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Managing the patient with psychiatric issues in dermatologic practice

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Abstract Patients often communicate emotions through their bodies and physical symptoms; the skin commonly serves as a means of expression in the patient-doctor relationship. It is important for the dermatologist to be able to indentify psychological issues that manifest in the skin and the interplay between psychiatric and dermatologic conditions. Delusional parasitosis, dermatitis artefacta, trichotillomania, and somatoform disorders all represent dermatologic conditions with underlying emotional causes. Many chronic dermatoses, such as psoriasis, atopic dermatitis, and acne, modulate and are influenced by psychosocial factors. Special issues, including significant medication interactions and the treatment of the "difficult" patient, are reviewed.

Introduction

Countless communications, needs, and wishes play out in the patient-doctor interaction. In the practice of dermatology, a patient's underlying psychiatric disorders, emotional dispositions, or an interplay between dermatologic and psychiatric issues may influence the presentation and experience of symptoms, influence how the patient manages his or her illness, and affect the patient-doctor relationship. The skin, with connections to the immune and central nervous systems and the surface of the body, can be seen as a relay station linking one's external environment with one's body, brain, and mind[1] and as a vital means of interpersonal communication and connection.[2] In this paper, approaches to different types of patients commonly seen in the dermatologist's office are reviewed.

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Communication #1: the disease that isn't there

> Ms. A is a 55-year-old single, now homeless, woman who presents to the dermatology clinic asking for help with her "bug problem," which she believes has worsened over the past 6 years. She points to marks on her skin and brings with her a jar containing dirt, pieces of dried skin, and scabs, as further "proof" of her parasites. She has been staying in shelters or sleeping on park benches for the past year, after abandoning her apartment for fear it had become infested.

Doctors presume that a patient will seek medical help for a definable disease—a condition with an ascertainable etiology and, in most cases, an available treatment. The expectation is that the patient will present with signs and symptoms related to an underlying pathophysiologic process (be it allergic, inflammatory, infectious, neoplastic, or otherwise), and will defer to the dermatologist's expertise. In actual practice, however, there can exist a significant

discrepancy between what the patient and doctor believe to be the problem. Such is the case with several conditions in which the unifying theme is that the patient believes he or she has a dermatologic condition that does not correlate adequately with physical findings or a disease process.

Ms. A seems to be suffering from delusional parasitosis, an example of a psychiatric illness manifesting with dermatologic manifestations and complaints. Also known as monosymptomatic hypochondriacal psychosis, delusional parasitosis is a form of delusional disorder, somatic type, characterized by a fixed, false conviction of being infested with parasites.[3-5] Impairment is usually confined to this specific belief, in the absence of additional delusions or disorders of thought typical of other psychotic disorders. Patients with delusional parasitosis typically present to the dermatologist eager for help; they have often been to several other providers and have felt that their concerns were not adequately appreciated. They characteristically have detailed descriptions of the behavior and biology of the insects and "evidence" of the bugs, including pieces of dried skin, lint, and dust in small containers (a sign known as the "matchbox sign").[6] Despite the limited focus of their false belief, these patients can be seriously impaired. They may have left a home due to their concern of infestation; they may be unable to work or maintain social connections due to their preoccupation with the parasites and the sense that others cannot appreciate the problem.

It is important for the dermatologist to rule out other medical conditions that could explain the patient's experience, including general medical and neurologic disorders, and substance intoxication or withdrawal (including prescription medication, alcohol, and illicit substances). Delusional parasitosis should be differentiated from other psychiatric disorders, including but not limited to obsessive compulsive disorder, major depressive disorder with psychotic features, and schizophrenia.[3] In the dermatologist's approach to the patient, it is important to keep in mind that the patient is extremely distressed by this problem. The patient has sought help before, may have felt disregarded or otherwise not taken seriously, and may have been identified as a "psych" patient instead of as someone with a "real" medical disorder. It is important for the dermatologist to validate the patient's concerns and distress, while neither agreeing with the specific beliefs nor using direct confrontation. Treatment with an antipsychotic agent, expressing that this might help lessen some of the patient's distress, may relieve many of the symptoms of this disorder, including the preoccupation and the perceptual abnormalities.

