

A survey assessment of the recognition and treatment of psychocutaneous disorders in the outpatient dermatology setting: How prepared are we?

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Background: Dermatologists provide the bulk of psychocutaneous care; however, recent studies suggest that dermatologists believe they are largely underprepared to treat most psychocutaneous conditions.

Objective: We sought to identify gaps in psychodermatologic knowledge among practicing dermatologists in two academic institutions.

Methods: An online survey was sent to 59 dermatologists at the Massachusetts General Hospital (Boston, MA) and Brigham and Women's Hospital (Boston, MA) from July 2010 through October 2011.

Results: The response rate was 40 of 59 (68%). More than 50% of dermatologists were comfortable making diagnoses for 8 of 10 psychocutaneous disorders. In all, 57% were comfortable making a diagnosis of depression. A total of 11% were comfortable starting antidepressants; 3%, antipsychotics; and 66%, medications for neuropathic pain. In all, 72%, 68%, and 21% of dermatologists never prescribe antidepressants, antipsychotics, or medications for neuropathic pain, respectively. Only 38% believed they were successful treating compulsive skin picking; 15%, body dysmorphic disorder; 27%, delusions of parasitosis; and 24%, depression.

Limitations: Limitations include small sample size, data extraction from an academic setting, self-reporting of outcome measures, and response bias.

Conclusion: Although the majority of the physicians surveyed believed they were capable of diagnosing psychocutaneous disease, very few were comfortable starting psychotropics or thought they were successful treating such conditions. (J Am Acad Dermatol 10.1016/j.jaad.2012.04.007.)

Key words: antidepressants; depression; health care surveys; mental illness; psychiatry; psychocutaneous disease; psychodermatology; psychoneuroimmunology; psychotropics.

Psychocutaneous medicine, sometimes known as psychodermatology, addresses skin conditions that sit at the interface of psychiatry and dermatology. These conditions can be classified into 3 categories: primary psychiatric disorders with skin manifestations (eg, compulsive skin picking, delusions of parasitosis, and body dysmorphic disorder [BDD]); skin disorders that are worsened by

Abbreviations used:

BDD: body dysmorphic disorder
 OCD: obsessive-compulsive disorder
 TTM: trichotillomania

stress (eg, anxiety precipitating a flare of atopic dermatitis); and primary skin disorders with

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secondary psychiatric symptoms (eg, depression precipitated by severe acne).

The prevalence of psychiatric comorbidity in the outpatient dermatology setting has been estimated to be as high as 25% to 30%.^{1,2} Despite this, referrals to psychiatry are often met with patient resistance, leaving dermatologists to provide the bulk of psychodermatologic care.

Unfortunately, recent studies suggest that dermatologists believe they are largely underprepared to treat most psychocutaneous conditions. In fact, earlier surveys have shown that only 18% of dermatologists reported an understanding of psychodermatology and 42% had never received training in the subject.² This leaves many patients with psychocutaneous disorders undertreated, which can have significant consequences. For example, unrecognized psychiatric comorbidity in prevalent dermatologic conditions such as acne and psoriasis can lead to worsening depression, anxiety, and even suicidal ideation.^{3,4}

To improve the care of patients with psychocutaneous conditions, we sought to identify specific targets for didactic intervention by assessing the diagnosis and treatment of patients with psychocutaneous disorders among outpatient dermatologists.

METHODS

An online survey was sent to all attending dermatologists at the Massachusetts General Hospital (Boston, MA) from July through August 2010 and then to all attending dermatologists at Brigham and Women's Hospital (Boston, MA) from August through October 2011. It was first piloted to 20 Harvard (Boston, MA) dermatology residents from April through May 2010. The survey, consisting of 10 multiple choice and open-ended questions regarding respondent and patient demographics, diagnosis, treatment, and referral patterns, was approved by the Partners Healthcare Institutional Review Board (2010-P-001161/2; approval date August 4, 2011). Study data were collected and managed using Research Electronic Data Capture (REDCap) tools hosted at Partners Healthcare (Boston, MA).⁵ REDCap is a secure, World Wide Web–based application designed to support data capture for research studies.

