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General considerations and tips for conducting a psychodermatological assessment

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Psychodermatology is still a comparatively recent and underdeveloped field of dermatology whose clinical significance and application have only expanded recently, although the history of this field is long [1]. It intersects many disciplines, including dermatology, psychology, sociology, psychiatry, neuroscience, and aesthetics [1].

Several studies in dermatology have shown that psychiatric morbidity is 30-40% in outpatients and up to 60% in inpatients [2]. 85% of patients with dermatological disorders stated that psychological aspects of their skin disorders play an important role in their condition [3]. The link between psychiatric disorders and dermatological disorders is well-reported [4]. Many dermatological disorders are linked to psychiatric disorders such as depressive disorders (including major depression), psychoses (including schizophrenia), personality disorders, dissociative personality disorders, anxiety disorders (including phobias), bipolar disorders, substance abuse disorders, and obsessive-compulsive disorder [4]. According to a recent study of a nationwide survey by the working party of the British Association of Dermatologists, 17% of dermatology patients require supportive psychological assistance to deal with the distress brought on by their skin condition, 14% have a psychological condition that exacerbates their skin disease, 8% have psychiatric problems worsen because of their skin disorders, and 3% have a primary psychiatric disorder [2]. Psychodermatology is categorized into 4 subcategories: Psychophysiological disorders, primary psychiatric disorders, secondary psychiatric disorders, and skin sensory disorders [5]. These subcategories are demonstrated and summarized in the following table (Table 1) [5,6].

Table 1. Subcategories of psychodermatology.

Subcategories	Notes and characteristics	Examples of such disorders
Psychophysiological disorders	- Skin disorders are promoted or worsened by psychological stress. - Patients demonstrate a clear and chronological link between stress and exacerbation of the disease.	Acne - atopic dermatitis - psoriasis - alopecia areata - rosacea - seborrheic dermatitis - chronic spontaneous urticaria
Primary psychiatric disorders	- There are no primary skin disorders; if there are skin lesions, they are self-inflicted. - These diseases are always accompanied by an underlying psychopathology or psychological conflict and are referred to as stereotypes of psychodermatological disorders.	Delusions of parasitosis - eating disorders - skin-picking syndromes - factitious disorders - obsessive-compulsive disorders - body dysmorphic disorder - trichotillomania - neurotic excoriations
Secondary psychiatric disorders	- These disorders are psychiatric illnesses that are a consequence of skin disorders. - The emotional issues become more evident as a result of the skin condition and the psychological consequences can lead to more severe outcomes than the physical symptoms. - Despite not being life-threatening, certain skin conditions have a serious psychosocial effect on the quality of life of patients.	Psoriasis - alopecia areata - vitiligo - albinism - ichthyosis - chronic eczema - hemangiomas - rhinophyma
Skin sensory disorders	- These conditions are characterized by abnormal skin sensations in patients who do not have a primary skin lesion or a diagnosable cause for this abnormal skin sensation.	Itching, burning, stinging, biting, or creeping sensations without an evident etiology.

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Physicians often face challenges when managing patients with psychodermatologic disorders as it is difficult to obtain a medical history, which leads to much confusion between the clinical symptoms and the diagnostic criteria [5]. Studies on psychodermatologic disorders highlight the difficulty patients have in accessing care and the lack of adequate knowledge and resources for physicians to diagnose and treat them appropriately [7]. Underestimation of psychodermatologic disorders may lead clinicians to overpsychologize these patients, which can result in psychosocial stress and secondary psychosocial comorbidities and even exacerbate cutaneous symptoms, especially itchiness, which has been documented in psychoneuroendocrinoimmunological researches [1].

Patients with psychodermatological disorders are best managed by a multidisciplinary team comprising dermatologists for the management of cutaneous conditions, psychiatrists to manage psychiatric concomitant conditions, and specialist psychologists to provide appropriate psychological management, as well as specialized nurses, primary care physicians, and allied health professionals [3]. The initial assessment of psychodermatological disorders is of utmost importance because it offers the chance to approach the patients considering their physical health alongside their psychosocial well-being [8]. Nevertheless, it is important to consider that most patients who visit dermatologists expect their skin to be examined, not their psychological wellness [8].