As these patients usually lack insight into the delusional nature of their disorder, it can be challenging and often impossible to convince them to see a psychiatrist. Sometimes, letting the patient know that the psychiatric consultation is just a part of the overall treatment plan and that the relationship with the dermatologist will remain primary, can help the patient to accept the referral. As these patients tend to become quite isolated, the dermatologist may be one of the few people in the world who the patient can trust and may take on an essential role in the life of this patient: caretaker, social support, and therapist. The treatment of such patients can be challenging, requiring patience and compassion; consultation with a psychiatric colleague for guidance may be useful for the dermatologist. Much of the time, despite optimal treatment, the patient will never fully give up the belief in the infestation; however, the goal for the provider is to help the patient become less preoccupied with the belief and improve his or her functioning, socially and occupationally.[7]

Patients may present with other dermatologic complaints that are delusional in nature. Patients with major depressive disorder may develop delusional somatic beliefs, such as that their bodies are rotting and emitting a foul odor. Patients with schizophrenia or bipolar disorder in manic-psychotic states may also develop delusions related to the skin. These patients have a serious psychiatric illness and therefore need to be in psychiatric treatment. Encouraging the patient to see the psychiatric consultant as another part of the full medical evaluation, in addition to the dermatologic component, may help the patient to seek necessary help. If there is concern that the patient is a danger to self or others because of the psychiatric condition, then the patient can be escorted to an emergency room, even against the patient's consent, for urgent psychiatric evaluation.

Patients with somatoform disorders also may present with dermatologic complaints that do not adequately correlate with the dermatologist's evaluation. Somatoform disorders are a class of conditions where patients' physical symptoms are suggestive of a medical condition but cannot be fully explained by a medical disorder, or by the direct effects of a substance or another psychiatric disorder (eg, profuse perspiration during a panic attack).[8] Patients may present to the dermatologist with skin complaints that are part of a somatization disorder, a type of somatoform disorder in which there are multiple physical complaints that are not a direct result of a general medical condition, or, where there is a related general medical condition, the degree of impairment exceeds that which would be expected from the medical findings.[8] These patients have symptoms associated with multiple systems, including neurologic, reproductive, and gastrointestinal. They may complain of pruritus or other dysesthesias.

Hypochondriasis, another somatoform disorder, is a preoccupation with having a serious disease based on misinterpretations of otherwise normal bodily sensations or signals; afflicted patients are not reassured by appropriate medical evaluations that disprove the presence of the disease.[8] Unlike somatization disorder (in which the patient has the experience of *being* ill), the hypochondriacal patient *fears* being ill. The patient with hypochondriasis may present to the dermatologist with a concern that a mole, assessed many times by doctors and deemed to be benign, is indeed cancerous, or that a small macule in the genital area is

evidence of an untreatable sexually transmitted infection. Further evaluation of the patient with somatization disorder or hypochondriasis commonly reveals the presence of other current and past medical complaints or worries, and a history of seeking help from multiple medical professionals over the years.

Patients may also come to the dermatologist with a conversion disorder. Another type of somatoform disorder, conversion disorder involves the appearance of signs and symptoms that cannot be fully explained after appropriate medical investigation; the patient does not intentionally produce the symptoms; and an underlying psychological process precipitates or exacerbates the symptoms.[8] Psychogenic purpura has been conceptualized by some to be a conversion disorder in which an autoimmune process creates painful ecchymoses in the setting of psychic stress. Psychogenic pruritus or chronic idiopathic pruritus, which can be understood as a conversion disorder, is a type of somatoform disorder in which a patient has chronic pruritic symptoms without an identified physical source. Those patients for whom a full medical workup for the pruritus has been unrevealing may have underlying psychiatric issues causing their symptoms. In a minority of patients, both medical and psychiatric causes may coexist. The incidence of psychogenic pruritus in dermatology clinics is approximately 2%, with a female predominance. Studies have found an association between chronic pruritus and low self-esteem and problems handling aggression.[9] Emotional distress appears to have an effect on itch threshold and the intensity and duration of histamine-induced pruritus.[10] Tricyclic antidepressants, such as doxepin, may be useful for chronic pruritus, and may also help with underlying depression or anxiety. Relaxation techniques, methods of distraction (eg, skin cooling) and enhancing communication skills and the expression of feelings may also serve to improve symptom severity and the emotional distress related to the symptoms.[9] Tingling, burning, and other sensory symptoms are common conversion symptoms faced in the dermatology practice.[2]

Patients with somatoform disorders understand themselves as medical and not psychiatric patients. It is often difficult, even futile, to engage these patients into a primarily psychological treatment program. The dermatologist can help patients with somatoform disorders best by validating the concerns while not reinforcing the belief that something is actually medically wrong. Scheduling regular appointments, limiting the patient's elaboration on the medical condition that is believed or feared (eg, by stating at the beginning of the appointment that the patient can discuss one specific concern during the session and for only a set period of time), and judiciously referring the patient to a psychiatric colleague as an adjunct treatment, and not as a replacement for the relationship with the dermatologist, can be useful therapeutic tactics with such patients.

