PRACTICAL PSYCHODERMATOLOGY

EDITED BY
ANTHONY BEWLEY • RUTH E. TAYLOR • JASON S. REICHENBERG • MICHELLE MAGID

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Practical Psychodermatology

For Arnold S. Coren (1922–1997) – for showing me the joy of medicine from the perspective of a patient. His memory continues to guide me.
J.S.R.

For Jeanette Magid (1947–2006) – a traditional mother who encouraged me to break tradition.
M.M.

For Anthony Downey (1963–1990).
A.P.B.

For my parents Alec and Elizabeth Taylor, husband Nicholas Moran, and children Hannah, Austin, and Mehetabel, with thanks for their love and support.
R.E.T

Practical Psychodermatology

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Foreword

From the US

"The dermatologist treats the disease; the psychodermatologist treats the patient who has the disease."

This new book on psychodermatology is extremely comprehensive. The content ranges from psychopharmacology to non-pharmacological approaches such as habit reversal therapy. It covers all age groups from pediatric to the elderly and is applicable to all providers including the nursing staff. This book is indeed a valuable addition to our specialty.

Psychodermatology is much more than delusions of parasitosis. Whereas dermatology has a tendency to focus more on minute details, psychodermatology encourages appreciating the patient as a whole. In fact, in the United States, a new book updating the entire field of psychodermatology is very timely. We are experiencing a radical change in reimbursement rates for physicians, whereby reimbursement becomes contingent on patient satisfaction. This new policy, "value based payment," increases or decreases compensation based on patient satisfaction as assessed by the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey mandated by many insurance payers including the US government. As electronic consumer ratings become more prominent, physicians will be publicly rated, similar to how restaurants are rated on the website. Yelp! The reality that reimbursement rates are becoming contingent on how the dermatologist relates to and is perceived by his/her patient must be faced. Because this is a very subjective variable, it behooves all physicians to be familiar with psychodermatological aspects of their practice.

In short, psychodermatology is a subject matter most worthwhile learning about because of its relevance in our day-to-day practice. It is vital to investigate and appreciate aspects of our patients that are not visible, such as the intensity of emotional stress involved, the presence of depression, or the degree of support a patient needs to be adherent with his/her treatment regimen. As healthcare evolves, psychodermatology expertise will be of growing importance to the way we practice, above and beyond how to deal with a delusional patient.

John Koo
San Francisco, California
December 2013

From the UK

In the early 1970s at Addenbrooke's Hospital, Cambridge, we were fortunate enough to follow each other in the post of Senior House Officer in Psychiatry and Dermatology. The link between the two departments was part architectural, part financial: the Psychiatric Ward was next to the Dermatology Ward, and each service could only afford half a junior doctor. Arthur Rook was one of the dermatologists.

He drew the attention of one of us [CB] to the book *Psychocutaneous Medicine* by the American dermatologist Maximilian Obermayer. Arthur Rook suggested that this important book was to many UK dermatologists incomprehensible and off-putting. What was needed was an

accessible and practically based volume that covered the important and fascinating clinical interface between psychiatry and dermatology.

After Addenbrooke's the two of us went our different ways, one to be a dermatologist, the other a psychiatrist, but 10 years later we found ourselves again working in the same hospital service in London. We decided to start a Psychodermatology Clinic together at the Daniel Turner Clinic, Westminster Hospital. Later at Chelsea & Westminster Hospital, we were fortunate to have working with us an energetic trainee dermatologist, Anthony Bewley.

In 2003 we inaugurated an annual meeting at the Medical Society of London for UK clinicians interested in psychodermatology. After 5 years we were delighted when Tony Bewley and Ruth Taylor agreed to continue to organize this regular event. We now have the pleasure of writing this foreword to a book that we know will provide the resource that Arthur Rook saw the need for 40 years ago.

The editors have here brought together an important spectrum of topics, with authors from a range of disciplines, and many parts of the world. But most important is the attractive layout and practical, hands-on design of the book. Here psychodermatology is no longer an obscure and esoteric subspeciality. This book clearly demonstrates psychodermatology has come of age. It is on the curriculum. Now it is important that patients everywhere with skin complaints can benefit from the important holistic approach that psychodermatology represents.

Christopher Bridgett and Richard Staughton
London
December 2013

Preface

Psychodermatology is an emerging subspecialty of dermatology. It encompasses the management of patients with primary psychiatric disease presenting to dermatologists (e.g. delusional infestation, body dysmorphic disease and factitious diseases), together with patients who have primary dermatological disease (e.g. psoriasis, atopic eczema, hair disorders and others) where there is a large psychiatric or psychological co-morbidity.

