological violence	3	30%
Parental conflict or rejection	3	30%
Bereavement or significant loss	10	100%
Persistent trauma in adulthood	3	30%

Relational, Sexual, and Emotional Dimensions of Trauma

This second axis encompasses traumatic experiences occurring in the relational or intimate sphere. These experiences profoundly affect participants' relationship to their bodies, sexuality, and relational trust.

Early Sexual Contact or Assault

Three participants (30%) reported experiences of sexual touching during childhood or adolescence (P2, P6, P7). These early events appear to represent ruptures in the perception of bodily boundaries and personal integrity.

Traumatic Romantic or Conjugal Relationships

Four participants (40%) described toxic relationships or non-consensual sexual experiences in adulthood (P2, P3, P5, P9). These situations were often accompanied by feelings of helplessness and shame, with a direct impact on dermatological symptoms:

> P3: "In my relationship, I accepted things for a long time that I did not want… every argument ended with a new flare-up."

Sexual Violation in Adolescence

One participant (10%) reported an attempted non-consensual sexual encounter at the age of 17 (P8), experienced as a major triggering event in her bodily history.

Theme 2. Summary

Type of Traumatic Experience	**Number of Participants**	**Percentage**
Sexual touching/assault (childhood–adolescence)	3	30%
Toxic relationships or non-consensual sex (adulthood)	4	40%
Attempted or completed sexual violation (adolescence)	1	10%

Positive Events and Emotional Support as Modulating Factors

Despite traumatic experiences, six participants (60%) identified positive events that contributed to emotional stabilization or improved management of the disease.

Personal and Professional Achievements

Two participants (20%) mentioned academic or professional successes as sources of validation and renewed self-esteem (P1, P3).

Restorative Support

One participant (P7) described encountering a compassionate healthcare professional, experienced as a reparative relationship in the context of bodily suffering.

Experiences of Freedom and Reconnection

Two participants (20%) reported meaningful travel experiences that fostered a sense of freedom and reconnection with themselves (P4, P8).

Supportive Romantic Relationships

One participant (10%) emphasized the importance of a balanced romantic relationship in emotional regulation and stress reduction (P2).

Theme 3. Summary

Type of Positive Experience	Number of Participants	Percentage
Personal achievements	2	20%
External restorative support	1	10%
Moments of freedom/reconnection	2	20%
Balanced romantic relationships	1	10%

Discussion

Trauma and the Context of Disease Onset

The primary aim of this study was to explore the psychological experience of ten women living with hidradenitis suppurativa (HS) and to examine the subjective links they establish between previous traumatic experiences and the onset or intensification of inflammatory flare-ups. Through a qualitative approach, this research sought to gain a deeper understanding of how participants make sense of the interactions between their traumatic histories and their illness within the unique context of their psychological and relational trajectories.

For the majority of participants, the first manifestations of hidradenitis suppurativa emerged during periods marked by loss, family conflict, physical or psychological violence, or sexual assault. These events frequently occurred within

painful or emotionally unstable relational contexts and occupied an important place in participants' narratives concerning the onset of their disease.

This observation is consistent with findings from psychodermatology showing that particularly stressful life events are frequently present in the histories of patients with chronic inflammatory dermatological conditions (Ghosh et al. 2013, Yu et al. 2020).

Analysis of the narratives revealed three major thematic areas: early experiences within the family environment, significant relational and sexual experiences, and the role of positive experiences and emotional support. Together, these themes provide a framework for understanding how certain life experiences become integrated into the subjective experience of illness.

Early Trauma and Psychosomatic Vulnerability

Seven participants reported difficult early experiences within their family environments, including physical or psychological violence, chronic conflict, experiences of rejection, as well as losses or separations occurring during childhood. Across these narratives, what emerges is not merely exposure to painful relational experiences, but also the presence of vulnerabilities in emotional containment and psychological elaboration processes. More than any particular form of parental violence, these accounts appear to reflect situations in which certain emotional experiences could not be sufficiently represented, thought about, or psychically integrated.

