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# HANDBOOK OF PSYCHODERMATOLOGY

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2nd Edition

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CHAPTER 2

# Case-taking in Psychodermatology

*Smitha Prabhu S*

**Key Messages**

- Both skin and brain originate from ectoderm. Diseases of one can affect the other. Unless we treat both the conditions simultaneously, therapeutic response will be less. So a detailed history-taking is essential to look out for the skin-mind connection.
- History-taking is an art to be acquired through repeated practice based on the best available knowledge.

## INTRODUCTION

Patient–doctor interaction is more complex than just treatment of disease. Patients have varied expectations from doctor, including being a confidante, guide, or even a friend at times, rather than just a healer of their diseases. They often expect miracles, even in chronic and extensive disease.

It is a well-known fact that up to 40% of dermatology patients have underlying psychological or psychiatric issues, either primary or secondary, to varying extents. Recognizing such patients is of utmost importance, as medical treatment of the dermatological disease alone may not suffice many a time. The underlying psychological/psychiatric distress is sometimes well hidden by the patient and comes into light only with a thorough and empathetic history taking.

Case-taking is an art to be honed by repeated practice. Nevertheless, there are a few facts to keep in mind while taking history, and examining the patient, in any field of medicine, be it dermatology, psychiatry, or psychodermatology.

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Psychodermatology, an interface between dermatology and psychiatry dealing with both the psyche and skin of the patient, is currently one of the upcoming specialties in psychiatry as well as dermatology with much potential for further development. A psychodermatological consultation is more time consuming than the conventional dermatological consult, as the patient requires more time to build confidence and to come out with the psychological problems. A dermatologist requires good relationship skills, empathy, and a basic understanding of psychodermatology to be an efficient psychodermatologist.

The interrelationship between mind, disease, environment, as well as genetic predisposition and interpersonal relations play a great part in disease progress and response to treatment.

A dermatologist should acquire basic skills in counseling, and may have to refer patient to a psychotherapist or psychiatrist if detailed psychotherapy or psychopharmacotherapy is indicated.

## APPROACH TO A POSSIBLE PSYCHODERMATOLOGY PATIENT

A possible psychodermatology patient is one who has primary psychiatric problem who comes with dermatoses, or one who has secondary psychiatric problems due to chronic, persistent, or disfiguring diseases or some minor or major stressors, which act as a trigger in common dermatological conditions such as psoriasis, atopy (psychophysiological conditions). Dermatological drugs can also cause psychological or psychiatric conditions **(Table 1 and Box 1)**.

**Table 1: Classification of psychodermatological disorders.**

| | |
|---|---|
| Psychophysiological disorders | Skin diseases exacerbated by stress: Acne, psoriasis, atopic dermatitis, and urticarial |
| Primary psychiatric disorders | Dysmorphophobia, delusion of parasitosis, and trichotillomania |
| Secondary psychiatric disorders | Psychosocial impact of skin disease such as anxiety and depression |
| Comorbidity with psychiatric disorders | Impact of skin disease on a primary psychiatric problem |

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**BOX 1: New proposed classification of psychodermatological disorders.**

*Group A: Primary psychodermatological disease—examples*:

- Alopecia areata
- Atopic dermatitis
- Chronic spontaneous urticaria
- Psoriasis
- Vitiligo

*Group B: Primary psychodermatological illness—examples:*

- Body dysmorphic disorder
- Delusional infestation
- Dysesthesias (e.g., burning mouth syndrome, vulvodynia)
- Psychogenic pruritus
- Self-inflicted skin lesions

*Group C: Secondary psychodermatological disorder*:

- Secondary dermatologic disease related to psychiatric medications—examples:
  - Acne: Lithium
  - Alopecia: Carbamazepine, fluoxetine, lithium, and valproic acid
  - Photosensitivity: Antipsychotics and tricyclic antidepressants
  - Skin pigmentation: Clozapine
  - Stevens–Johnson syndrome and toxic epidermal necrolysis: Carbamazepine and lamotrigine
- Secondary psychiatric illness related to dermatologic medications—examples:
  - Depersonalization: Minocycline
  - Mood disorders: Isotretinoin, methotrexate, and systemic steroids
  - Psychoses: Dapsone and hydroxychloroquine
  - Sedation and drowsiness: Antihistamines

*Source*: Adapted from Ferreira BR, Jafferany M. Classification of psychodermatological disorders. J Cosmet Dermatol. 2021;20(6):1622-4.