There are a number of psychodermatology clinics starting out globally, and there has been provenance in the pioneering of psychodermatology by illustrious dermatological colleagues such as Dr John Koo from the US and Drs Richard Staughton, John Cotterell, Les Millard and John Wilkinson from the UK. But psychodermatology requires the input of a multidisciplinary team. In the UK, Dr Chris Bridgett, a consultant psychiatrist, helped found psychodermatology services. In mainland Europe, colleagues such as Dr John de Korte (The Netherlands), Françoise Poot (Belgium), Dennis Linder (Italy), Klaus-Michael Taube (Germany), Sylvie Consoli (France), Uwe Gieler (Germany), Gregor Jemec (Denmark), Andrey Lvov (Russia), Jacek Szepietowski (Poland) and Lucía Tomás (Spain) have provided inspiration and leadership in the field of psychodermatology for many years.

In *Practical Psychodermatology* two dermatologists (Drs Anthony Bewley and Jason Reichenberg) have combined forces with two psychiatrists (Drs Michelle Magid and Ruth Taylor) to edit a practical guide to the management of psychodermatological conditions. We aimed to emphasize the practicality of this book. Often, colleagues ask us "*How do you manage a patient with delusional infestation?*" or "*What's the best way to engage a patient with dermatitis artefacta?*" and so we wanted to produce a practical, hands-on approach to the management of patients with psychocutaneous disease. We are mindful that the management of patients with psychodermatological disease requires the input of a wide multidisciplinary team including dermatologists, psychiatrists, psychologists, primary care physicians, nurses, paediatricians, pain specialists and a whole range of other healthcare professionals HCPs. We have tried to include authorship of as wide a range of HCPs as possible, and we hope that *Practical Psychodermatology* will appeal to all those who are involved in the care and support of individuals with psychocutaneous disease. We have also tried to encompass the views of individuals who live with psychocutaneous disease, and we have specifically asked patient advocate groups such as Changing Faces to contribute to *Practical Psychodermatology*. In doing so, we aim to guide HCPs to useful resources that can be accessed either online or via other means of contact.

Just a note about the use of English in this book. We have kept the written English consistent with the author's origin, so where American English is used we have kept it as such and similarly for British English.

Finally we intend that *Practical Psychodermatology* is a text that trainees in dermatology, psychiatry, psychology, medicine, nursing and other HCP training programmes will find useful in their studies and clinical preparations. We are aware that colleagues are beginning to set up psychodermatology clinics across the globe and we hope that this practical guide will provide a helpful reference clinically and a source from which colleagues can access further research.

Anthony Bewley, July 2013

Over the past several months, as I began to review each of the submitted chapters for this textbook, I was struck by clear differences in the chapters written by authors from different countries. I was not surprised by variations in language or patient demographics , but instead by the large differences between the authors' concept of what it meant to offer a "practical" approach to patient care.

The chapters written by authors from the US are focused, precise guides to medication management, psychiatric care, or therapeutic techniques, varying by the disease type discussed. I found them very useful in my day-to-day practice and in teaching students who are new to psychodermatology. Just what I needed! The chapters written by authors from the UK, however, were not what I expected. They focused on patient resources, family education, and spoke about multidisciplinary care. It was clear the authors had many years' experience in working on healthcare "teams" and shared a common vocabulary of acronyms such as "CPA" and "NICE." This information has helped me to greatly improve collaboration and patient care in my practice. Before I read these chapters, I did not know what I was missing.

In the UK, it is clear that the practitioners have spent their careers working within a system where patient-centered, evidence-based medicine was expected. In the US, there has been a recent shift toward coordination of care and quality of life measures, but these ideas have not been in play for very long. I hope that readers from outside of the UK (myself included) will take a cue from these authors and utilize all the "practical" approaches in this book.

Jason Reichenberg, July 2013

SECTION 1

Introduction

CHAPTER 1
Introduction

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Psychodermatology: interfaces, definitions, morbidity and mortality

Psychodermatology or psychocutaneous medicine refers to the interface between psychiatry, psychology and dermatology. It involves the complex interaction of the brain, cutaneous nerves, cutaneous immune system and skin. Psychocutaneous conditions can be divided into three main categories, as illustrated in Figure 1.1.

Most patients attending psychodermatology clinics have either a primarily dermatological disease with secondary psychosocial co-morbidities or a primarily psychiatric disorder with a significant cutaneous symptomatology (Table 1.1). Clinical research has shown that there is an increasing burden of psychological distress and psychiatric disorder amongst dermatology patients [1]. In addition, stress is frequently reported as a precipitant or exacerbating factor of skin disease and is a major factor in the outcome of treatment [2]. Skin conditions may have a detrimental effect on most aspects of an individual's life, including relationships, work and social functioning. A national survey undertaken by the British Association of Dermatologists (BAD) in 2011 [3] to assess the availability of psychodermatology services, revealed poor provision despite dermatologists reporting:

- 17% of dermatology patients need psychological support to help them with the psychological distress secondary to a skin condition;
- 14% of dermatology patients have a psychological condition that exacerbates their skin disease;
- 8% of dermatology patients present with worsening psychiatric problems due to concomitant skin disorders;
- 3% of dermatology patients have a primary psychiatric disorder;
- 85% of patients have indicated that the psychosocial aspects of their skin disease are a major component of their illness;
- patients with psychocutaneous disease have a significant mortality from suicide and other causes.