RESULTS

Of the 59 dermatologists surveyed, 40 (68%) responded. Their demographic breakdown is shown in Table I.

Comfort making psychiatric diagnoses

Diagnoses evaluated in this survey include compulsive skin picking, trichotillomania (TTM), BDD, obsessive-compulsive disorder (OCD), delusions of parasitosis, psychosis, depression, anxiety, cutaneous sensory disorder, factitious disorder, and borderline personality disorder. Overall, greater than 50% of attending physicians surveyed were comfortable making diagnoses for 8 of 10 psychodermatologic disorders (Fig 1). Dermatologists were most comfortable making the diagnosis of psychiatric disorders that commonly affect the skin. For example, 87%

of the respondents were comfortable diagnosing compulsive skin picking; 83%, TTM; and 80%, delusions of parasitosis. In contrast, 10% of attendings were comfortable making diagnoses of borderline personality disorder and psychosis. Only 57% of dermatologists were comfortable making a diagnosis of depression.

Treatment patterns

Dermatologists surveyed rarely prescribed psychotropics (Table II). For example, 72% never prescribed antidepressants; 69%, antipsychotics; 75%, anxiolytics; and 21%, medications for neuropathic pain. The most frequently started antidepressants were doxepin, amitriptyline, and bupropion. The most common antipsychotics started were pimozide and olanzapine. The most commonly prescribed anxiolytic was lorazepam, and the most common medication started for neuropathic pain was gabapentin, followed by amitriptyline and pregabalin.

Similarly, few dermatologists surveyed were comfortable starting most psychotropics (Fig 2). In fact, only 3% were comfortable starting antipsychotics (no one reported being extremely comfortable), 11% were comfortable starting antidepressants (3% were extremely comfortable), and 66% were comfortable starting medications for neuropathic pain (18% were extremely comfortable). Excluding antipruritics,

CAPSULE SUMMARY

- Despite providing the bulk of psychocutaneous care, recent studies suggest that dermatologists believe they are unprepared to treat most psychocutaneous conditions.
- The majority of physicians surveyed in this study believed they were capable of diagnosing psychocutaneous disease. Very few were comfortable starting psychotropics or thought they were successful treating such conditions.
- Additional training is needed to improve care of these patients.

Table I. Attending respondent demographics

Characteristic	%
Responses (n = 59)	
Total	68
Gender (n = 37)	
Male	38
Female	62
Year of American Board of Dermatology certification (n = 35)	
2000-2010	69
1990-1999	14
1980-1989	6
1970-1979	11
<1970	3
Locally trained (n = 29)	
Yes	41
No	56

Listed number of respondents in each category does not equal study sample size because of nonreporting.

these 3 medications are the psychotropics most often used in the outpatient dermatologic setting. When stratified by year of American Board of Dermatology certification (<1999 vs 2000-2010), no significant differences between the two groups were found regarding comfort with starting psychotropics. There was also no difference in this analysis between genders or sites of residency training.

Perceived outcome of treatment

Despite being fairly comfortable with the diagnosis of psychodermatology conditions, dermatologists did not think they were successful treating them (Fig 1). Respondents felt most successful treating anxiety disorders (42%) and compulsive skin picking (38%). They were least comfortable treating borderline personality disorder (10%) and psychosis (10%). Only 15% of respondents believed they could successfully treat BDD; 27%, delusions of parasitosis; and 24%, depression. Despite the lack of perceived success, an estimated 16% of patients who were thought to potentially benefit from psychiatric referral were actually referred.

Benefit to a multidisciplinary psychodermatology clinic

A total of 72% of respondents reported there would be a significant benefit to the addition of a multidisciplinary psychodermatology clinic. The most important benefit expected from the integration of psychiatry and dermatology into a joint clinic was help with psychotherapy (79%), followed by psychopharmacology guidance

(74%), ease of referral (53%), and diagnostic clarification (45%).

