Practical Psychodermatology
For Arnold S. Coren (1922–1997) – for showing me the joy of medicine from the perspective of a patient. His memory continues to guide me.

J.S.R.


M.M.


A.P.B.

For my parents Alec and Elizabeth Taylor, husband Nicholas Moran, and children Hannah, Austin, and Mehetabel, with thanks for their love and support.

R.E.T
Practical Psychodermatology

Anthony Bewley  BA (Hons), MBChB, FRCP
Consultant Dermatologist
The Royal London Hospital & Whipps Cross University Hospital
Barts Health NHS Trust
London, UK

Ruth E. Taylor  BSc (Hons Psychology), MBChB, MRCPsych, MSc (Psych), MSc (Epid), PhD
Senior Lecturer and Honorary Consultant in Liaison Psychiatry
Centre for Psychiatry, Wolfson Institute of Preventive Medicine
Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK

Jason S. Reichenberg  MD, FAAD
Associate Professor, Department of Dermatology
University of Texas Southwestern
Clinical Assistant Professor
University of Texas Medical Branch
Clinical Director for Dermatology
University Medical Center Brackenridge
Austin, TX, USA

Michelle Magid  MD
Clinical Associate Professor, Department of Psychiatry
University of Texas Southwestern
Clinical Assistant Professor, University of Texas Medical Branch
Clinical Assistant Professor, Texas A&M Health Science Center
Austin, TX, USA
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Contributors

Jonathan S. Abramowitz PhD
Professor of Psychology
Department of Psychology
University of North Carolina at Chapel Hill
Chapel Hill, NC, USA

Andrew G. Affleck BSc (Hons), MBChB, MRCP (UK)
Consultant Dermatologist, Dermatological Surgeon and Honorary Senior Clinical Teacher
Ninewells Hospital and Medical School
Dundee, UK

Christine S. Ahn BA
Dermatology Research Assistant
Center for Dermatology Research
Department of Dermatology
Wake Forest School of Medicine
Winston-Salem, NC, USA

Emma Baldock PhD, DClinPsy, PGDipCBT
Clinical Psychologist & Academic Tutor
Institute of Psychiatry, King’s College London and the South London & Maudsley NHS Foundation Trust
London, UK

Susan Bradbrooke
Skin Camouflage Practitioner
Changing Faces
The Squire Centre
London, UK

Christopher Bridgett MA (Oxon), BM BCh, FRCPsych
Consultant Psychiatrist
Chelsea & Westminster Hospital
Honorary Clinical Lecturer
Imperial College London
London, UK

Alison Bruce MBChB
Consultant Dermatologist and Associate Professor of Dermatology
Mayo Clinic
Rochester, MN, USA

Christine Bundy PhD, AFBPsS, CPsychol, HCPC registered practitioner
Senior Lecturer in Behavioural Medicine
Centre for Dermatology Research
Institute of Inflammation and Repair
University of Manchester and Manchester Academic Health Sciences Centre
Manchester, UK

Anna Burnside MBChB, MRCpsych, MA
Consultant, Liaison Psychiatry Service
West London Mental Health NHS Trust
London, UK

Maureen Burrows MD, MPH
Forensic Psychiatrist
Central Texas Forensic Psychiatry Consultation Service
Austin, TX, USA

Lis Cordingley PhD, AFBPsS, CPsychol, HCPC registered practitioner
Senior Lecturer in Health Psychology
Centre for Dermatology Research
Institute of Inflammation and Repair
University of Manchester and Manchester Academic Health Sciences Centre
Manchester, UK

Fiona Cowdell RN, DProf
Senior Research Fellow
Faculty of Health and Social Care
University of Hull, Hull, UK
Mark D.P. Davis MD  
Professor of Dermatology  
Chair, Division of Clinical Dermatology  
Department of Dermatology  
Mayo Clinic  
Rochester, MN, USA

Wendy Eastwood  
Changing Faces Practitioner  
Changing Faces  
The Squire Centre  
London, UK

Libby Edwards MD  
Chief of Dermatology  
Carolinas Medical Center  
Charlotte, NC, USA

Steven Ersser RGN, PhD  
Professor of Nursing and Dermatology Care and Dean, Faculty of Health and Social Care  
University of Hull, Hull, UK