These findings are not unusual and are mirrored throughout Europe, North America and globally.

The psychodermatology multidisciplinary team

Though patients often present to dermatologists, dermatologists are not usually able, in isolation, to manage patients with psychocutaneous disease. For these patients, there is increasing evidence that a psychodermatology

Practical Psychodermatology, First Edition. Anthony Bewley, Ruth E. Taylor, Jason S. Reichenberg and Michelle Magid.

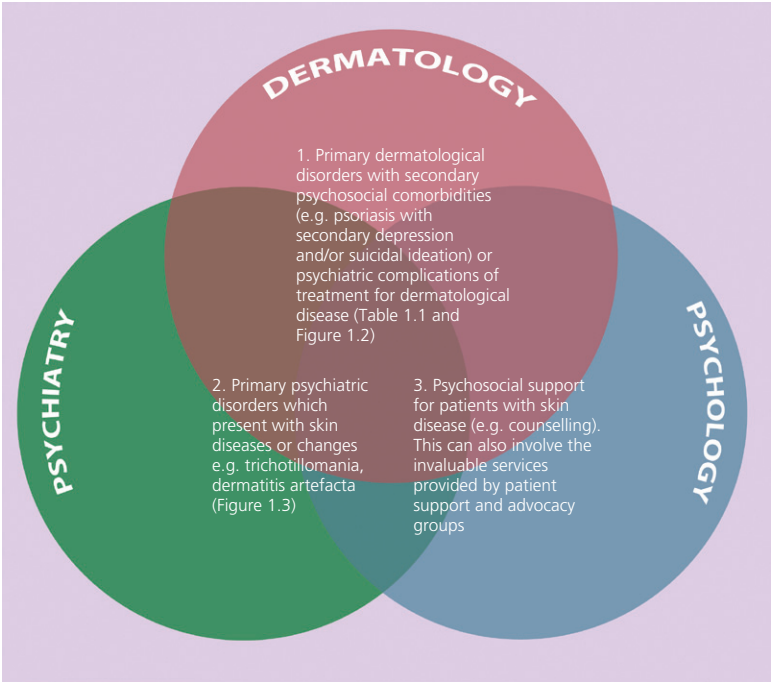


Figure 1.1 Psychodermatology interfaces (courtesy of Trevor Romain).

Table 1.1 Psychocutaneous disease

Primary dermatological disorders caused by or associated with psychiatric co-morbidity (Figure 1.2)	**Primary psychiatric disorders that present with skin disease (Figure 1.3)**
Psoriasis, eczema, alopecia areata, acne, rosacea, urticaria, vitiligo Visible differences (disfigurements) Inherited skin conditions (e.g. ichthyosis) **May be caused, exacerbated by or associated with:** Depression, anxiety, body image disorder, social anxiety, suicidal ideation, somatization, psychosexual dysfunction, schema, alexithymia, changes in brain functioning	Delusional infestation Body dysmorphic disorder Dermatitis artefacta Obsessive-compulsive disorders Trichotillomania Neurotic excoriation Dysaesthesias Somatic symptom disorders Substance abuse Factitious and induced injury Others

multidisciplinary team (pMDT) can improve outcomes [4]. Specialists who make up a pMDT require dedicated training in the management of patients with psychocutaneous disease, though such training is difficult to obtain (Box 1.1). This book, then, is aimed at being a practical, hands on guide to the *management* of psychodermatological diseases by *all* healthcare professionals. We are *not* saying that each patient with a psychocutaneous problem needs to be reviewed by a pMDT as that would be impractical and probably unnecessary. We *are* saying that for some

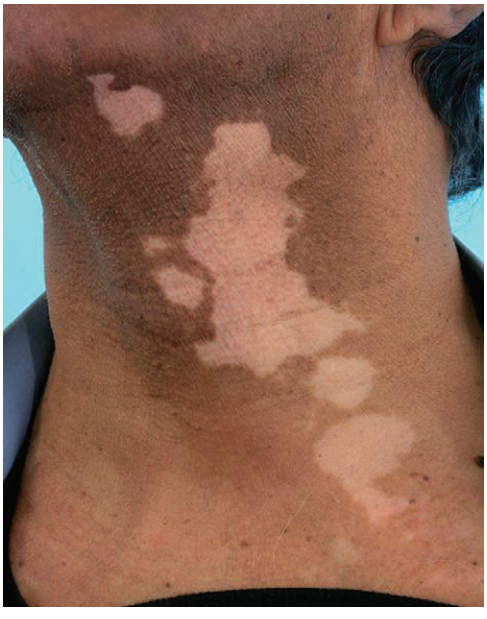


Figure 1.2 Patients with dermatological disease such as vitiligo may have psychological co-morbidities even if the condition is hidden or "milder". Such patients may feel out of control of their bodies, desperate and disempowered.