DISCUSSION

Coinciding with the growing integration of medical specialties is the emergence of the multidisciplinary team as a collaborative approach to outpatient care.⁶ Ideally, this collaboration would take place between psychiatry and dermatology and then this effort could serve as a bridge to more intense psychiatric care, if needed. If this collaboration cannot be achieved, whenever possible or feasible, consultation with psychiatry should be undertaken. Unfortunately, patient resistance to psychiatric intervention sometimes inhibits the potentially useful partnership between the two specialties and the suggestion for a patient to see psychiatry often results in termination of treatment. Therefore, the brunt of responsibility to recognize and treat many psychiatric issues falls upon the dermatologist; however, in line with previous studies, we found that most dermatologists believed they were largely underprepared to provide the full spectrum of psychodermatologic care. By focusing closely on practice patterns, this study was also able to identify the specific gaps of psychodermatologic knowledge that require attention.

The dermatologists surveyed in this group believed they were prepared to make most psychodermatologic diagnoses. Not unexpectedly, there was most diagnostic comfort with psychiatric disorders that typically have a skin manifestation such as delusions of parasitosis and compulsive skin picking. However, emerging studies indicate that primary psychiatric conditions such as depression, anxiety, BDD, and somatoform disorders are more frequently encountered by dermatologists than once believed.^{3,4,7} A 2010 cross-sectional study of 300 patients found that BDD is overrepresented in dermatology patients.⁸ Conrado et al⁸ found that the prevalence of BDD was 7% of general dermatology patients and 14% of cosmetic dermatology patients, when compared to approximately 2% of the general population.

The prevalence of depression in the outpatient dermatology setting is estimated at 34%, and is comorbid with many frequent dermatologic conditions including psoriasis, acne, urticaria, pruritus, and atopic dermatitis.^{3,4,9,10} In fact, the lifetime prevalence of depression in patients with BDD is estimated to be as high as 74%.¹¹ However, only 57% of dermatologists we surveyed were comfortable making a diagnosis of depression. Studies have shown increased rates of suicidal ideation with psoriasis, atopic dermatitis, and BDD, yet the