Paul Farrant BSc, MBBS, FRCP  
Consultant Dermatologist  
Brighton and Sussex University Hospitals (BSUH) Trust  
Brighton, UK

Steven R. Feldman MD, PhD  
Professor of Dermatology, Pathology & Public Health Sciences  
Wake Forest School of Medicine  
Winston-Salem, NC, USA

Roland Freudenmann PD Dr med  
Associate Professor of Psychiatry  
Department of Psychiatry  
University of Ulm  
Ulm, Germany

Tania M. Gonzalez Santiago MD, DTM&H  
Dermatology Resident  
Department of Dermatology  
Mayo Clinic  
Rochester, MN, USA

Chris Griffiths MD, FRCP, FMedSci  
Professor of Dermatology, Centre for Dermatology Research  
Institute of Inflammation and Repair  
University of Manchester and Salford Royal NHS Foundation Trust  
Manchester Academic Health Science Centre  
Manchester, UK

Lesley Howells BA (Hons), MAppSci (Psychological Medicine)  
Maggie’s Consultant Clinical Psychologist and Research Lead (UK)  
Maggie’s Centre  
Ninewells Hospital  
Dundee, UK

Markus Huber MD  
Specialist in Psychiatry, Consultant Psychiatrist and Assistant Medical Director  
Department of Psychiatry  
General Hospital Bruneck  
South Tyrol, Italy

Sara A. Hylwa MD  
Dermatology Resident  
Department of Dermatology  
University of Minnesota  
Minneapolis, MN, USA

Ryan J. Jacoby MA  
Graduate Student  
Department of Psychology  
University of North Carolina at Chapel Hill  
Chapel Hill, NC, USA

Simon Kirwin BEng (Hons), MSc(Eng), MBChB, MRCPsych  
Speciality Registrar in Liaison Psychiatry  
East London NHS Foundation Trust  
London, UK

Sussann Kotara MD  
Psychosomatic Medicine Fellow  
Department of Psychiatry  
University of Texas Southwestern  
Austin, TX, USA
**Tillmann H.C. Kruger MD**  
Consultant Psychiatrist and Associate Professor  
Department of Psychiatry, Social Psychiatry and Psychotherapy  
Center of Mental Health, Hannover Medical School (MHH)  
Hannover, Germany

**Peter Lepping MRCPsych, MSc**  
Honorary Professor  
School of Social Sciences and Centre for Mental Health and Society  
Bangor University  
Consultant Psychiatrist and Associate Medical Director  
BCULHB, North Wales, UK

**Peter J. Lynch MD**  
Professor Emeritus of Dermatology  
UC Davis Medical Center  
Sacramento, CA, USA

**Osman Malik MBBS, MRCPsych**  
Consultant Child and Adolescent Psychiatrist  
Newham Child and Family Consultation Service  
London, UK

**Sue McHale**  
Senior Lecturer in Psychology  
Department of Psychology, Sociology and Politics  
Sheffield Hallam University  
Sheffield, UK

**Jonathan Millard BSc(Hons), MMedSc, MBChB, MRCPsych**  
Consultant Psychiatrist  
South West Yorkshire Partnerships Foundation Trust, UK

**Leslie Millard MBChB, MD, FRCP(Lond), FRCP(Edin)**  
Consultant Dermatologist  
Hathersage, Derbyshire, UK

**Audrey Ng MBChB, MRCPsych, MA**  
Consultant Liaison Psychiatrist  
West London Mental Health NHS Trust  
London, UK

**Mark R. Pittelkow MD**  
Professor of Dermatology  
Department of Dermatology and Biochemistry and Molecular Biology  
Mayo Clinic  
Rochester, MN, USA

**Steven Reid MBBS, PhD, MRCPsych**  
Clinical Director, Psychological Medicine  
Central and North West London (CNWL) NHS Foundation Trust  
St Mary’s Hospital  
London, UK

**William H. Reid MD, MPH, FACP, FRCP (Edin)**  
Clinical and Forensic Psychiatrist  
Horseshoe Bay, TX  
Clinical Professor, Texas Tech University Medical Center, Lubbock  
Adjunct Professor, University of Texas Medical Center, San Antonio  
Adjunct Professor, Texas Tech College of Medicine  
University of Texas Southwestern Medical School  
Austin, TX, USA

**Angharad Ruttley MBBS, MRCPsych, LLM**  
Consultant Liaison Psychiatrist  
Imperial College Healthcare NHS Trust and West London Mental Health NHS Trust  
London, UK