Body dysmorphic disorder (BDD), discussed in detail separately in this issue, is a somatoform disorder characterized by a preoccupation with an imagined defect in appearance, or a markedly exaggerated concern about a real, although slight, physical anomaly.[8] Commonly, patients with BDD present to the dermatologist seeking help for a perceived defect of skin or hair; their belief about the defect may be frankly delusional. They may request invasive or otherwise considerable procedures to treat the anomaly; repeated exposure to such treatment can lead to significant morbidity. The risk of mortality in patients with BDD is high; up to 25% of patients with BDD attempt suicide at some point, and the rate of completed suicide may be twice that of other serious psychiatric disorders, such as major depressive disorder.[11]

In patients with somatoform disorders and other disorders involving unrealistic beliefs about one's skin, the common thread is an investment in believing that one has a dermatologic issue in the absence of adequate biological evidence. These patients can be very challenging for dermatologists, as they are seeking help for a problem the doctor does not believe to be "real." They are "sick" without a clear disease, something that seems to violate one of the basic agreements between doctors and patients; nonetheless, it is essential for physicians to be able to understand that these patients are suffering and that they need help. For many of them, they will accept help only from a person they identify as their "medical" doctor, in this case the dermatologist. Of utmost importance with such patients is to minimize harm. These kinds of patients, because of their unfailing beliefs about their conditions, and the fact that many physicians do not have the patience or awareness to understand what is going on for the patient, are often subject to excessive medical testing and treatment, and subsequent significant morbidity and even mortality. Promoting the wellness of these patients involves limiting unnecessary procedures and enhancing psychosocial support and functioning.

This topic prompts a discussion of a particular response to illness; essentially, the converse of a false belief that there is something wrong with one's body is the rigid conviction that nothing is wrong despite definitive findings of disease. Denial, a defense mechanism that is used to protect from overwhelming anxiety in the face of a frightening reality, is not uncommon in people coping with medical illness.[12,13] It can sometimes be adaptive consciously to put aside one's fear in the setting of acute illness so as to move forward with treatment and do what is necessary; however, when patients flagrantly refuse to accept an illness or reject needed treatment, significant problems arise. Treating the patient with a history of melanoma who does not come in for skin exams, avoids the doctor's phone calls, and minimizes others' concerns by saying that he or she is "just fine" can be terrifying and even enraging to the physician. In working with these patients, it is important to keep in mind the goal of containing the patient's anxiety while promoting necessary treatment and minimizing risk. Confronting the patient's denial is rarely useful, but encouraging a conversation about what the patient is afraid of, while maintaining a

nonthreatening and supportive stance can help to move patient and doctor past the impasse.[13] Psychiatric consultation to assist in understanding the patient's resistance and promoting self-care may be indicated.

Communication #2: the disease that is self-inflicted

> Mr. B, a 29-year-old man who works as a phlebotomy technician, comes to the emergency room complaining of recurrent and persistent spontaneous ulcerations on his skin and asking to see a dermatologist. He states that he believes he has an "immune problem." He tells the consulting dermatologist in the emergency room that he stopped seeing his last 2 dermatologists, because they were "closed minded" and were not helpful in finding out the cause of his lesions. A nurse later spotted a scalpel, plus a hypodermic needle and syringe, falling out of his coat pocket onto the floor.

A diagnosis of dermatitis artefacta, or factitious dermatitis, likely characterizes the case of Mr. B. This condition is a type of factitious disorder—a disorder in which the patient intentionally produces signs and symptoms (in contrast to conversion disorder, in which the symptoms are unconsciously driven) with the goal of assuming the sick role. Factitious disorder is distinguished from malingering, in which the patient feigns a condition for a secondary gain of financial, occupational, or legal benefit.[8] In dermatitis artefacta, the patient creates skin lesions or aggravates existing lesions; the produced sores can be quite serious, leading to scarring, infection, and even death. The condition is more commonly found in women than men in a ratio of at least 3:1 and in adolescents and young adults compared with older adults.[14] Individuals often have had contact with medicine in the past, including a history of working in the health care field. The condition often appears in the setting of severe psychosocial stress or trauma.[15] The lesions themselves might be distinguished from primary dermatoses by features such as being on readily accessible parts of the body (where the patient can reach), having sharp, geometric borders with normal-appearing skin outside the margin, and appearing odd or unlike known skin lesions. Other clues include elements from the interaction with the patient, such as a "hollow" or vague history, or responsivity to suggestion by the physician about where the next lesion will be or what it will look like.[2,16] These patients typically seek medical procedures and invasive interventions with multiple providers, and frequent clinics and emergency rooms. They are at high risk for significant morbidity (infection, disfigurement, disability) as a result of the physician's earnest efforts to "get to the bottom" of the condition.