These observations are consistent with research that has explored the role of adverse relational experiences in chronic dermatological diseases. Several studies have shown that individuals with chronic dermatoses more frequently report histories of traumatic experiences, dissociative manifestations, and significant difficulties in emotional regulation (Giovannelli et al. 2016). More specifically, patients with hidradenitis suppurativa reported a greater number of traumatic life events than healthy controls, with emotional trauma occurring during childhood being particularly common (Gielen et al. 2020). The authors nevertheless emphasize that such findings primarily invite clinicians and researchers to consider patients' psychosocial histories when seeking to understand their lived experiences and healthcare trajectories.

The findings of the present study are consistent with this perspective. Many participants described experiences of loss, violence, rejection, or relational insecurity that they considered significant both in their personal histories and in the ways they understood the course of their illness. These narratives highlight the place such experiences occupy in the construction of meaning surrounding the disease, without presupposing the mechanisms that may be involved.

These findings may be approached from different theoretical perspectives. While contemporary research highlights the importance of psychosocial factors in the experience of chronic inflammatory diseases, psychosomatic approaches have focused more specifically on the ways in which emotional experiences may be elaborated, transformed, or, conversely, remain difficult to represent within psychic functioning.

From a psychosomatic perspective, Dejours (1993, 2009) argues that somatic disorganization may occur when psychic activity becomes overwhelmed by excitations that cannot be mentally elaborated. In such situations, the body may become the site of

expression for experiences that fail to achieve sufficient psychic representation, without reducing somatic manifestations to the experiences reported by participants. This perspective offers a framework for understanding the psychosomatic vulnerability observed among participants while respecting the heterogeneity of their experiences.

Similarly, Fain (1992) notes that adults who later develop psychosomatic disorders frequently recall childhood experiences perceived as traumatic, even when the content of these experiences remains difficult to specify or verbalize. The focus is therefore less on identifying a specific traumatic event than on highlighting a more general vulnerability linked to early failures within the relational environment.

This interpretation appears consistent with the diversity of situations reported in the present study, where experiences of violence, rejection, conflict, or loss seem less related to isolated events than to relational contexts enduringly marked by emotional insecurity.

Szwec (2012) further emphasizes that psychosomatic manifestations may arise in contexts characterized by early depressive states or failures of the primary environment, whether these take the form of overt aggression or a lack of emotional availability and protection. Such experiences contribute to the development of a vulnerable psychic organization that may increase sensitivity to later situations involving stress, loss, or relational rupture.

From this perspective, the experiences reported by the participants may be understood as elements of their affective and relational histories that contribute to the development of a particular psychological vulnerability. The findings of this study therefore invite consideration of symptom emergence within the broader context of participants' subjective histories, in line with the psychosomatic and psychodermatological perspectives presented in the literature.

Absence of Reported Trauma and Defensive Processes

Three participants did not report any explicitly traumatic events. One participant described an inability to recall her childhood, which may suggest the presence of defensive mechanisms such as repression or dissociative processes. Another participant was raised by her grandparents due to her parents' professional obligations and did not report any overt experiences of violence; this situation may be better understood as a form of emotional deprivation rather than trauma in the strict sense. The third participant described chronic stress and emotional difficulties without linking them to any clearly identifiable event.

These narratives highlight the complexity of identifying traumatic experiences. They also underscore the importance of considering defensive processes, as well as individuals' capacities for mentalization (Marty 1990) and for representing and processing emotional experiences, when seeking to understand psychosomatic trajectories.

Loss, Separation, and the Continuity of Vulnerability

Across all narratives, experiences of loss or early bereavement were present, regardless of whether participants identified an explicit trauma. In both the psychosomatic and dermatological literature, significant life events are frequently associated with losses such as the death of a loved one, separation, job loss, or relocation (Pomey-Rey 1992). Such situations may reactivate earlier experiences of separation or abandonment that are sometimes only partially accessible to memory. Consoli (2003) also emphasizes the destabilizing effects of loss and disruptions in emotional bonds on psychological functioning.

