Challenges of Treating Primary Psychiatric Disease in Dermatology

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RESIDENT **PEARL**

- Patients often present to dermatology with primary psychologic disorders such as delusional infestation or trichotillomania. Treatment of such conditions with antidepressants and antipsychotics can be highly effective and is within our scope of practice. Increased emphasis on psychopharmacotherapy in dermatology training would increase access to appropriate care for this patient population.

Psychiatric disorders are common among dermatology patients. They may be secondary to skin disease but also can be the primary cause of cutaneous concerns. Because patients with primary psychiatric disorders who present to dermatology often refuse referral to mental health providers, dermatologists are challenged with management of various psychiatric conditions, such as delusional infestation and trichotillomania. Effective, evidence-based treatments are available for psychodermatologic disorders, and dermatologists should be comfortable with their implementation.

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Dermatology patients experience a high burden of mental health disturbance. Psychiatric disease is seen in an estimated 30% to 60% of our patients.[1] It can be secondary to or comorbid with dermatologic disorders, or it can be the primary condition that is driving cutaneous disease. Patients with secondary or comorbid psychiatric disorders often are amenable to referral to a mental health provider or are already participating in some form of mental health treatment; however, patients with primary psychiatric disease who present to dermatology generally do not accept these referrals.[2] Therefore, if these patients are to receive care anywhere in the health care system, it often must be in the department of dermatology.

What primary psychiatric conditions do we see in dermatology?

Common primary psychiatric conditions seen in dermatology include delusional infestation, obsessive-compulsive disorder and related disorders, and dermatitis artefacta.

Delusional Infestation—Also known as delusions of parasitosis or delusional parasitosis, delusional infestation presents as a fixed false belief that there is an organism or other foreign entity that is present in the skin and is the cause of cutaneous disruption. It often is an isolated delusion but can have a notable psychosocial impact. The term *delusional infestation* is sometimes preferred, as it is inclusive of delusions focused on any type of organism, not just parasites. It also encompasses delusions of infestation with nonliving matter such as fibers, also known as Morgellons disease.[3]

Obsessive-Compulsive Disorder and Related Disorders—This broad category includes several conditions encountered in dermatology. Body dysmorphic disorder (BDD), olfactory reference syndrome (ORS), excoriation disorder, and trichotillomania are some of the most common variants. In patients with BDD, skin and hair are the 2 most common preoccupations. It has been estimated that 12% of dermatology patients experience BDD. Unsurprisingly, it is more common in patients presenting to cosmetic dermatology, but general dermatology patients also are affected at a rate of 7%.[2] Patients

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with ORS falsely believe they have body odor and/or halitosis. Excoriation disorder manifests as repetitive skin picking, either of normal skin or of lesions such as pimples and scabs. Trichotillomania presents as repeated hair pulling, and trichophagia (eating the pulled hair) also may be present.

Dermatitis Artefacta—Almost 1 in 4 patients who seek dermatologic evaluation for primarily psychiatric disorders have dermatitis artefacta, the presence of deliberately self-inflicted skin lesions.[2] Patients with dermatitis artefacta have unconscious motives for their behavior and should be distinguished from malingering patients who have a conscious goal of secondary gain.

What treatments are available?

Antidepressants—Selective serotonin reuptake inhibitors are one of the first-line treatments for BDD and may be useful in ORS. In excoriation disorder and trichotillomania, selective serotonin reuptake inhibitors are the most commonly prescribed pharmacotherapy, but they have limited efficacy.[2]

Antipsychotics—The recommended treatment of delusional infestation is antipsychotic pharmacotherapy. Treatment with risperidone and olanzapine has been reported to achieve full or partial remission in more than two-thirds of cases.[4] Aripiprazole, a newer antipsychotic, has fewer side effects and has been successful in several case reports.[5-7]

Cognitive Behavioral Therapy—Psychotherapy, most often in the form of cognitive behavioral therapy, has been reported as effective treatment of several psychocutaneous diseases. Cognitive behavioral therapy is considered first-line treatment of body-focused repetitive behavior disorders such as excoriation disorder and trichotillomania.[2] It addresses maladaptive thought patterns to modify behavior.

Who treats patients with neurodermatoses?

If a patient presents to dermatology with a rash found to be related to an underlying thyroid disorder, the treatment plan likely would include referral to an endocrinologist. Similarly, patients with primary psychiatric conditions presenting to dermatology should ideally be referred to psychiatrists or psychotherapists, the providers most thoroughly trained and best equipped to treat them. The challenge in psychodermatology is that patients often are resistant to the assessment that the primary pathology is psychiatric. Patients may deny that they are "crazy" and see numerous providers in search of a dermatologist who "believes" them.[8]

Referral to mental health professionals almost always is refused by patients with primarily psychiatric neurodermatoses, which presents dermatologists with a dilemma. As the authors of the "Psychotropic Agents" chapter of *Comprehensive Dermatologic Drug Therapy* put it: "A dermatologist has two choices. The first is to try to 'look the other way' and pacify the patient by providing relatively benign, but minimally effective treatments. The other option is to try to directly address the psychological/psychiatric problems." The chapter then provides a thorough guide for the use of psychotropic medications in the dermatology population, advocating for option 2: treatment by dermatologists.[9]

Should a dermatologist prescribe psychotropic drugs?

In *Dermatology*, the principle reference textbook in many dermatology training programs, it is stated that "[a]lthough less comprehensive than treatment delivered in collaboration with a psychiatrist, in the authors' opinion, management of these issues by a dermatologist is better than no treatment at all."[10] Recent reviews in the dermatologic literature of psychiatric diseases and drugs in dermatology agree that dermatologists should feel comfortable with prescribing pharmacologic treatment.[2,8,11] Performance of psychotherapy by dermatologists, on the other hand, is not recommended based on time constraints and lack of training.

Despite the apparent agreement in the texts and literature that pharmacotherapy of psychiatric neurodermatoses is within our scope of practice in dermatology, most dermatologists do not prescribe psychotropic agents. Dermatology residencies generally do not provide thorough training in psychopharmacotherapy.[9] Unsurprisingly, a survey of 40 dermatologists at one academic institution found that only 11% felt comfortable prescribing an antidepressant and a mere 3% were comfortable prescribing an antipsychotic.[12]

Final Thoughts

The challenges involved in managing patients with primary psychiatric disease in dermatology are great and many patients are undertreated despite the availability of effective, evidence-based treatment options. We need to continue to work toward providing better access to these treatments in a way that maximizes the chance that our patients will accept our care.

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