**Laura F. Sandoval DO**  
Clinical Research Fellow  
Center for Dermatology Research  
Department of Dermatology  
Wake Forest School of Medicine  
Winston-Salem, NC, USA

**Krysia Saul**  
User  
Changing Faces  
The Squire Centre  
London, UK

**Reena B. Shah BSc (Hons), MSc, DClin Psych, CPsychol**  
Chartered Clinical Psychologist  
Department of Dermatology  
Whipps Cross University Hospital  
London, UK
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Institution</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henrietta Spalding</td>
<td>Head of Advocacy</td>
<td>Changing Faces</td>
<td>London, UK</td>
</tr>
<tr>
<td>Wei Sheng Tan MBBS</td>
<td>Senior Resident</td>
<td>National Skin Centre</td>
<td>Singapore</td>
</tr>
<tr>
<td>Mark B.Y. Tang MBBS (Sing)</td>
<td>Senior Consultant Dermatologist and Director of Research</td>
<td>National Skin Centre</td>
<td>Singapore</td>
</tr>
<tr>
<td>Hong Liang Tey MBBS(S’pore), MRCP(UK), FAMS</td>
<td>Consultant Dermatologist</td>
<td>National Skin Centre</td>
<td>Singapore</td>
</tr>
<tr>
<td>Andrew R. Thompson BA, DClinPsy, Dip. Prac. Cognitive Analytic Therapy, C Psychol., AFBPs</td>
<td>Reader in Clinical Psychology &amp; Practising Clinical Health Psychologist</td>
<td>University of Sheffield</td>
<td>Sheffield, UK</td>
</tr>
<tr>
<td>Rochelle R. Torgerson MD, PhD</td>
<td>Assistant Professor of Dermatology</td>
<td>Department of Dermatology</td>
<td>Rochester, MN, USA</td>
</tr>
<tr>
<td>David Veale FRCPsych, MD, BSc, MPhil</td>
<td>Visiting Senior Lecturer</td>
<td>Institute of Psychiatry, King’s College London</td>
<td>London, UK</td>
</tr>
<tr>
<td>Alexander Verner BSc (Hons), MSc (Dist), MMBCh (Hons), MRCPsych</td>
<td>Consultant in General Adult and Addictions Psychiatry</td>
<td>Tower Hamlets Specialist Addictions Service (SAU)</td>
<td>East London Foundation NHS Trust</td>
</tr>
<tr>
<td>Birgit Westphal MD, MRCPsych</td>
<td>Consultant Child and Adolescent Psychiatrist</td>
<td>Paediatric Liaison Team, Barts and The London Children’s Hospital</td>
<td>Royal London Hospital</td>
</tr>
<tr>
<td>Wojtek Wojcik MD</td>
<td>Consultant Psychiatrist</td>
<td>Royal Edinburgh Hospital</td>
<td>Edinburgh, UK</td>
</tr>
<tr>
<td>M. Axel Wollmer MD</td>
<td>Head of Department, Asklepios Clinic North</td>
<td>Head of Department, Asklepios Clinic North</td>
<td>Hamburg, Germany</td>
</tr>
<tr>
<td>Cooper C. Wriston MD</td>
<td>Dermatologist</td>
<td>Department of Dermatology</td>
<td>Rochester, MN, USA</td>
</tr>
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From the US

“The dermatologist treats the disease; the psychodermatologist treats the patient who has the disease.”

This new book on psychodermatology is extremely comprehensive. The content ranges from psychopharmacology to non-pharmacological approaches such as habit reversal therapy. It covers all age groups from pediatric to the elderly and is applicable to all providers including the nursing staff. This book is indeed a valuable addition to our specialty.

Psychodermatology is much more than delusions of parasitosis. Whereas dermatology has a tendency to focus more on minute details, psychodermatology encourages appreciating the patient as a whole. In fact, in the United States, a new book updating the entire field of psychodermatology is very timely. We are experiencing a radical change in reimbursement rates for physicians, whereby reimbursement becomes contingent on patient satisfaction. This new policy, “value based payment,” increases or decreases compensation based on patient satisfaction as assessed by the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey mandated by many insurance payers including the US government. As electronic consumer ratings become more prominent, physicians will be publicly rated, similar to how restaurants are rated on the website. Yelp! The reality that reimbursement rates are becoming contingent on how the dermatologist relates to and is perceived by his/her patient must be faced. Because this is a very subjective variable, it behooves all physicians to be familiar with psychodermatological aspects of their practice.