*Pointers toward psychodermatology patient examination*:

- Always conduct patient consultation in a private area, with least external disturbance.
  I have noticed in my practice that patients open up only if confidentiality and privacy is assured, especially when relating to delicate issues such as spousal relations, sexual problems, and interpersonal strifes.

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- Greet the patients with warmth, give them a seat and make them comfortable.
  A patient is always slightly apprehensive of the doctor and what a medical visit implies. Unless we seem nonconfrontational and nonthreatening, they never disclose full facts of either disease, or attendant psychosocial issues.

Initially, a general history-taking in presence of the bystander can be done to get preliminary information regarding dermatology condition and psychological well-being. After that, the bystander may be requested to be outside the consultation room and will be called as and when needed (in front of others, patient usually will not disclose highly personal confidential matters).

*Then start more detailed history-taking*:

- In the beginning of a consultation, never ask potentially embarrassing questions such as—"Are you stressed out?"; "Is your disease related to any psychological problem?". The immediate response will be a denial in most cases. Many dermatology patients will not accept a psychological cause for their ailments. Indirect questions such as—"How is your sleep and appetite? Do you experience any lack of energy or lack of interest in common pleasurable activities?", etc., help in opening up patients' to the doctor's line of questioning. Direct or leading questions followed by detailed history-taking are then possible.
- Keep asserting that many skin diseases have direct relationship with mind, so that patients do not feel embarrassed or confused while being asked about their intimate details. Some examples of direct questions are:"How is this disease affecting you?; Has this disease caused any problem in your day-to-day life in any manner–work, relationships, friendships, studies, concentration, etc.?". Direct questions should be asked only when there is some rapport or positive eye contact with the patient.
- Keenly observe the body language of the patient: How the patient talks, behaves, and also for nonverbal clues such as eye contact, gloomy face, tears, change in pitch and tonality of voice, tremors, etc., from patient or relatives. Look for any strife between patient and relative while asking questions and also observe for any hidden signs of anxiety, agitation, and depression.
- Many a times, a careful observation unearths matters which would otherwise remain hidden. A nervous tic, or frequent lip lick, or

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even blinking away tears can be easily missed. Many bystanders interfere and try to dominate during history-taking, especially in case of children, parents, and spouses. Observing the interpersonal play can give a clue as toward the troubles faced by the patient at the family and social front.

- Ensure confidentiality, if deemed necessary, by sending out bystanders, students, nurses, etc., from the room.
  Many patients are shy and withhold information in front of their relatives or friends, especially so in case of very personal and sexual problems. The sexual and psychological stigma or isolation can sometimes be elicited only under strict privacy. We have to emphasize our nonjudgmental attitude before asking highly private questions.
- Enquire about the condition, duration, response to previous treatment, if any, and possible cause or any other factor deemed important by the patient.
  Longer duration, frequent relapses, and less than expected response to treatment can be equated to more psychological stress. Try to verify if the patient is conscientiously taking the treatment prescribed in the last visit. Indirect questions such as have you finished the prescribed medicine, if so, how many days ago? How many tubes of cream you used in the past? When do you make time to apply the cream, etc., help a long way in assuring whether the patient has been compliant.
- Enquire about occupation/studies/imminent exams or placement stress.
  People involved in occupation which necessitates dealing with many people are often psychologically more affected by socially disabling diseases such as psoriasis, vitiligo, and severe acne. It is observed that many students are under very high educational stress. Refractory prurigo nodularis is common in such group as they tend to scratch at or pick at their lesions as a stress reduction method. Some students may not be initially aware of this but later on they will be on the lookout for this behavior.
- Enquire about sleep, appetite, and hobbies, which may give an indirect indication toward the mental health of the patient.
  Reduced or excessive sleep, insomnia, unexplained weight gain or loss, irritable bowel syndrome, etc., can point toward psychological morbidity.