In the present study, the losses described were often concrete and emotionally significant, particularly the death of a close relative. For example, one participant lost her sister at a very young age and, although she retained no conscious memory of the event, she described its lasting impact on family dynamics. The theme of loss thus emerged repeatedly through fears of losing important attachment figures or of being deprived of essential relational anchors.

Relational and Sexual Trauma and the Relationship to the Body

Eight participants reported experiences such as unwanted sexual touching, sexual assault, or coerced physical and sexual relationships occurring during childhood, adolescence, or adulthood. These experiences appeared to have profoundly shaped their relationship to both their bodies and to others. Several participants described difficulties with physical contact, associating touch with fear, disgust, or intrusion. Others expressed a form of ambivalence, oscillating between a desire for closeness and the reactivation of painful memories.

This transformation in the relationship to the body may be understood as a form of libidinal disinvestment, whereby the body becomes more closely associated with pain, threat, or shame than with pleasure. The skin, as a boundary between self and other, thus appears as a particularly sensitive site upon which tensions linked to traumatic relational experiences may become inscribed.

The experiences of sexual violence reported by several participants may also be considered in light of Herman's (1992) work, which emphasizes the enduring effects of sexual trauma on the relationship to the body, the sense of safety, and interpersonal relationships. The difficulties related to physical contact, intimacy, and trust described by some participants are consistent with these observations and highlight the impact of such experiences on their bodily and relational lives.

Similarly, Van der Kolk (2014) underscores the central role of the body in traumatic experience, arguing that certain traces of trauma may persist through bodily sensations, physical experiences, and patterns of relating to others. The difficulties with physical contact, the ambivalence toward relational closeness, and the feelings of shame and vulnerability described by several participants appear consistent with these observations. While these findings do not allow for the establishment of a specific link between trauma and somatic manifestations, they provide additional insight into the bodily, emotional, and relational consequences of the traumatic experiences reported in this study.

Among the two participants who did not report a history of sexual trauma, one described significant distress related to infertility despite multiple attempts to conceive. This experience may be understood as another form of bodily and narcissistic injury, illustrating how bodily limitations and repeated disappointments can profoundly affect an individual's subjective experience of the body. More broadly, it highlights the extent to which the body may become invested with issues of identity, self-worth, and personal fulfillment, particularly when it is experienced as failing to meet deeply held desires or expectations.

Emotional Support and Resilience

Participants primarily focused on the painful aspects of their life histories, and few spontaneously referred to experiences of support, repair, or recovery. Nevertheless, some described personal achievements, professional accomplishments, or moments of self-reclamation, reflecting psychological resources and capacities for resilience.

One participant, in particular, emphasized the importance of a therapeutic or relational experience that was perceived as containing, supportive, and validating. Such accounts suggest that, even within a context marked by chronic pain and bodily shame, the presence of a benevolent and recognizing other may foster psychological relief, facilitate processes of emotional elaboration, and support a gradual reinvestment of the body.

More broadly, these findings highlight the potential protective role of supportive relationships in the subjective experience of illness. They suggest that experiences of recognition, emotional support, and interpersonal security may constitute important resources in coping with the psychological burden associated with hidradenitis suppurativa.

Theoretical Implications and Limitations

Overall, the findings of this study highlight the frequent presence of adverse early experiences, relational difficulties, and significant life events in the histories of women living with hidradenitis suppurativa, as well as the persistence of certain forms of emotional and bodily vulnerability over time. Experiences of loss, separation, relational insecurity, and bodily distress emerged as recurring themes in participants' narratives and appeared to form part of a broader subjective continuity throughout their life trajectories.

These findings may be considered in light of psychosomatic approaches that focus on the psychic elaboration of emotional experiences. From a psychosomatic perspective, hidradenitis suppurativa may be understood within contexts in which the elaboration of affective experiences appears limited and where the body occupies a central place in the management of emotional tensions (McDougall 1989, Dejours 2009, Dumet 2019). Such a perspective does not imply that the disease functions as a form of communication or represents the direct consequence of traumatic experiences. Rather, it invites attention to situations in which certain emotional experiences remain difficult to represent, elaborate, or integrate psychically.