The essential considerations of successful assessment of patients with psychodermatologic disorders can be summarized as follows [8]:

- Make it clear to the patient that you are interested in providing holistic treatment.
- Explain to patients that although the shared information is confidential, certain information might be disclosed to other medical professionals.
- Avoid sharing unnecessary details and ensure that all information has been given to the patient in one letter (excluding conditions where it is better to fully disclose the diagnosis in phases). To confirm the details and messages shared during the consultation, it is good practice to copy all letters to patients.
- Ensure that the clinic room is appropriate with regard to both privacy and security. It should have an unimpeded exit for the clinicians. Preferably, an alarm button should also be provided so that assistance can be called if necessary.
- The frequent visits and departures of other staff members in the dermatology clinic must be kept to a minimum so that patients can address issues that they may find embarrassing or stigmatizing.
- Explain to the patient that psyche and skin are closely related, that skin conditions can have a substantial impact on mental health, and that mental illness can affect the skin.
- Emphasize the importance of assessing the skin condition of the patients and how it impacts their emotional and social well-being.
- During the initial visit, ensure that you have given careful attention to the patient's medical history. The likelihood of patients engaging with you will significantly increase if they perceive that you have paid attention to them and comprehend their dermatological problem.
- Give patients the opportunity to express their resentment and frustration regarding their illness and prior treatments.
- Do not be dismissive, regardless of how peculiar and atypical the patient's signs and symptoms may be.
- Schedule longer appointments (45 minutes for new patients, 30 minutes for follow-ups) and let the patient know that you will have more time to perform a thorough examination.
- Inform the patients that you can schedule follow-up appointments to conclude the assessment if you are unable to provide them with more time when they visit you.

Managing patients with primary psychiatric disorders may pose the greatest challenge [5]. Especially, patients who suffer from delusional parasitophobia require an approach in a different manner because they have specific needs and are not aware of their condition [5]. Acknowledging a patient's delusions with empathy does not imply that you endorse them [5]. It can reinforce a set belief or behavior to act as though you agree with them [5]. Even if there is not an actual skin condition, it is still vital to recognize the symptoms and inform the patients that you will collaborate with them in searching for the underlying cause [5].

For patients with skin disorders that trigger psychiatric conditions such as depression or anxiety, the most effective approach is to treat the skin disorders with aggressive therapy [5]. Aggressive therapy of skin disorders further improves secondary psychiatric conditions and expectation management [5]. If patients experience uncomfortable skin sensations such as itching, stinging, or burning, an objective diagnosis must be made to rule out an organic cause for these symptoms [5]. Thus, the patient may need a general practitioner or neurological examination to ensure that there is no primary illness that warrants treatment, such as diabetes [5].

Ferreira, Jafferany, and Patel proposed the most important points to consider when taking the clinical history of patients with psychodermatologic disorders [9,10]:

- The existence and distribution of cutaneous lesions whether they are primary or secondary.
- Presence of itching or dysesthesia.
- Duration of cutaneous symptoms and history of previous episodes.
- The existence of factors that may exacerbate or cause the cutaneous symptoms. Are they induced by stress?
- Personal medical history: Is there a prior diagnosis of cutaneous lesions, psychiatric disorders, sleep problems, or other medical conditions?
- Family medical history: Do chronic skin diseases and mental disorders have antecedents?
- Is the patient taking treatment for the cutaneous symptoms? And for psychiatric symptoms? And for sleeping? What type of treatment? And for how long?
- Social context description: from childhood to the current situation (job, relationships, and family context).

Although psychodermatology has proven to be relevant, dermatologists may not feel fully qualified to work in this important area of dermatology due to a lack of time and training [11]. In many European countries, there are very few specialist clinics and hardly any access to adequate training in psychodermatology [7]. On the other hand, there are very few experts in psychodermatology in U.S. dermatology programs, resulting in limited exposure throughout dermatology training and making it difficult to recruit faculty with psychodermatology expertise [11].

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Psychodermatology should be regarded as a subspecialty of medicine as well as a vital subspecialty of dermatology that needs to be more widely acknowledged and investigated by general dermatologists [1]. This will help general practitioners properly understand the conditions and refer patients to psychodermatology specialists [1]. The establishment of clinics with multidisciplinary teams offers both clinical benefits and cost reduction in the management of skin conditions and psychosocial comorbidity [7]. By limiting inaccurate diagnoses, ineffective therapies and unnecessary referrals, time resources, and costs can be reduced [7]. Dermatology journals should also highlight this subspecialty and encourage authors to publish articles on psychodermatology to help enrich this underdeveloped field in the medical literature. The inclusion of such information on emerging trends or directions in psychodermatology will stimulate further discussion and research.

Disclosure Statement

No potential conflict of interest was reported by the author.

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