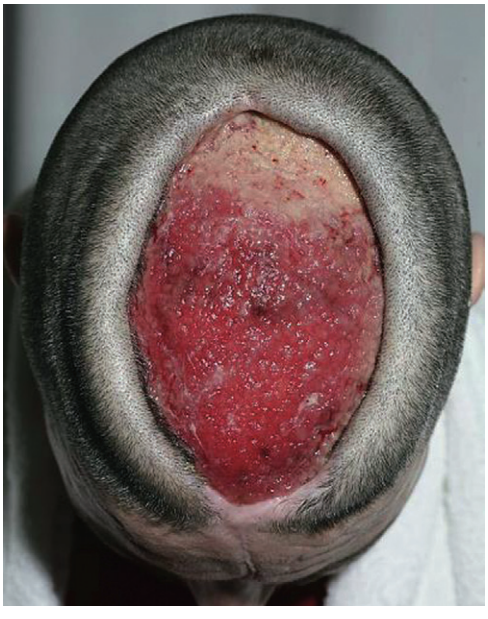


Figure 1.3 A patient with severe dermatitis artefacta (factitious and induced illness) of the scalp who required the careful input of a psychodermatology multidisciplinary team that included dermatologists, psychiatrists, plastic surgeons, nursing staff and psychologists in order to resolve her dermatological and psychosocial problems.

patients with psychocutaneous disease, a pMDT will be essential for their speedy, appropriate and effective management.

DSM-IV and DSM-5

The American Psychiatric Association (APA) has recently published the fifth edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (www.dsm5.org). The fourth version of the DSM (DSM-IV-TR, with a text revision) was published in 2000. The aim of the DSM manual is to provide general categorizations and diagnostic criteria for psychiatric disorders. These manuals are tools for healthcare professionals and do not represent a substitute for expert

Box 1.1 Possible members of the psychodermatology multidisciplinary team (pMDT)

- Dermatologists
- Psychiatrists
- Psychologists
- Dermatology and other nursing colleagues
- Child and adolescent mental health specialists (CAMHS)
- Paediatricians
- Geriatricians and older age psychiatrists
- Social workers
- Trichologists
- Primary care physicians
- Child and/or vulnerable adult protection teams
- Patient advocacy and support groups

clinical opinion. It is also important to note that categorization of psychodermatological disease is difficult and patients may exhibit symptoms of a variety of DSM diagnoses. For example, a patient with body dysmorphic disease (classified as an obsessive-compulsive related disorder) may have clear psychotic symptoms as well as being depressed at the same time; or a patient with psoriasis (a physical skin disease) may have symptoms of severe anxiety and depression as well as a substance use disorder.

The DSM-IV-TR consists of five axes (broad groups):

Axis I: Clinical psychiatric disorders (e.g. depression, schizophrenia)

Axis II: Personality disorders and mental retardation

Axis III: General medical conditions

Axis IV: Psychosocial and environmental problems

Axis V: Global assessment of functioning (0–100 scale of functioning level)

Of note, the DSM-5 work groups felt that there was no scientific basis for this separation and abandoned the axis system.

ICD-10

The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems (ICD-10)* offers a general classification of all disease. As with the DSM-5, it does not include all psychodermatological conditions, but can be helpful in organizing psychodermatological conditions.

We have specifically designed *Practical Psychodermatology* to be as user friendly and hands on as possible. To this end, we have divided the chapters into the following sections:

1. *Introductory chapters* – introduction and psychodermatological history and examination.
2. *Management in psychodermatology* – these chapters aim to address psychological assessments as well as assessment of risk and management strategies for patients with psychocutaneous disease. The chapters include psychopharmacology; adherence in the treatment of chronic skin disease; psychological assessment and interventions for people with skin disease; risk and risk management in psychodermatology; self-help for management of psychological distress associated with skin conditions; habit reversal therapy; and nursing interventions in psychodermatology.
3. *Skin disease with secondary psychiatric disorders* – including psychological impact of hair loss; psoriasis and psychodermatology; living well with a skin condition; and chronic skin disease and anxiety, depression and other affective disorders.
4. *Psychiatric disorders with secondary skin manifestations* – including delusional infestation; body dysmorphic disorder; obsessive-compulsive and related disorders; and dermatitis artefacta and other factitious skin disease.
5. *Cutaneous sensory (pain) disorders* – including medically unexplained symptoms and health anxieties: somatic symptom and related disorders; dysesthetic syndromes; chronic idiopathic mucocutaneous pain syndromes: (vulvodynia, penodynia and scrotodynia); burning mouth syndrome; and nodular prurigo.
6. *Special populations and situations* – including child and adolescent psychodermatology; psychodermato-oncology: psychological reactions to skin cancer; botulinum toxin treatment in depression; the Morgellons debate; and substance misuse and the dermatology patient.

