Psychodermatology in daily practice

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Don't ever think that what appears to be a simple medical visit lacks a psychological dimension. There is a moment in the career of every dermatologist when he or she becomes aware of the psychological. The moment may occur during residency training, or later on, but in either case the work of dermatology suddenly seems more complicated, less linear, and perhaps even awesome. If the physician is honest, there will be a realization of the psychological dimension in interactions with every patient. Moreover, depending upon the particular circumstances with the patient, and certainly also upon the past experiences of the dermatologist, there may also be feelings of curiosity, intellectual stimulation,

frustration, boredom, annoyance, or even anger. Call it what you will - psychodermatology, psychocutaneous medicine, psychosomatic dermatology, dermato-psychiatry - the subject is enormous. It includes a very broad range of topics. Among them are the doctor-patient relationship, the psychological effects of skin diseases, and also a group of skin disorders that have, to a greater or lesser degree, a psychological or psychiatric basis. What can the dermatologist do in such little time devoted to the dermatological consultation?

BUILDING THE RELATIONSHIP

First of all the dermatologist has to build a rapport, a relationship with the patient so that this could dare to say what is in his mind about this disease. It is also clear that this will enhanced the adherence to the treatment[1] and the patient's satisfaction. Doctors and patients don't have the same agenda in mind. The Calgary Cambridge model to the medical interview is to know and to be kept in mind.[2]

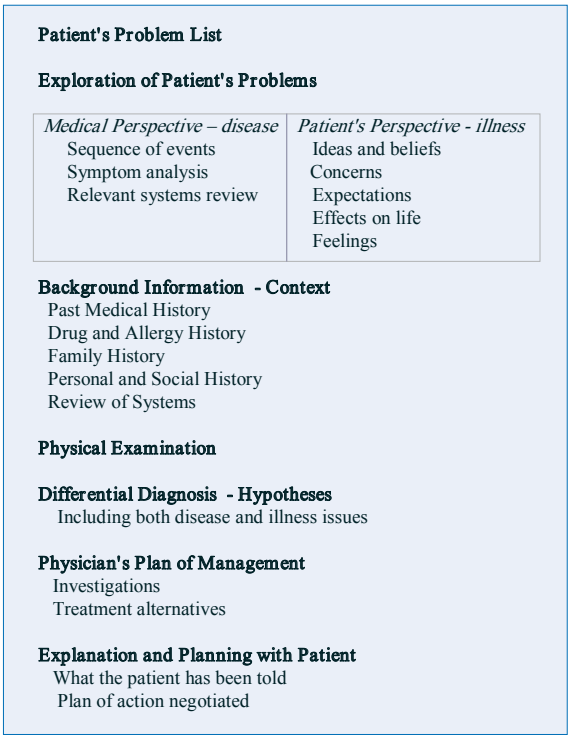

Figure 1. The enhanced calgary-cambridge guide to the medical interview.

The dermatologist should ask open questions so-that the patient can express himself and alternated them with more closed questions to understand better what the patient means. This will not take more time than you have. Do you know that the doctors interrupt their patients usually after 22 sec.? When you let the patient talk it takes 92 seconds before he stops talking.[3] Using a structured consultation[4] will help you also to manage the time. You can remember the acronym SOAP

- **S:** Subjective symptoms. Some patients tell the doctors right away that there are other problems, otherwise the doctor should ask the patient a simple question: "Is there anything else that you'd like to show me?" The same question may be repeated again. Once all information is out, the doctor can rank all the problems in order of importance. She/he can then tell the patient that there is only enough time to deal with the first 2 problems, and that a second consultation will be needed for the remaining problems. However, it is important to take the time to explain that treating the problems will take longer than the time allotted, and that there are other patients waiting who also need to be examined. Generally, this works fine if the doctor is straightforward and nice about it.
- **O:** Objective symptoms: This is when the doctor examines the specific lesions. Patients need to feel that their doctor has examined them. Moreover, by forcing themselves to examine each and every patient carefully, physicians may even find themselves correcting mistakes made in their initial diagnosis.
- **A:** Assessment: Based on what doctors find in their clinical examination, and on what patients tell them, they make a diagnosis. Thinking aloud will help physicians to explain their diagnosis to patients. If they are uncertain or have no idea what that diagnosis could be, there is nothing wrong with telling the patients so.[5] Patients prefer doctors who feel at ease and are not afraid of admitting that their diagnosis is uncertain and requires verification.
- **P:** Plan, prognosis and prescription: This is when doctors explain to patients what tests need to be done to confirm their diagnosis, determine a prognosis (which is very important for them) and issue prescriptions (which are often excessive). This moment is an opportunity to find out what the patients would like to do and to be more in sync with their expectations.[6]

To do all that a good rapport should be created. It means using good communication skills. This can be learned by participating in workshops to using an adequate non-verbal behavior and reading the patient's one. It needs also to show empathy and to clarify that we have well understood the patient's feelings.