This reflection is also consistent with Marty's (1990) work, which places greater emphasis on the ways in which life events are mentalized, elaborated, and integrated into psychic functioning than on the nature of the events themselves. From this perspective, the experiences of loss, violence, and relational insecurity reported by participants may be understood as elements contributing to the development of a particular psychological vulnerability, without reducing somatic manifestations to these experiences.

The findings also resonate with the work of Fain (1992) and Szwec (2012), who emphasized the importance of early failures within the relational environment in the development of certain psychosomatic vulnerabilities. Participants' narratives revealed recurring contexts characterized by affective insecurity, conflict, separation, and experiences of rejection, suggesting the importance of considering relational history when seeking to understand the subjective experience of illness.

Furthermore, the experiences of emotional support, recognition, and self-reclamation described by some participants highlight the importance of affective relationships in processes of psychological transformation. This dimension echoes Consoli's (2003) reflections on the structuring role of emotional bonds in maintaining psychological equilibrium and facilitating emotional elaboration.

The findings may also be discussed in light of contemporary research in health psychology and psychodermatology. These approaches emphasize the importance of emotional, relational, and psychosocial factors in the experience of chronic illness while highlighting the complexity of interactions between psychological experience, life circumstances, and bodily manifestations (Ghosh et al. 2013, Conversano & Di Giuseppe 2021). Recent studies have shown that individuals with chronic dermatological conditions more frequently report difficulties in emotional regulation, traumatic experiences, and relational vulnerabilities (Giovannelli et al. 2016, Gielen et al. 2020). The findings of the present study are consistent with this literature, highlighting the central role that certain affective experiences occupy in the ways participants understand and make sense of their illness.

Nevertheless, several limitations should be acknowledged. The sample was relatively small and consisted exclusively of women, limiting the generalizability of the findings to the broader population of individuals living with hidradenitis suppurativa. In addition, the data were based on subjective and retrospective accounts, which primarily reflect the meanings participants attribute to their experiences and should therefore be interpreted with caution. Finally, the qualitative design of this study does not allow conclusions to be drawn regarding the mechanisms involved in the onset or progression of the disease. Rather, its purpose was to deepen understanding of participants' subjective experiences and the meanings they attribute to their life histories and illness trajectories.

Perspectives for Future Research

Future studies could explore processes of symbolization, emotion regulation, and psychological repair through longitudinal and therapeutic approaches, to better understand how some patients transform bodily pain into psychically integrated

experiences. Additionally, findings suggest that clinical interventions addressing trauma, emotional regulation, and relational support may benefit individuals with HS.

Conclusion

In conclusion, this study highlights the prevalence of early relational and sexual adversity among women with HS, suggesting a potential psychosomatic continuity in which the skin reflects unprocessed psychic experiences. Despite chronicity and associated suffering, narratives of emotional support indicate that psychological transformation and reinvestment in the body remain possible. These findings underscore the importance of considering both trauma history and relational context in understanding HS, and they offer directions for future research and clinical practice in psychodermatology.

References

Alavi A, Farzanfar D, Lee RK, Alhusayen R (2018) Quality-of-life impairment in patients with hidradenitis suppurativa: a Canadian study. *American Journal of Clinical Dermatology* 19(1): 123–130.

Bewley A (2017) Psychodermatology: an overview. *British Journal of Dermatology* 176(3): 613–620.

Caccavale S, Tancredi V, Boccellino MP, Babino G, Fulgione E, Argenziano G (2023) Hidradenitis suppurativa burdens on mental health: a literature review of associated psychiatric disorders and their pathogenesis. *Life* 13(1): 189.

Consoli S (2003) *La tendresse*. Paris: Odile Jacob.

Conversano C, Di Giuseppe M (2021) Emotion regulation and quality of life in patients with chronic diseases. *Frontiers in Psychology* 12: 635708.

Dalgard FJ, Gieler U, Tomas-Aragones L, Lien L, Poot F, Jemec GBE, et al. (2015) The psychological burden of skin diseases: a cross-sectional multicenter study among dermatological out-patients in 13 European countries. *Journal of Investigative Dermatology* 135(4): 984–991.