In short, psychodermatology is a subject matter most worthwhile learning about because of its relevance in our day-to-day practice. It is vital to investigate and appreciate aspects of our patients that are not visible, such as the intensity of emotional stress involved, the presence of depression, or the degree of support a patient needs to be adherent with his/her treatment regimen. As healthcare evolves, psychodermatology expertise will be of growing importance to the way we practice, above and beyond how to deal with a delusional patient.

John Koo
San Francisco, California
December 2013

From the UK

In the early 1970s at Addenbrooke’s Hospital, Cambridge, we were fortunate enough to follow each other in the post of Senior House Officer in Psychiatry and Dermatology. The link between the two departments was part architectural, part financial: the Psychiatric Ward was next to the Dermatology Ward, and each service could only afford half a junior doctor. Arthur Rook was one of the dermatologists.

He drew the attention of one of us [CB] to the book Psychocutaneous Medicine by the American dermatologist Maximilian Obermayer. Arthur Rook suggested that this important book was to many UK dermatologists incomprehensible and off-putting. What was needed was an
accessible and practically based volume that covered the important and fascinating clinical interface between psychiatry and dermatology.

After Addenbrooke’s the two of us went our different ways, one to be a dermatologist, the other a psychiatrist, but 10 years later we found ourselves again working in the same hospital service in London. We decided to start a Psychodermatology Clinic together at the Daniel Turner Clinic, Westminster Hospital. Later at Chelsea & Westminster Hospital, we were fortunate to have working with us an energetic trainee dermatologist, Anthony Bewley.

In 2003 we inaugurated an annual meeting at the Medical Society of London for UK clinicians interested in psychodermatology. After 5 years we were delighted when Tony Bewley and Ruth Taylor agreed to continue to organize this regular event. We now have the pleasure of writing this foreword to a book that we know will provide the resource that Arthur Rook saw the need for 40 years ago.

The editors have here brought together an important spectrum of topics, with authors from a range of disciplines, and many parts of the world. But most important is the attractive layout and practical, hands-on design of the book. Here psychodermatology is no longer an obscure and esoteric subspeciality. This book clearly demonstrates psychodermatology has come of age. It is on the curriculum. Now it is important that patients everywhere with skin complaints can benefit from the important holistic approach that psychodermatology represents.

Christopher Bridgett and Richard Staughton
London
December 2013
Preface

Psychodermatology is an emerging subspecialty of dermatology. It encompasses the management of patients with primary psychiatric disease presenting to dermatologists (e.g. delusional infestation, body dysmorphic disease and factitious diseases), together with patients who have primary dermatological disease (e.g. psoriasis, atopic eczema, hair disorders and others) where there is a large psychiatric or psychological co-morbidity.

There are a number of psychodermatology clinics starting out globally, and there has been provenance in the pioneering of psychodermatology by illustrious dermatological colleagues such as Dr John Koo from the US and Drs Richard Staughton, John Cotterell, Les Millard and John Wilkinson from the UK. But psychodermatology requires the input of a multidisciplinary team. In the UK, Dr Chris Bridgett, a consultant psychiatrist, helped found psychodermatology services. In mainland Europe, colleagues such as Dr John de Korte (The Netherlands), Françoise Poot (Belgium), Dennis Linder (Italy), Klaus-Michael Taube (Germany), Sylvie Consoli (France), Uwe Gieler (Germany), Gregor Jemec (Denmark), Andrey Lvov (Russia), Jacek Szepietowski (Poland) and Lucía Tomás (Spain) have provided inspiration and leadership in the field of psychodermatology for many years.