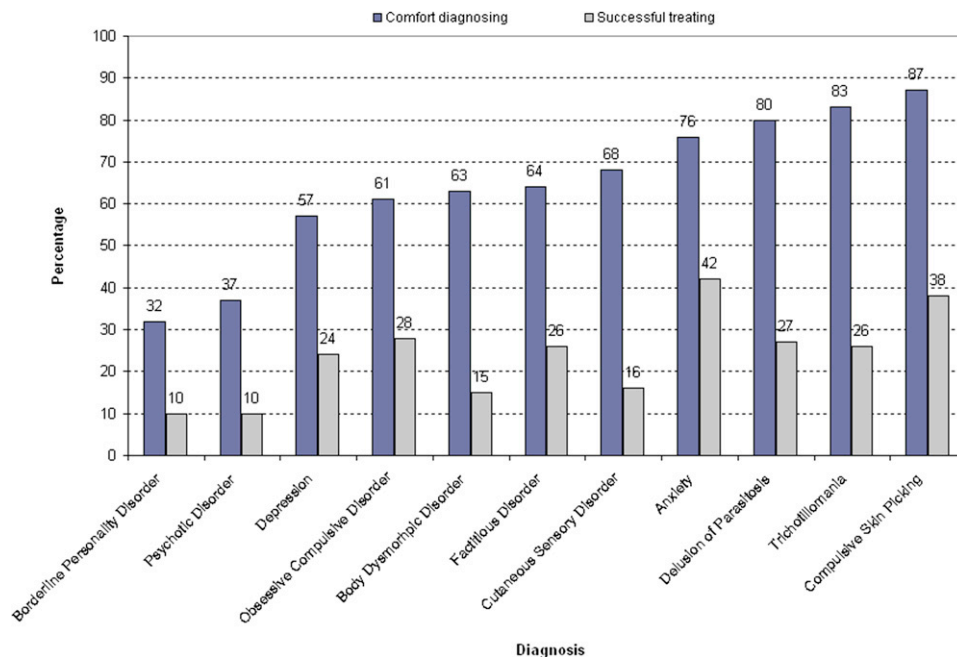


Fig 1. Percent of respondents who are comfortable diagnosing and believe they are successful treating psychocutaneous conditions.

Table II. Frequency of starting psychotropic prescriptions

	Antidepressants	Antipsychotics	Mood stabilizers	Anxiolytics	Antipruritics	Neuropathic pain medications
Often*	5%	0%	0%	3%	90%	33%
Rarely†	23%	31%	5%	22%	5%	46%
Never	72%	69%	95%	75%	5%	21%

*Including very often and somewhat often.

†Including somewhat rarely and very rarely.

typical patient encounter in the outpatient dermatology setting rarely includes a safety assessment. Presumably, brief didactics on diagnosing the most common psychodermatologic conditions with particular emphasis on depression could not only be beneficial, but in some cases, lifesaving.

Despite relative diagnostic competence, our study shows that dermatologists believed they were largely unsuccessful treating patients with psychocutaneous disorders and uncomfortable prescribing psychotropics. As the first-line treatment of many psychodermatologic disorders includes psychotropics and therapy, the perceived lack of success is not unexpected. However, the level of discomfort prescribing antidepressants, the mainstay of treatment not only for depression, but compulsive skin picking, BDD, TTM, and OCD, is quite surprising, particularly when combined with infrequent psychiatric referrals. In addition, although respondents were uncomfortable starting certain psychotropics, they still used them in practice. For example, 31% of dermatologists

reported using antipsychotics in practice, yet only 3% reported comfort prescribing this class of medication.

The use of psychotropics in general dermatology is also gaining momentum. Patel and Yosipovitch¹² are endorsing psychotropics as the first-line treatment for some subsets of pruritus. Data have classically supported the use of doxepin in histamine-related itch, yet there are new data to support the use of paroxetine and mirtazapine as initial agents in renal and cholestatic pruritus.¹²⁻¹⁵ Prurigo nodularis and lichen simplex chronicus (“neurodermatitis”) are two pruritic conditions that are difficult to treat and are considered by some experts to be the model for psychoneuroimmunology.¹⁶ Most treatment algorithms have highlighted topical therapies such as potent topical steroids, light therapy, and topical tacrolimus as semieffective therapies. However, these conditions have a prominent psychologic component that is often not addressed in conventional therapeutic approaches.