PSYCHODERMATOLOGICAL DISEASES

The dermatologist should be well informed about the psychodermatological diseases he can encounter and about the treatment he can already provide.

First of all there are dermatological diseases enhanced by the stress. After having explored the patient's idea, meaning of his disease, you can ask some more closed questions about the sleeping, the scratching, the way to make the treatment etc. Then a good way to introduce the psychological side is to talk about the stress. What kind of stress are we looking for: the stress that the patient cannot change, where he has no power on. This is the negative

Table 1. Different levels of the psychodermatological process.

Qualification	Aim	Result
Level 1: managed by well-informed dermatologists	There is no request for psychological change	dermatological psychology
Level 2: managed by dermatologist + psychotherapist (or dermatologist recognized as psychotherapist)	The psychological change is accepted	1. counselling: = focused on explicit asking 2. psychotherapy = working with the patient's resistances

Table 2. Special ability of the well-informed dermatologist.

Patient's problem	Ability needed
Delusional patients	Prescription of antipsychotic drugs
Patients not able to undertake psychotherapy: • Social or financial problem • Cultural difficulties	Prescription of antidepressant or other psychotropic drugs together with relational skills
Difficult patients	Relational skills
Patients needing psychotherapy	Ability to recognize it and to send to a psychodermatologist or to a psychodermatology team
Patients with factitious disorders	Ability to recognize it and to react on it

Table 3. Classification of psychodermatological disorders.[7]

Psychophysiological disorders	All skin diseases enhanced by psychological conditions: e.g. psoriasis, atopic dermatitis, acne, urticaria, pruritus, alopecia
Primary psychiatric disorders	E.g. OCD*, trichotillomania, BDD**, delusions, factitious disorders
Secondary psychiatric disorders	Psychosocial impact of skin disorders
Comorbidity with psychiatric disorders	The impact of skin disorders is linked to psychiatric morbidity: e.g. on quality of life when there is also a depression

*Obsessive compulsive disorders ** Body dysmorphic disorders

stress that makes all the HHS axes working badly. If there is no actual stress it is interesting to look back to the family of the patient. Difficult infancy and youth lead to an insecure attachment and this will give psychosomatic problem further on.

ANXIETY AND DEPRESSION

In our recent study we found anxiety in 17,2%, depression in 10% and suicidal ideation in 12% of dermatological patients.[8] We should assess it and propose help with psychotherapy, medication or even with several consultations with us if possible in our country. We can also inform the GP about this state and ask them to provide a treatment. A very useful questionnaire is the HADS scale (hospital anxiety and depression scale). It is better to fill it with the patient when possible because even the idea to be anxious or depressed is sometimes refused or not perceived because of their alexythymia.[9]

PSYCHIATRIC DISEASES

We should be able to diagnose psychiatric troubles. Sometimes we are the only doctor the patient will consult and we have to treat his/her disorder. They will not go in for psychiatry. Delusion of parasitosis, Morgellons, delusion of odors is our lot. We should be able to treat it with antipsychotics. The self-inflicted lesions are another domain that we should be able to treat and recognize without angriness. Even the secret ones.[10] Being aware about Body Dysmorphic Disorder patients and their suicidality is another big issue. Talking about suicidal ideation is not provoking the act. On the reverse it will refrain them to do it. We should ask about their plan and when this is organized we should refer to the psychiatrist as soon as possible. We should also know about borderline personalities. Those patients are the one we met the first when starting with psychodermatology because they are knowing the best that they need psychological help. They are difficult to manage.

AVOIDING BURN-OUT

Taking care of ourselves is important. Limits should be placed thanks to good communication skills. Dealing with difficult patients can lead to burn-out. For that purpose a Balint group is a great help. Sharing our feelings with other doctors or with the help of a mental health professional is recommended when necessary.

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