By sectioning *Practical Psychodermatology* in this way we are intending that readers understand and logically access the broad sub-groups of psychocutaneous disease. We have where possible cross-referenced specific chapters to direct readers to further reading material.

Models of working psychodermatology services

There are several models of how psychodermatology services are delivered, all of which are compatible with a pMDT. These include:

- a dermatologist who refers a patient to a psychiatrist or psychologist who is in an adjacent room;
- a dermatologist who refers a patient to a psychiatrist or psychologist who is in a remote clinic;
- a dermatologist who has a psychiatrist sitting in clinic at the same time and a patient is seen by both specialists concurrently;
- a dermatologist who has a psychologist as a clinical adjacency (psychologists rarely sit in on clinics with dermatologist or psychiatrists).

Much of how a service is developed depends on local factors (availability of interested colleagues, finance) and there is little evidence that any one model is preferred over another. However, research makes it clear that at least regional psychodermatology services are essential [5] to cost- and clinically-effectively meeting the demands of psychodermatology patients [6].

Setting up a psychodermatology clinic

Many colleagues ask about how to set up a psychodermatology clinic in their area. The recommendations for setting up a psychodermatology service include [7]:

- *Financial investment* – managing psychodermatology patients in a general dermatology clinic is both frustrating and difficult. Dedicated psychodermatology services are mistakenly perceived as being expensive as there may be more than one healthcare professional (HCP) involved in the patient's care and because patients require longer consultations than routine dermatology patients and may need greater follow-up care. Joint delivery of care by dermatologists and psychiatrists can double the medical costs. So, it is important to cost psychodermatology services accordingly. This may require a specific psychodermatology tariff or reimbursement. Hospitals and managers will expect a business case outlining the requirements of the service, especially for joint clinics. There is increasing evidence that psychodermatology services provide cost-effective use of resources (as otherwise psychodermatology patients will see a plethora of specialists without having their physical and psychological disease managed successfully) [6,7].
- *The team* – psychodermatology is a multidisciplinary sub-speciality. Developing expertise among nursing staff, psychiatrists and psychologists requires access to training.
- *Clinic templates* – consultations are often lengthy and appointments should be 45 minutes for new patients and 30 minutes for follow-up patients. Psychologists usually see patients for hour-long appointments.
- *Separate dedicated time* to coordinate care and to liaise with other healthcare providers.
- *Facilities* – counselling and consultation rooms are ideally situated within the dermatology unit and in a quiet, undisturbed area suitable for psychological interventions. For joint clinics, the consulting room will need to be of an appropriate size to accommodate two clinicians, the patient and a caregiver.

British Association of Dermatologists Psychodermatology Working Party Report

In 2012 the BAD reported the minimum standards required to support psychodermatology service provision in the UK [7], mindful of the UK Government's document *No Health Without Mental Health* [8]. The working party recommended:

- formalization of regional and national clinical networks to identify training needs of staff;
- development of at least regional dedicated psychodermatology service with a trained specialist psychodermatologist;

- development of at least regional dedicated clinical psychologist support;
- access to cognitive-behavioural therapy (CBT), delivered by a trained individual;
- that all dermatology units have a *named lead dermatologist* who has some experience and expertise in psychodermatology, and access to the Child and Adolescent Mental Health Service (CAMHS), integrated specialist adult psychiatric services, old age psychiatric services and community mental health teams.

Psychological interventions

Talk therapies such as CBT and habit reversal are backed by strong evidence, as discussed in subsequent chapters. Other treatment modalities that have begun to acquire a following include biofeedback, eye movement desensitization and reprocessing (EMDR), neuro-linguistic programming (NLP) and mindfulness relaxation therapy.

Psychopharmacology

Pharmacology relates to psychodermatology in that:

- medication may be necessary for the treatment of psychodermatological conditions;
- medication used in dermatology may have psychiatric and psychological sequelae;
- pharmacological treatment of psychiatric conditions may have dermatological side effects.

These issues will be discussed in Chapter 3.

Assessments tools for psychodermatology patients

Many HCPs are able to assess patients' psychosocial co-morbidities through a standard consultation/clinical interaction. However, simple well-validated tools do exist. For example:

- Dermatology specific:
  - Dermatology Life Quality Index (DLQI);
  - Skindex 29.
- Dermatological disease specific (usually validated for physical and psychosocial disease extent):
  - Cardiff Acne Disability Index;
  - Salford Psoriasis Index.
- Non-dermatology specific:
  - Hospital Anxiety and Depression Score (HADS);
  - Patient Health Questionnaire 9 (PHQ-9).