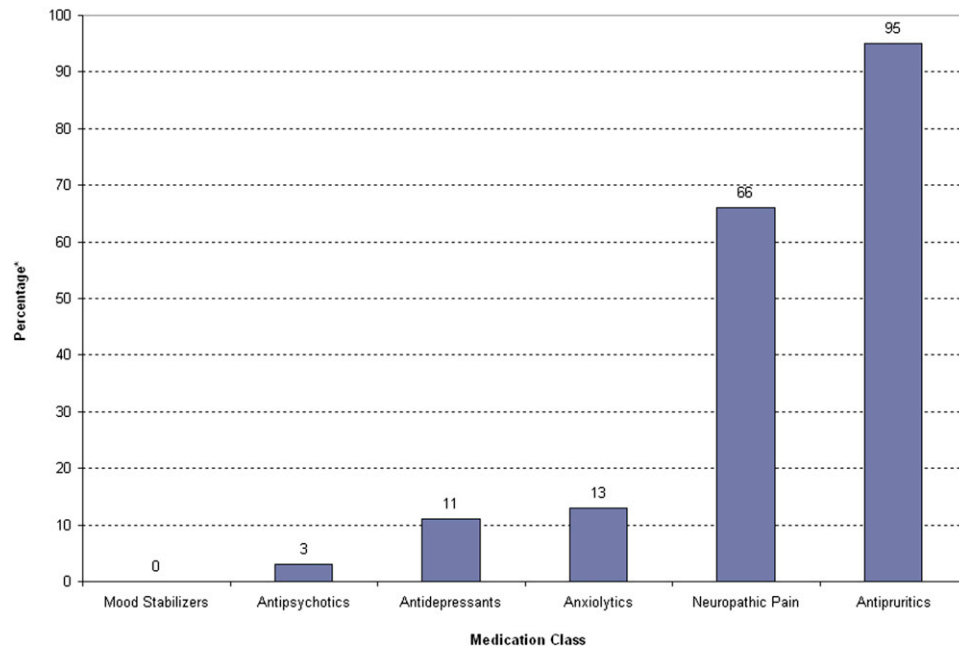


Fig 2. Percent of respondents who report comfort starting psychotropics. *None of these respondents were extremely comfortable starting mood stabilizers and antipsychotics.

Studies have shown that both psychotropics (especially gabapentin) and psychotherapy can be effective.¹⁷⁻¹⁹ Lastly, gabapentin has been recently endorsed by the dermatology community as an effective adjunctive therapy for the prevention and treatment of postherpetic neuralgia.²⁰ Green and Stratman²¹ acknowledge that dermatologists' lack of understanding and use of gabapentin in the setting of postherpetic neuralgia is a practice gap and urge them to learn effective and safe dosing of the medication to prevent this condition.

Adequate treatment of psychodermatologic conditions and psychiatric comorbidity in general dermatology conditions requires that dermatologists either become familiar with the relevant psychopharmacology or improve rates of referral. Our study showed that referral was rare, in part because of being unaware of referral options. As an example, our hospital is fortunate to have a specialized psychiatric center that specifically treats patients with OCD and OCD-spectrum behaviors including compulsive skin picking, TTM, and BDD, yet 63% of respondents were unaware of these facilities. An alternative approach to referral would be the creation of multidisciplinary clinics with psychiatrists and dermatologists jointly treating patients in a dermatology setting. Although a handful of such clinics do exist, logistical and financial requirements prevent widespread establishment.

With the expansion of psychiatric principles into dermatologic practice, it is important that

dermatologists believe they are equipped to encounter the challenges of this intersection. Our survey suggests that they currently do not. For example, pimozide was the most frequent antipsychotic prescribed by our dermatologists, over 20 years after the emergence of effective atypical antipsychotics such as risperidone that have a more acceptable safety profile. In addition to the creation of multidisciplinary clinics, another, but more practical, solution would be the introduction of didactics for dermatologists at all levels of training that target relevant psychopharmacology, referral strategies, and brief diagnostic review. In 2007, Poot et al²² devised a skill set that a well-informed dermatologist must acquire to effectively and competently treat psychodermatology patients: the ability to prescribe psychotropics, the possession of relational skills with difficult patients, the ability to recognize when patients might benefit from psychotherapy, and the identification of patients with factitious disorders.

Although that article highlights an ideal end point for dermatologists, current psychodermatology trends and our survey data suggest that some deficient areas of knowledge need prompt attention. We suggest that areas to prioritize should be diagnosis of depression, safe prescription of antidepressants, and awareness of site-specific referral options. Such topics could be addressed in 1 to 3 lectures or potentially through Continuing Medical Education activities. Additional areas for training might include brief review of other commonly encountered

psychiatric diagnoses such as delusions of parasitosis and BDD, strategies for building a therapeutic alliance with the psychodermatology patient, when and how to most effectively involve the psychiatrist, and the safe prescribing of antipsychotics. We predict that these didactics, although relatively undemanding, will greatly improve the care of patients with psychocutaneous disorders.

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