The dermatologist who suspects factitious dermatitis should make sure to rule out any serious disorder, while minimizing the use of unwarranted tests or procedures. As these patients will often switch to a new doctor when they feel the doctor is suspicious or withholding treatments (and therefore be vulnerable to further invasive interventions and promotion of the condition), it is important to make efforts to build a therapeutic alliance. Essential, albeit sometimes challenging, is the role of the physician's empathy. These patients have difficulty tolerating certain emotions (hence, their translation of psychic stress into physical symptoms). Direct confrontation about the production of symptoms will rarely work. With a strong alliance, validation of the suffering the patient experiences, and some exploration of the patient's underlying psychological stressors may be possible. Relaxation techniques, anxiolytics, antidepressants, and antipsychotics may be useful for such patients.[17] Although the patient will likely be resistant to a psychiatric referral, treatment should involve a gentle but firm request for a consultation with a psychiatrist with expertise in this area.

Psychogenic excoriation is another condition in which the patient produces skin lesions. As with factitious dermatitis, these patients are aware of the self-inflicted nature of their lesions; unlike factitious disorders, these patients are not attempting to feign a dermatologic condition, but are damaging their skin because of skin sensations or an attempt to remove a skin defect. The etiology of the behavior can vary among individuals. For some, the behavior is related to obsessional thoughts and compulsions (eg, a thought that there is an irregularity of the skin that the patient feels needs to be picked or otherwise manipulated). For others, the act may be pleasurable or a relief from tension, as with impulse-control disorders.[8] The behavior might be caused by an underlying depressive disorder, bipolar disorder, or even a psychotic disorder. Lesions in psychogenic excoriation are typically on parts of the body that are easily reached, and often are superimposed on existing skin conditions. The case of *acne excoriée* deserves special mention. Patients with this condition excessively pick their acne pimples because of concern about their appearance, often causing further lesions and scarring. In the subtype *acne excoriée des jeunes filles*, some have postulated that these adolescent girls who pick their acne lesions are creating more pronounced disfigurement, mostly unconsciously, as a justification for avoiding some of the age-appropriate tasks they are being faced with, including separation and individuation, sexuality, and career development.[18]

Unlike patients with factitious dermatitis, some patients with psychogenic excoriation may be able to talk about the self-inflicted nature of their skin condition. Such patients will benefit from a nonjudgmental and empathic stance. Serotonin reuptake inhibitors, antipsychotic agents, and naltrexone have all demonstrated efficacy in reducing the behaviors. Behavioral and relaxation techniques may also be helpful.[19]

Trichotillomania is a disorder in which an individual repeatedly pulls out hair, resulting in noticeable hair loss, and experiences an increasing sense of tension before the action and pleasure or relief after pulling out the hair.[8] Some patients will present to the dermatologist because of patches

of alopecia or infections at the site of the follicles. Trichotillomania shares features with, and may be comorbid with, obsessive-compulsive disorder; it may coexist with other anxiety disorders, depression, substance abuse disorders, eating disorders, and personality disorders.[20,21] Trichotillomania has a mean age of onset at 13. It can persist for years and be difficult to treat. Serotonin reuptake inhibitors, including clomipramine, have been shown to be useful for patients with trichotillomania; augmentation with antipsychotic agents may be useful. Behavioral approaches that include increasing the patient's awareness of the behavior and the triggers for the behavior, as well as relaxation training and skills for preventing the behavior can be effective for patients. A combination of psychopharmacology and behavioral therapy may be more effective than either treatment alone.[21]