These indices are used extensively in research, but are becoming increasingly important in everyday dermatology practice as they offer a standardized snapshot of the patient's psychosocial well-being (some also include scores of disease extent). Some dermatology-specific indices may also be disease specific. Assessment tools are discussed in Chapter 5.

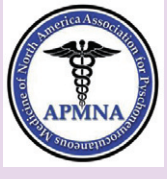
Global psychodermatology groups

Psychodermatology is a sub-specialty of dermatology that is gaining a voice and momentum within dermatological practice. There are a number of organizations that champion the clinical and academic excellence of psychocutaneous medicine (Table 1.2).

Medicolegal and ethical issues

Patients with psychocutaneous disease may be medicolegally challenging for a variety of reasons. Some may have personality disorders, which make negotiation with HCPs difficult; some may have forensic psychiatric problems; and some may have a delusional disorder, which may be difficult to manage. These issues will be discussed in Chapter 6.

Table 1.2 Organizations concerned with psychocutaneous medicine

	Organization/website	Meetings
	Psychodermatology UK www.psychodermatology.co.uk	Annually on fourth Thursday in January at the Royal Society of Medicine, London
	The European Society for Dermatology and Psychiatry (ESDaP) www.psychodermatology.net	Biennial meeting which rotates throughout Europe, and a satellite meeting at the spring and autumn meetings of the European Academy of Dermatology and Venereology
	Association of Psycho-neuro-cutaneous Medicine of North America (APMNA) www.psychodermatology.us	Annual meetings on the Thursday before the American Academy of Dermatology meeting
	Japanese Society of Psychosomatic Dermatology www.jpsd-ac.org	Annual meetings

PRACTICAL TIPS

- Psychiatric and psychological factors are important in up to 85% of dermatology patients, and involve the complex interaction of the brain, cutaneous nerves, cutaneous immune system and skin.
- Dedicated training in psychocutaneous medicine is essential for healthcare professionals working in psychodermatology services, as psychocutaneous disease carries a substantial morbidity and a significant mortality.
- Psychodermatology multidisciplinary teams (pMDTs) are essential for the cost- and clinically-effective management of patients with complex psychocutaneous disease.
- Quality of life and level of disability in dermatology patients is influenced more by associated psychiatric morbidity than by severity of dermatological disease. Quality of life measures are useful verified standardized tools for assessing psychosocial burden of disease and progress with treatment.
- Therapeutics for psychodermatology patients include psychotherapies, psychopharmacological interventions, and support from family, social workers and patient advocacy groups.
- Globally, groups are emerging that champion the clinical and academic excellence of the study of psychodermatology.

References

1. Sampogna F *et al*. Living with psoriasis: prevalence of shame, anger, worry, and problems in daily activities and social life. *Acta Derm Venereol* 2012; 92(3): 299–303.
2. Fortune DG *et al*. Psychological distress impairs clearance of psoriasis in patients treated with photochemotherapy. *Arch Dermatol* 2003; 139: 752–756.
3. Bewley AP *et al*. Psychocutaneous medicine and its provision in the UK. *Br J Dermatol* 2012; 167(Suppl 1): 36–37.
4. Mohandas P *et al*. Dermatitis artefacta and artefactual skin disease: the need for a psychodermatology multidisciplinary team to treat a difficult condition. *Br J Dermatol* 2013; 169(3): 600–606.
5. http://www.bad.org.uk/site/1464/default.aspx
6. Akhtar R *et al*. The cost effectiveness of a dedicated psychodermatology service in managing patients with dermatitis artefacta. *Br J Dermatol* 2012; 167(Suppl 1): 43.
7. http://www.bad.org.uk/Portals/_Bad/Clinical%20Services/Psychoderm%20Working%20Party%20Doc%20Final%20Dec%202012.pdf
8. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

CHAPTER 2
History and examination

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A psychodermatological assessment requires both a comprehensive dermatological and psychiatric assessment. Most commonly, a dermatologist with an interest in psychodermatology will be the one to complete the initial assessment, with a psychiatrist brought in as the patient accepts the need to address the mind as well as the body. In a formal psychodermatology clinic, a dermatologist and psychiatrist may see the patient jointly.

The first visit

A patient with psychocutaneous disease will usually present to a dermatologist because he/she believes the problem is primarily related to the skin (even if this is not the case). The practitioner should approach a patient with a suspected psychocutaneous disease in the same way as he/she would approach any other patient with a dermatological complaint (i.e. on the first visit, the practitioner should begin with a comprehensive history and physical examination of the patient). Attentive listening and a willingness to "lay on hands" will serve to set the tone for a therapeutic relationship in the future.