Dejours C (1993) *Travail: usure mentale. De la psychopathologie à la psychodynamique du travail*. Paris: Bayard.

Dejours C (2009) Corps et psychanalyse. *L'Information Psychiatrique* 85(3): 227–234.

Dumet N (2014) *Somatisations et/ou symbolisations?* In: Brun A, Roussillon R (eds), Formes primaires de la symbolisation. Paris: Dunod, pp. 73–90.

Esmann S, Jemec GBE (2019) Psychosocial impact of hidradenitis suppurativa: a qualitative study. *Acta Dermato-Venereologica* 99(3): 328–332.

Fain M (1992) La vie opératoire et potentialité traumatique. *Revue Française de Psychosomatique* 2: 5–24.

Ghosh S, Alzghoul B, Mehregan DR (2013) Psychodermatology: interface of psychiatry and dermatology. *Dermatologic Clinics* 31(1): 23–32.

Gielen S, Janmohamed SR, Van Laethem A, Del Marmol V, Suppa M, Gutermuth J, Willemsen R (2020) Hidradenitis suppurativa is associated with childhood and lifetime traumatic events: a case-control study. *Journal of the European Academy of Dermatology and Venereology* 34(12): 2877–2883.

Giovannelli I, Plazzi G, Conversano C, et al. (2016) Trauma, alexithymia, and dissociation in dermatological patients: a controlled study. *Journal of Psychosomatic Research* 88: 38–44.

Gupta MA, Gupta AK (2017) Psychodermatology: an update. *Journal of the American Academy of Dermatology* 76(5): 857–871.

Herman JL (1992) *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror*. New York: Basic Books.

Kimball AB, Jacobson C, Weiss S, Vreeland MG, Wu Y (2005) The psychosocial burden of psoriasis. *American Journal of Clinical Dermatology* 6(6): 383–392.

Krajewski PK, Matusiak Ł, Szepietowski JC (2021) Hidradenitis suppurativa markedly decreases quality of life and professional activity. *Journal of Clinical Medicine* 10(6): 1162.

Marty P (1990) *La psychosomatique de l'adulte*. Paris: Presses Universitaires de France.

McDougall J (1989) *Théâtre du corps: le psychosomatique en psychanalyse*. Paris: Gallimard.

Patel ZS, Hoffman LK, Buse DC, Cohen SR (2022) Suicidality in hidradenitis suppurativa: a systematic review. *Journal of the American Academy of Dermatology* 86(2): 425–432.

Phan K, Huo YR, Smith SD (2020) Hidradenitis suppurativa and psychiatric comorbidities, suicides and substance abuse: systematic review and meta-analysis. *Annals of Translational Medicine* 8(13): 821.

Pomey-Rey D (1992) *Bien dans sa peau, bien dans sa tête*. Paris: Bayard.

Revankar R, Willis E, Alavi A (2021) Hidradenitis suppurativa and intimate relationships: patient experiences and psychosocial impact. *International Journal of Women's Dermatology* 7(4): 462–468.

Szabó C (2020) Psychotrauma and the skin. *Journal of the European Academy of Dermatology and Venereology* 34(12): 2689–2690.

Szwec G (2012) *Troubles à expression psychosomatique*. In: Ferrari P, Bonnot O (eds), Traité européen de psychiatrie et de psychopathologie de l'enfant et de l'adolescent. Cachan: Lavoisier, pp. 506–526.

Thorlacius L, Cohen AD, Gislason GH, Jemec GBE, Egeberg A (2018) Increased suicide risk in patients with hidradenitis suppurativa. *Journal of Investigative Dermatology* 138(1): 52–57.

Van der Kolk BA (2014) *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Viking.

Yu J, Sun Q, Xu W, et al. (2020) Psychological stress and chronic inflammatory skin diseases: a review. *Clinical, Cosmetic and Investigational Dermatology* 13: 623–632.

Zhang XJ, Xu H, Wang DQ, et al. (2021) Psychosocial adaptation among people with chronic skin disease: a grounded theory study. *Nursing Open* 8(5): 2673–2685.