Patients who create skin conditions, including patients with factitious dermatitis, psychogenic excoriation, and trichotillomania, as well as individuals who self-injure as an indication of borderline personality disorder or who bite their nails because of anxiety or other emotional triggers, can be difficult for the dermatologist to take care of and understand. Doctors, trained to relieve suffering and cure disease, can be perplexed, saddened, or angered by patients who create physical lesions and conditions. These patients clearly suffer, although the primary suffering—and the cause of the skin conditions—is emotional in nature. A nonjudgmental approach with emphasis on supporting wellness, minimizing further harm, and encouraging open expression of feelings can serve the dermatologist well in dealing with these patients. It is important to try to understand the cause of the self-inflicted injury, as the symptom may indicate different underlying pathologies, from anxiety, to obsessive-compulsive disorder, to depression or psychosis.[22] As these patients sometimes prefer to see a medical doctor rather than a psychiatrist, the dermatologist plays a key role as a supporter and caretaker. Working with such a patient can be challenging, but can also be very rewarding, as when a trusting alliance is made and the patient feels more able to effect change.

Communication #3: the connection between mind and skin

> Ms. C, a 43-year-old woman with a history of depression and psoriasis, presents frequently to her dermatologist with exacerbations of psoriasis. She has a good relationship with her doctor and is adherent with the prescribed treatments, which have included topical agents and ultraviolet light. She finds that her psoriatic lesions get worse during times of stress and when she feels more depressed. Ms. C has recently stopped working, citing embarrassment about her appearance; she worries her husband will leave her. Her dermatologist considers her psoriasis to be mild when well-controlled, and moderate during flares.

There is a well-established relationship between many dermatologic disorders and psychosocial factors. Conditions including psoriasis, atopic dermatitis, acne, rosacea, alopecia areata, herpes simplex, urticaria, seborrheic dermatitis, and cutaneous dysesthesia have been shown to be associated with, and modulated by, stress and emotional symptoms.[1,18,23] At least 30% of dermatology outpatients have psychiatric disorders,[24] and many more may experience psychological distress that affects quality of life. Psychosocial stress and emotional disturbances have been linked to the first episode of some chronic dermatologic conditions, including psoriasis and atopic dermatitis; such factors also appear to contribute to exacerbations of these disorders and others, including acne.[1,18] Individuals with psoriasis who feel dependent on others or who have difficulty expressing anger may be more prone to stress-induced disease exacerbations. Patients with atopic dermatitis have been shown to have higher rates of depression and anxiety and impaired ability to express some emotions, including anger.[18] Distress from chronic skin disorders, because of disfigurement, sensations of pain or pruritus, and other characteristics, can lead to psychological symptoms, commonly depression, anxiety, and anger. Individuals with skin disease are more likely to have impaired social support than others, for reasons including the psycho-social-economic burdens of having a chronic illness, self-esteem factors, and stigma associated with skin conditions.[23]

The dermatologic disorder may carry special meaning for an individual and affect one's life in different ways, depending on the patient's history and psychology. The development of alopecia areata after pregnancy may make a woman feel unattractive to her spouse, leading to depression and affecting the patient, her relationship, and her ability to bond with her baby. The patient with vitiligo in the genital area may be concerned about his or her sexual appeal, or may perceive the lesion as a punishment for sexual activity. The aging patient may fear that his or her wrinkles or age spots will be seen as signs that he or she is weak or ineffective, and may have difficulty functioning at work or withdraw from loved ones.

Emotional upset contributes to the release of proinflammatory cytokines, reduces the body's natural defenses, impairs wound healing, and may even predispose to the development of cancer.[1,23] Depression is associated with elevated levels of circulating cytokines, which may negatively affect inflammatory dermatologic conditions.[25] Patients with psoriasis and atopic dermatitis have demonstrated abnormalities in hypothalamic-pituitary-adrenal axis functioning; stress modulates mast cell activity, precipitating flares of urticaria.[1] A vicious cycle therefore may develop in vulnerable individuals in which emotional factors trigger physiologic activity that produces visible lesions and sensory symptoms, which then lead to further psychophysical changes.[23]

Individuals with skin disease experience elevated levels of distress as measured by standardized scales.[26]

Dermatologic conditions have as significant an effect, or greater, on quality of life, disability, financial status, and health-related measures as other chronic diseases, such as heart disease, cancer, arthritis, and depression.[27] Conditions that present during childhood, such as atopic dermatitis, can influence parent-child relationships, psychological development, and family economic and social functioning.[18,27]

The emotional and functional consequences of dermatologic disorders, such as acne and psoriasis, often do not correlate directly with the objective severity of disease. Psychological responses to the condition and psychiatric comorbidity seem to have a greater effect on quality of life than does the degree of physical impairment.[18,27] This would indicate that individual factors—susceptibility to psychiatric illness, styles of coping with stress, emotional meaning of the symptoms specific to the person, and so forth—have significant impact on overall outcome for patients with dermatologic conditions.[18]