Setting expectations

Patients with psychocutaneous disease will require more time than a routine dermatological visit. It is often this time pressure that causes the most strain during the patient–physician interaction. A dermatologist should book these patients at intervals of 30 minutes or more. In a joint clinic setting, an hour is allocated for each new patient assessment. When a patient is encountered during a general clinic and no additional time is immediately available, it can be helpful to point out to the patient that additional appointments may be required to complete the assessment.

The patient should be made aware that skin problems can have a big impact on a person's psychological well-being, and therefore it will be important to evaluate them both physically and psychologically. Patients may be concerned about who will have access to their psychiatric assessment. They should be informed that the conversation is confidential, but that information will be shared with other healthcare professionals (HCPs) as appropriate (e.g. letter to the referrer and to their primary care provider) and with their permission. When writing letters, the consultant should avoid sharing unnecessary details with other providers and make sure that all of the information in these letters has been discussed with the patient beforehand.

The setting

The unique challenges of seeing a patient with psychocutaneous disease require the consultation room to be chosen with an eye towards

Practical Psychodermatology, First Edition. Anthony Bewley, Ruth E. Taylor, Jason S. Reichenberg and Michelle Magid.

safety and confidentiality. Though it is uncommon, patients with psychiatric disturbance may become very agitated or aggressive towards HCPs. The room needs an unobstructed exit with the physician sitting between the patient and the door. There should be a communication system to ensure rapid assistance from outside staff if the need arises.

It is common in standard dermatology clinics for there to be a lot of coming and going in the consultation room. This kind of disturbance needs to be minimized when seeing patients with psychocutaneous disease in order to help develop a setting in which patients will feel more able to discuss psychosocial issues that they may find embarrassing or stigmatizing.

Medical history

It is vital that every patient receives a comprehensive medical work-up, even if primary psychiatric disease is suspected. This will ensure that no medical conditions are left undetected and will serve to document and treat (if possible) any underlying disease, even if it is distinct from the patient's chief complaint. In addition, the patient is much more likely to share psychosocial concerns if he/she feels his/her skin and physical health concerns are being addressed.

Even those patients with a previously documented "delusional" disorder can be misdiagnosed; in one study of patients referred for a diagnosis of delusions of parasitosis, 11% were found to have an undiagnosed medical condition contributing to their disease, and 17% had obsessive-compulsive traits and no true delusions [1].

After the patient has received a thorough work-up (including laboratory testing and empiric treatments when warranted), it is important that the patient's other providers and the patient receive a copy of this work. This will prevent the patient from receiving the same work-up and treatment again, which can increase costs and impact on morbidity. It may be necessary on subsequent visits to repeat some investigations (such as examining specimens provided by a patient with delusional infestation) to maintain trust and rapport, but repeat testing should be limited.

The keystone of the first visit with a patient with suspected psychocutaneous disease is the patient interview. Many patients with psychocutaneous disease will have had the experience of being dismissed and rejected by medical professionals, so it is very important to let them ventilate any feelings of frustration and anger, and to fully hear their story.

For many patients, the most important question is: "*What do you think is going on?*" It is during this conversation that the healthcare provider can assess whether the patient has insight into the psychiatric aspect of his/her disease. Fears should be addressed; most dermatological patients have concerns of cancer or infection, and often will leave the visit not feeling that these issues have been specifically discussed [2].

If there are family members or friends available, it is helpful to ask them to corroborate the history of present illness, if any changes in behaviour have been observed (e.g. delirium or dementia) and what medications the patient is taking. They can also give useful information about the patient's premorbid personality and any changes in personality (see below).

The patient should be asked to provide a list of all the HCPs (including psychiatrists) who have cared for them in the past few years, and records should be obtained for a comprehensive review.

Psychiatric interview

If the patient is being seen in a joint clinic with appropriate time allotted, it is possible to complete a detailed psychiatric assessment at the initial visit. If the patient is being seen only by a dermatologist, the dermatologist should aim to start the psychiatric assessment and continue the discussion at subsequent visits. Some patients are keen to discuss the psychosocial impact of their disorder and are open to the idea of a psychiatric referral. Other patients (often those with delusional disorders or a body

Box 2.1 Psychocutaneous history

- Presenting complaint
- History of present illness:
  - Duration, previous episodes, known triggers?
  - Recent episodes of stress (physical or psychiatric) that may have precipitated psychiatric disease
  - Character of symptoms (burning, crawling, electric shock)
  - Distribution (dermatomal, sparing inaccessible areas)
- Previous medical history
- Previous psychiatric history
- History of substance abuse (see Chapter 27)
- Current medications:
  - Prescription and over-the-counter medications
  - Herbs/medications obtained from non-physician providers such as traditional healers
  - Look for polypharmacy
  - Look for medications that can especially affect the mental state (see Chapter 3):
    - Medications with strong anticholinergic activity (e.g. antihistamines and loop diuretics)
    - Narcotics
    - Steroid-containing medications
- Family history (of both physical and mental health problems)
- Social history:
  - Childhood
  - Schooling
  - Occupation
  - Living arrangements
  - Relationship/marital history/children
  - Present social circumstances
  - Social support
- Forensic history:
  - History of legal difficulties
  - History of aggressive or violent behaviour
- Premorbid personality

dysmorphic disorder) may be hostile to such suggestions. In this latter group, pursuing the psychiatric assessment too soon can be detrimental to the therapeutic rapport to the extent that the patient may not return.

