

Psychodermatology: where skin meets mind

Dr Faraz Mughal, GP, RCGP Clinical Fellow in Mental Health, NIHR In-Practice Fellow, Keele University

Dr Jon Goulding, Consultant Dermatologist, Heart of England NHS Foundation Trust

Dr Kate Martin, Senior Clinical Psychologist, Heart of England NHS Foundation Trust

Introduction

Psychodermatology refers to the overlap between conditions affecting the skin and the mind. Patients may present with a primary mental health problem and secondary skin manifestations, for example delusional infestation or skin-picking disorder (widespread excoriations and scarring). More commonly patients present with a primary skin condition (eczema or psoriasis), accompanied by symptoms of social phobia, depression, anxiety, and substance or alcohol misuse.

Psychodermatological disease is incredibly common, yet it often goes unrecognised and untreated.^{1,2} Up to 85% of patients with skin conditions say that psychosocial aspects of their disease are a major component of their illness.³ Suicidal ideation and suicide risk is higher than average in patients with a range of skin diseases.⁴

In this article, we refer predominantly to patients who have a primary psychiatric illness and secondary skin manifestations.

The relationship between skin disease and mental health problems

Skin disease and mental illness form a large part of the general practice workload, thus awareness of their connectedness and the bidirectional relationship that exists between both areas is very important in facilitating holistic patient care:

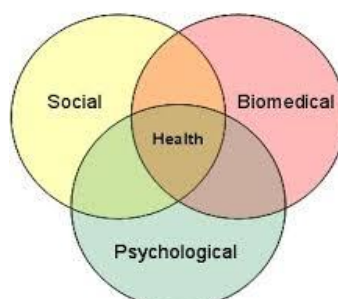
(Figure 1) All patients with dermatological problems exist somewhere on a continuous spectrum between 'pure' skin disease at one end and overt psychiatric disease at the other.



In line with the biopsychosocial model of health,⁵ the three main spheres of enquiry that every general practitioner (GP) should address when suspecting a psychodermatological presentation are:

- 1) Tell me about your skin?
- 2) How have you been feeling?
- 3) How are things at home and at work?

(Figure 2) The biopsychosocial model of health. All aspects need to be addressed to achieve a rounded understanding of a patient's presentation.



Tips for GPs:

- 1) If one suspects a presentation of a primary mental illness with secondary skin signs, the single most important factor in achieving a successful resolution is to set aside sufficient time. **Offering the patient booked follow-up, and ensuring continuity** will assist in on-going management.
- 2) Much time initially needs to be spent **simply listening and empathising, building rapport and trust**, defusing any anger, and demonstrating an open mind to diagnostic possibilities.
- 3) A first step should be to consider and exclude internal systemic and primary dermatological explanations for patients' symptoms.
- 4) It often helps to ask what was happening around the time that symptoms first started. There is frequently a **traumatic physical or psychological trigger** event which helps to explain subsequent developments.
- 5) A **thorough skin examination** is required to exclude organic skin disease. This should include a review of the entire skin surface, including nails, scalp, buccal mucosa, and genitals if appropriate. Look for scabietic burrows and palpable lymph nodes in those with pruritus.
- 6) A succinct **mental state examination** is important, assessing affect, disorders of thought content (delusions, ruminations, over-valued ideas etc), abnormal perceptions (hallucinations), and risk to self or others. This needs to be done sensitively since patients may object to the implied suggestion, at this early stage of assessment, that their symptoms may have a mental health basis.
- 7) Patients who present specimens from their skin must be taken seriously. **Inspect them carefully**, with a dermatoscope if available, and send for microbiological analysis. Encourage the patient to provide more samples if so desired - showing that you are taking their concerns seriously, and to aid negotiation if results are negative.
- 8) Using a validated questionnaire, to aid identification of those whose skin condition has a **significant impact on quality of life**, and to help diagnose **concomitant anxiety and depression** is useful. The Dermatology Life Quality index (DLQI),⁶ Generalized Anxiety Disorder scale (GAD-7)⁷ and the Patient Health Questionnaire (PHQ-9)⁸ are particularly useful, though these must not be administered at the expense of taking time to listen and build rapport.
- 9) Treat **patients' skin and mental health equally**, both through time invested in assessing each aspect, and in providing treatments. Patients expect and need some degree of physical symptom management alongside psychological support and therapy.

- 10) Take any opportunity to **deliver basic psychoeducation**. This may include informing patients their symptoms are real and distressing but that successful treatments are available.
- 11) Where patient insight is limited, it helps to focus on the visible distress and negative impact on patient well-being and daily functioning. Seeking mutually acceptable ways to try and improve this side of things may be more palatable than overt discussions about psychopathology.
- 12) Recognise that these presentations are often **complex, multifactorial, and long-standing**. A multidisciplinary team approach is crucial in achieving success, ideally involving the local psychodermatology service, if available, and with regular general practice follow up and patient education over time.

Useful resources for clinicians and patients:

- www.skinsupport.org.uk (patients)
- www.psychodermatology.co.uk (clinicians)
- Practical Psychodermatology. Bewley A, Taylor RE, Reichenberg JS, Magid M, eds. 1st edn. Oxford: John Wiley & Sons Ltd, 2014.

Acknowledgements:

We would like to thank the RCGP Clinical Advisors for their valuable feedback

References:

1. All Party Parliamentary Group on Skin. The psychological and social impact of skin diseases on people's lives. London, 2013. Available at: <http://www.appgs.co.uk/publication/the-psychological-and-social-impact-of-skin-diseases-on-peoples-lives-final-report-2013/> (last accessed 20th October 2017).
2. The King's Fund. How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK? Available at: <http://www.bad.org.uk/shared/get-file.ashx?id=2348&itemtype=document> (last accessed 20th October 2017).
3. Working Party Report on Minimum Standards for Psycho-Dermatology Services 2012. Available at: <http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1622> (last accessed 20th October 2017).
4. Dalgard FJ, Gieler U, Tomas-Aragones L, Lien L et al. The psychological burden of skin diseases: a cross-sectional multicentre study among dermatological out-patients in 13 European countries. *J Invest Dermatol* 2015; **135(4)**: 984-991.
5. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* 1977; **196**: 129-36.
6. Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI) - a simple practical measure for routine clinical use. *Clin Exp Dermatol* 1994; **19**:210-16.
7. Spitzer RL, Kroenke K, Williams JW, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med* 2006; **166**:1092-7.
8. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001; **16**:606-13.