Given the relatively high prevalence of psychiatric morbidity in the dermatology patient, it serves the dermatologist to be informed about, and be comfortable with, identifying psychosocial issues and psychiatric illness, and using psychologically informed approaches. Signs in a patient that could alert the dermatologist to the presence of associated psychosocial problems or mental illness include significant emotional distress connected to dermatologic symptoms, repetitive dermatologic consultations, and worse-than-expected response to treatment or greater frequency of relapse.[17] Repeated complaints of dermatological and other somatic symptoms might indicate an underlying depression in a patient. When emotional or social troubles are suspected, the dermatologist, who may be one of the few health care providers the patient with skin symptoms trusts, can help to uncover some of the problems, lend support, and suggest therapeutic options. To elicit symptoms of depression, questions such as "how has your mood been?" or "have you been feeling sad or discouraged?" can be useful; for patients who have more difficulty exploring emotional issues, a focus on symptoms, such as sleep, appetite, and energy, might reveal a depressive disorder.[22] Routinely asking about current activities, transitions, and stressors may help the patient to feel supported and understood, and will also serve as practical data for the dermatologist who is trying to connect exacerbations and fluctuations in disease with the patient's psychosocial milieu.

Standardized tools can be used during patient visits, such as the General Health Questionnaire, which measures emotional well-being and can be delivered in a brief patient-administered format, and the SF-36, which assesses aspects of quality of life and can be self- or clinician-administered.[28,29] The Dermatology Life Quality Index and the Psoriasis Quality of Life Questionnaire are examples of short self-administered tools that measure issues relevant to patients with dermatologic disorders.[27,30,31]

Once identified, addressing and ameliorating psychiatric and psychosocial issues can have the effect of improving mental health, dermatologic disease, and social and occupational functioning. Nonpharmacological approaches to primary psychiatric illness and psychological symptoms that are secondary to a chronic skin condition include psychotherapy, support groups, biofeedback, hypnosis, meditation, and massage. Such adjunctive approaches may lead to the patient needing less frequent or potent biological treatment for the skin disease (eg, less ultraviolet light therapy, or lower doses of oral medications).[23] For the patient with significant psychiatric illness, such as moderate to severe depression, or anxiety that is impairing many areas of life, psychopharmacologic treatment and psychiatric referral may be indicated. In general, patients who experience significant emotional distress because of their skin condition are receptive to exploring their worries and stressors, and will be extremely grateful to the dermatologist for giving them permission to do so in a supportive and safe setting.[22]

Communication #4: *difficult patients*

We now discuss 4 types of patients encountered in all areas of medicine who, because of personality traits or psychiatric illness, can be particularly challenging to treat. The borderline patient, who may or may not fulfill criteria for borderline personality disorder, is an individual who uses maladaptive defense mechanisms, such as splitting, and who acts out intolerable feelings rather than talking about them or processing them in a more functional way. This patient struggles with interpersonal boundaries, and often fluctuates between wanting to be overly close with the medical provider and aggressively rejecting the relationship. This patient, fearing rejection and abandonment, may be overly seductive (by being overtly sexual, or through other means, eg, idealizing the physician as the best doctor in the world or the only one who really "understands"). This can reverse in an instant to devaluation, leaving the physician feeling useless, angry, and confused. The borderline patient has a tendency to express psychic pain through physical complaints. The patient, who may have experienced abuse or maltreatment earlier in life and who had complicated attachments to parental figures, may struggle with trusting the doctor. The dermatologic exam, often a full-body inspection, may be perceived as abusive, or as a demonstration of love and concern. The patient often rejects recommendations, while simultaneously demanding that the physician fill a limitless well of emotional need. For such a patient, the physician is served best by setting firm limits around what can and cannot be accommodated (ie, frequency of visits, number of phone calls fielded or prescriptions written). The physician must also manage personal reactions to the patient, such as feelings of omnipotence that might lead to making exceptions of usual practice, helplessness that makes one want to give up, or rage so intense that it precipitates wishes to take it out on the patient.

