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 comorbidities 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
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
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

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**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.

**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);
  ◦ Skinex 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).

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).

**Global psychodermatology groups**

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**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

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<th>Organization/website</th>
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| 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.