Even given time constraints, as a minimum the dermatologist should ask about the impact the problem is having on the patient's life and enquire about mood, and thoughts of harm to self or others should be assessed. If the patient expresses thoughts of harm, it is mandatory to explore them and make some assessment of how likely it is that the patient will act on these thoughts (see Chapter 5). If the dermatologist is concerned that the risk is high, he/she should seek further advice from psychiatric colleagues. It is therefore important that the dermatologist knows the route for urgent psychiatric referral. Where relevant, child protection issues should be assessed (see Chapter 6).

The dermatologist should aim to eventually cover all of the various areas of psychiatric history and mental state, as outlined in Boxes 2.1 and 2.2. For detailed information about how to conduct a mental state examination, the reader should refer to undergraduate psychiatry textbooks, any of which will cover this in detail.

Box 2.2 The mental state examination

- Appearance and behaviour
- Speech
- Mood: subjective and objective
- Thought: form and content
- Perception (e.g. auditory, visual, olfactory hallucinations)
- Cognitive assessment, including orientation, attention and concentration, registration and short term memory, recent memory, remote memory, intelligence, abstraction
- Insight

Assessment of personality

Personality disorders are enduring patterns of behaviours that deviate from the expectations of the individual's culture. These patterns are persistent, inflexible and affect interpersonal functioning, emotional response, impulsivity and cognition (i.e. ways of perceiving the self and others). They usually begin in adolescence or early adulthood. In order to be diagnosed as

Table 2.1 Types of personality disorder

Cluster A	Paranoid	• Pattern of irrational suspicion and mistrust of others
	Schizoid	• Lack of interest in and detachment from social relationships, and restricted emotional expression
	Schizotypal	• Pattern of extreme discomfort interacting socially, distorted cognitions and perceptions
Cluster B	Antisocial	• Pervasive pattern of disregard for the rights of others, lack of empathy
	Borderline	• Pervasive pattern of instability in relationships, self-image, identity, behaviour and affect, often leading to self-harm and impulsivity
	Histrionic	• Pervasive pattern of attention-seeking behaviour and excessive emotions
	Narcissistic	• Pervasive pattern of grandiosity, need for admiration and a lack of empathy
Cluster C	Avoidant	• Pervasive feelings of social inhibition and inadequacy, extreme sensitivity to negative evaluation
	Dependent	• Pervasive psychological need to be cared for by other people
	Obsessive compulsive (personality)	• Characterized by rigid conformity to rules, perfectionism and control

Box 2.3 Personality disorders commonly encountered with dermatitis artefacta

Features of borderline personality disorder

- Frantic attempts to avoid abandonment
- Unstable and intense interpersonal relationships
- Unstable sense of self-image and identity
- Impulsiveness (e.g. in substance misuse, spending, bingeing or sex)
- Suicidal behaviour, gestures or threats
- Episodes of emotional instability over a period of hours
- Chronic feelings of emptiness
- Intense anger
- Stress-related symptoms that may superficially appear psychotic

Features of histrionic personality disorder

- Likes to be the centre of attention
- Inappropriately seductive or provocative
- Shallow and changeable displays of emotion
- Uses physical appearance to draw attention to self
- Speech that lacks detail and is excessively impressionistic
- Emotion that is exaggerated, theatrical and shows self-dramatization
- Easily influenced
- Over estimates degree of intimacy in relationships

Features of paranoid personality disorder

- Believes, without grounds, that they are being exploited, harmed or deceived
- Is preoccupied with doubts about loyalty and trustworthiness of associates
- Does not confide in others due to fear of information being misused against them
- Sees hidden, demeaning meanings in innocuous events or remarks
- Bears grudges
- Reacts angrily to perceived attacks not apparent to others
- Has recurrent suspicions, without justification, of fidelity of partner

a disorder, they must have a significant impact on the individual's social and occupational functioning. In assessing personality, it is important not just to rely on the patient, but to also elicit a description of patterns of behaviour from an informant (friend or relative) who knows the patient well.

DSM-5 lists ten main personality disorders, grouped into three clusters. ICD-10 lists nine of the same personality disorders, but classifies