The narcissistic patient devalues others and demands special status; this patient, in a desperate attempt to avoid

feeling inferior, behaves in an entitled way, asking for special favors or refusing to abide by the rules of the clinic, which can madden even the most even-tempered physician. The narcissistic patient may have consulted with numerous clinicians in the past, always finding them lacking in skill or competence. The physician may find it useful to use the patient's entitlement as a hook in engaging the patient, ie, by communicating that the patient does indeed deserve the "best" care available, and asking for the patient's participation as a partner in the treatment. The physician's own sense of self-esteem is often threatened by such patients and it is of utmost importance to be aware of what the patient is doing, so as not to allow the patient to manipulate one's self-worth and optimism.

The manic patient, a patient with bipolar I or II disorder who periodically becomes manic or hypomanic, can be especially difficult to manage. These patients, in a state of elevated self-esteem and reduced awareness of reality and its consequences, may disregard the need for treatment, miss appointments, or behave in an irritable or aggressive manner. The patient may also present as irresistibly charming or beguiling, compelling the physician to make exceptions for the patient, perhaps by offering unnecessary treatments, or colluding with the patient's denial of disease. The patient, who may be adherent with treatment when euthymic or depressed, intermittently presents with an exacerbation of dermatologic symptoms; during these periods, the physician picks up on subtle signs of elevated mood, and a review of systems indicates a recent reduced need for sleep and increased activity and energy. It is important to be watchful for associated states to which these patients are predisposed, including depression, psychosis, and mixed manic episodes (in which there is significant energy and agitation, but low mood); such states impair a patient's functioning, and increase the risk of poor judgment and self-harm. The physician should encourage evaluation with a psychiatrist; as patients commonly enjoy being hypomanic or manic, it is more fruitful to emphasize the help the psychiatrist can provide for the depressed phase of the illness.

The suicidal patient may have major depressive disorder or some other mood, psychotic, or personality disorder. The patient may be responding to feelings of hopelessness, delusional beliefs, or impulsive wishes. Patients with chronic medical illness have an elevated risk of suicide.[32] Dermatologic disorders that cause distress through physical disfigurement or discomfort may lead to depression, demoralization, low self-worth, and suicidal thoughts.[17] Patients with acne, psoriasis, and body dysmorphic disorder may be particularly prone to suicidality, with more than 5% of patients with acne and psoriasis having had suicidal thoughts or behaviors, and up to 25% of patients with BDD having attempted suicide.[11,18] Suicidality is very troubling for physicians and they may experience the patient with fear, distress, or even anger. Patients who are contemplating suicide may not disclose the information spontaneously; if the clinician is concerned about suicide risk, a direct inquiry should be made about suicidal thoughts or plans of suicide. A direct and empathic approach gives the patient the license to talk about suicidal feelings and decreases the stigma associated with the topic when the clinician is able to validate the patient's feelings. If there is concern about suicidality, urgent psychiatric evaluation or referral to an emergency room is essential.

In working with these patients, communication with the patients' mental health providers is useful and empowering. This support may allow the dermatologist to treat patients who are more psychiatrically challenging. An interdisciplinary dialogue about medications and other treatments can optimize the mental and physical health of patients with active psychiatric issues—patients who are more likely in general to get less adequate medical care.[33] When patients are resistant to pursuing psychiatric treatment, the dermatologist supports the patient with a nonjudgmental stance and a willingness to meet the patient where he or she is; give indicated treatment with psychotropic medication; and encourage the patient to consult with a psychiatrist as a supplement to, and not a replacement for, the primary therapeutic relationship.

Conclusions

The skin, with its connectivity to mind, brain, and endocrine and immune systems, often becomes a focal point of complex communications for patients. With disorders that patients create for psychological reasons, the dermatologist can help the patient put into words what he or she is attempting to express physically. Dermatologic disorders that are strongly influenced by emotional factors are best addressed from a biopsychosocial perspective. Patients with psychiatric illness or difficult interpersonal styles offer yet another challenge to the dermatologist. By understanding a patient's experiences of his or her dermatologic condition, and viewing the patient as a person within a broader social context, the dermatologist will gain empathy for the patient and traction in the treatment, and thus be able to provide the patient with optimal care and enhancement of both body and mind.

References

1. Tausk F, Elenkov I, Moynihan J. Psychoneuroimmunology. Dermatol Ther 2008;21:22-31.
2. Gupta MA. Somatization disorders in dermatology. Int Rev Psychiatry 2006;18:41-7.
3. Lee CS. Delusions of parasitosis. Dermatol Ther 2008;21:2-7.
4. Johnson GC, Anton RF. Delusions of parasitosis: differential diagnosis and treatment. South Med J 1985;78:914-8.
5. Wykoff RF. Delusions of parasitosis: a review. Rev Infect Dis 1987;9: 433-7.
6. Lee WR. Matchbox sign. Lancet 1983;2:457-8.
7. Gould WM, Gragg TM. Delusions of parasitosis: an approach to the problem. Arch Dermatol 1976;112:1745-8.

8. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC: American Psychiatric Association; 2000. p. 485-517;674-7.
9. Yosipovitch G, Samuel LS. Neuropathic and psychogenic itch. Dermatol Ther 2008;21:32-41.
10. Fjellner B, Arnetz BB, Eneroth P, et al. Pruritus during standardized mental stress: relationship to psychoneuroendocrine and metabolic parameters. Acta Derm Venereol 1985;65:199-205.
11. Phillips KA. Suicidality in body dysmorphic disorder. Prim Psychiatry 2007;14:58-66.
12. Appelbaum PS, Grisso T. Capacities of hospitalized, medically ill patients to consent to treatment. Psychosomatics 1997;38:119-25.
13. Muskin PR, Feldhammer T, Gelfand JL, et al. Maladaptive denial of physical illness: a useful new "diagnosis." Int J Psychiatry Med 1998; 28:463-77.
14. Koblenzer CS. Psychocutaneous Disease. Orlando, FL: Grune & Stratton; 1987.
15. Stein DJ, Hollander E. Dermatology and conditions related to obsessive-compulsive disorder. J Am Acad Dermatol 1992;26:237-42.
16. Hollender MH, Abram HS. Dermatitis factitia. South Med J 1973;66: 1279-85.
17. Sambhi R, Lepping P. Psychiatric treatments in dermatology: an update. Clin Exp Dermatol 2010;35:120-5.
18. Gupta MA, Gupta AK. Psychiatric and psychological co-morbidity in patients with dermatologic disorders: epidemiology and management. Am J Clin Dermatol 2003;4:833-42.
19. Arnold LM, Auchenbach MB, McElroy SL. Psychogenic excoriation. Clinical features, proposed diagnostic criteria, epidemiology and approaches to treatment. CNS Drugs 2001;15:351-9.
20. Cohen LJ, Stein DJ, Simeon D, et al. Clinical profile, comorbidity, and treatment history in 123 hair pullers: a survey study. J Clin Psychiatry 1995;56:319-26.
21. Duke DC, Keeley ML, Geffken GR, et al. Trichotillomania: a current review. Clin Psychol Rev 2010;30:181-93.
22. Lee CS, Accordino R, Howard J, et al. Psychopharmacology in dermatology. Dermatol Ther 2008;21:69-82.
23. Fried RG, Hussain SH. Nonpharmacologic management of common skin and psychocutaneous disorders. Dermatol Ther 2008;21:60-8.
24. Gupta MA, Gupta AK. Psychodermatology: an update. J Am Acad Dermatol 1996;34:1030-46.
25. Filaković P, Petek A, Koić O, et al. Comorbidity of depressive and dermatologic disorders—therapeutic aspects. Psychiatr Danub 2009;21:401-10.
26. Hughes J, Barraclough B, Hamblin L, et al. Psychiatric symptoms in dermatology patients. Br J Psychiatry 1983;143:51-4.
27. Hong J, Koo B, Koo J. The psychosocial and occupational impact of chronic skin disease. Dermatol Ther 2008;21:54-9.
28. Goldberg DP, Gater R, Sartorius N, et al. The validity of two versions of the GHQ in the WHO study of mental illness in general health care. Psychol Med 1997;27:191-7.
29. Ware JE, Snow KK, Kosinksi M. SF-36 Health Survey Manual and Interpretation Guide. Boston: The Health Institute, New England Medical Center; 1993.
30. Finlay AY, Khan GK. Dermatology life quality index (DLQI: a simple practical measure for routine clinical use). Clin Exp Dermatol 1994;19: 210-6.
31. Bronsard V, Paul C, Prey S. What are the best outcome measures for assessing quality of life in plaque type psoriasis? A systematic review of the literature. J Eur Acad Dermatol Venereol 2010;24:17-22.
32. Goodwin RD, Marusic A, Hoven CW. Suicide attempts in the United States: the role of physical illness. Soc Sci Med 2003;56:1783-8.
33. Karasu TB, Waltzman SA, Lindenmayer JP, et al. The medical care of patients with psychiatric illness. Hosp Community Psychiatry 1980;31: 463-72.