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- Enquire about absenteeism, the working atmosphere, and any adjustments the patient has to make in view of the disease. Any disease which warrants frequent absenteeism can cause havoc with job opportunities and promotions, thus, imposing more psychological burden.
- Ask leading questions, only if the patient seems comfortable, as to interpersonal relationship with spouse, children, close family members, friends:
    - Any incident where the patient had to suffer humiliation about the disease
    - Any incidence of ostracism due to the disease
    - Any feeling of guilt, frustration, and helplessness, and episodes of panic
    - As to feeling of unworthiness, persistent sadness interfering with day-to-day activities and suicidal ideation.
- While taking history, try to differentiate between frank delusions, psychosis, or dermatoses secondary to psychoses, which primarily require psychiatric therapy. A tendency toward hypochondriac behavior also should be looked out for.
- If history feels incomplete, or if the patient holds back in the first visit, try to elicit more in subsequent visits, but being careful not to intimidate the patient or make them give up on the consultation.
- Family history is important as many dermatological as well as psychological conditions as these conditions have a genetic background.
- While examining, look for hidden signs of psychiatric distress—nail biting, skin biting, hesitation cuts, patchy hair loss, and neglectful hygiene.
- Ask leading questions to diagnose or exclude common psychiatric comorbidities in dermatology like depression, anxiety, adjustment disorder, obsessive compulsive disorder, etc. (clinical details discussed in the respective chapters). A very detailed history taking as done in psychiatry is usually not needed in psychodermatology.
- After a diagnosis is arrived at, if the patient fits into any of the below diagnoses, he or she requires a psychiatric/psychological help:
    - A primary psychiatric disorder
    - Secondary psychiatric comorbidity?
    - Underlying stressors that trigger or exacerbate the existing dermatological condition

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In a primary care setting, where there is no psychodermatology liaison clinic or a psychiatrist at hand, and if the dermatologist has the basic knowledge in counseling and pharmacotherapy, they may attempt to manage the patient on their own.

The following situations make it is advisable to seek a psychiatric/psychological consultation:

- Primary psychiatric disorder (dysmorphophobia, delusional disorder, and trichotillomania)
- Major secondary psychiatric comorbidity (major depression with suicidal ideation, severe social withdrawal)
- Tendency for substance abuse
- Lack of insight
- Lack of response to treatment.

Patient may not cooperate with, or even be hostile to abrupt orders as to get a psychiatric consultation done. Such a situation should be tactfully handled. Patients with delusions and factitious disorders are very difficult to manage and extreme tact and gentle handling is required to prevent the patient from being angry or abusive.

Having a psychodermatology liaison clinic or a psychiatrist within the dermatology clinic helps to a great extent in such cases.

A psychodermatology practitioner should have a special ability to prescribe common psychotropic and antidepressant medications with a good knowledge of their effects and side-effects, good relationship skills, and the ability to recognize the need for a psychologist or psychodermatologist at the earliest.

## COUNSELING OF A PSYCHODERMATOLOGY PATIENT

Patients do not easily accept that they need a psychological or psychiatric intervention, because, according to them, they suffer purely from a skin disease, and not a mental disease. Hence, it is very essential that the patient should be explained in simple terms why their skin disorder is linked to their psyche. A simple diagram drawn on a piece of paper while simultaneously explaining this goes a long way in helping the patient understand the skin mind body connection. The interrelationship between mind and skin should be stressed upon, i.e., brain and skin has a common origin, and anything that affects the skin can affect the brain and hence, your mind, and vice versa, is a simple way to put forth a complex idea to the patient. They should be made to realize that approaching a psychiatrist or psychologist is

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nothing to be ashamed of and they will not be stamped as a "mental or mad patient." The need to regularly take dermatological as well as psychiatric medications prescribed should be stressed upon. The need for regular consultations also should be explained. The symptoms of the disease should be integrated with the psychological signs as well as fears and dysfunction of the patient, and explained in simple terms. We should let them know that we are there to help them, any time and conquering over the disease is a teamwork.

## CONCLUSION

A good psychodermatologist needs to be open with good communication skills, knowledge about psychopharmacology medications, and the ability to recognize as to when a patient requires psychiatrist's help. Self-awareness and empathy are as important as technical skill and medical knowledge.

## FURTHER READINGS

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# HANDBOOK OF PSYCHODERMATOLOGY

Handbook of Psychodermatology is the first book on Psychodermatology from India and probably from South Asia, written by a multidisciplinary team of psychiatrists, psychologists, and dermatologists. This book is simple yet comprehensive and reader-friendly, touching all aspects of psychodermatology. It contains relevant information useful for a beginner and an expert. In this edition, thorough revision of previous chapters is done, and many new chapters are added.

*It offers a summarizing overview of:*

- Clinical patterns in psychodermatology
- Psychoneuroimmunology
- Psychological aspect of cosmetic dermatology
- Sexually transmitted diseases
- Geriatrics and adolescent issues
- Hansen's disease
- Psychological interventions including meditation
- Psychopharmacology
- Psychodermatology liaison clinic
- Research activities in psychodermatology

It is a landmark publication useful for dermatologists, psychiatrists, psychologists, and health professionals who treat patients with skin problems.



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