In Practical Psychodermatology two dermatologists (Drs Anthony Bewley and Jason Reichenberg) have combined forces with two psychiatrists (Drs Michelle Magid and Ruth Taylor) to edit a practical guide to the management of psychodermatological conditions. We aimed to emphasize the practicality of this book. Often, colleagues ask us “How do you manage a patient with delusional infestation?” or “What’s the best way to engage a patient with dermatitis artefacta?” and so we wanted to produce a practical, hands-on approach to the management of patients with psychocutaneous disease. We are mindful that the management of patients with psychodermatological disease requires the input of a wide multidisciplinary team including dermatologists, psychiatrists, psychologists, primary care physicians, nurses, paediatricians, pain specialists and a whole range of other healthcare professionals HCPs. We have tried to include authorship of as wide a range of HCPs as possible, and we hope that Practical Psychodermatology will appeal to all those who are involved in the care and support of individuals with psychocutaneous disease. We have also tried to encompass the views of individuals who live with psychocutaneous disease, and we have specifically asked patient advocate groups such as Changing Faces to contribute to Practical Psychodermatology.

In doing so, we aim to guide HCPs to useful resources that can be accessed either online or via other means of contact.

Just a note about the use of English in this book. We have kept the written English consistent with the author’s origin, so where American English is used we have kept it as such and similarly for British English.

Finally we intend that Practical Psychodermatology is a text that trainees in dermatology, psychiatry, psychology, medicine, nursing and other HCP training programmes will find useful in their studies and clinical preparations. We are aware that colleagues are beginning to set up psychodermatology clinics across the globe and we hope that this practical guide will provide a helpful reference clinically and a source from which colleagues can access further research.

Anthony Bewley, July 2013
Over the past several months, as I began to review each of the submitted chapters for this textbook, I was struck by clear differences in the chapters written by authors from different countries. I was not surprised by variations in language or patient demographics, but instead by the large differences between the authors’ concept of what it meant to offer a “practical” approach to patient care.

The chapters written by authors from the US are focused, precise guides to medication management, psychiatric care, or therapeutic techniques, varying by the disease type discussed. I found them very useful in my day-to-day practice and in teaching students who are new to psychodermatology. Just what I needed! The chapters written by authors from the UK, however, were not what I expected. They focused on patient resources, family education, and spoke about multidisciplinary care.

It was clear the authors had many years’ experience in working on healthcare “teams” and shared a common vocabulary of acronyms such as “CPA” and “NICE.” This information has helped me to greatly improve collaboration and patient care in my practice. Before I read these chapters, I did not know what I was missing.

In the UK, it is clear that the practitioners have spent their careers working within a system where patient-centered, evidence-based medicine was expected. In the US, there has been a recent shift toward coordination of care and quality of life measures, but these ideas have not been in play for very long. I hope that readers from outside of the UK (myself included) will take a cue from these authors and utilize all the “practical” approaches in this book.

Jason Reichenberg, July 2013
SECTION 1
Introduction
CHAPTER 1

Introduction

Anthony Bewley,1 Michelle Magid,2 Jason S. Reichenberg3 and Ruth E. Taylor4

1 The Royal London Hospital & Whips Cross University Hospital, Barts Health NHS Trust, London, UK
2 Department of Psychiatry, University of Texas Southwestern, Austin, TX, USA
3 Department of Dermatology, University of Texas Southwestern, Austin, TX, USA
4 Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK

Psychodermatology: interfaces, definitions, morbidity and mortality

Psychodermatology or psychocutaneous medicine refers to the interface between psychiatry, psychology and dermatology. It involves the complex interaction of the brain, cutaneous nerves, cutaneous immune system and skin. Psychocutaneous conditions can be divided into three main categories, as illustrated in Figure 1.1.

Most patients attending psychodermatology clinics have either a primarily dermatological disease with secondary psychosocial co-morbidities or a primarily psychiatric disorder with a significant cutaneous symptomatology (Table 1.1). Clinical research has shown that there is an increasing burden of psychological distress and psychiatric disorder amongst dermatology patients [1]. In addition, stress is frequently reported as a precipitant or exacerbating factor of skin disease and is a major factor in the outcome of treatment [2]. Skin conditions may have a detrimental effect on most aspects of an individual’s life, including relationships, work and social functioning. A national survey undertaken by the British Association of Dermatologists (BAD) in 2011 [3] to assess the availability of psychodermatology services, revealed poor provision despite dermatologists reporting:

- 17% of dermatology patients need psychological support to help them with the psychological distress secondary to a skin condition;
- 14% of dermatology patients have a psychological condition that exacerbates their skin disease;
- 8% of dermatology patients present with worsening psychiatric problems due to concomitant skin disorders;
- 3% of dermatology patients have a primary psychiatric disorder;
- 85% of patients have indicated that the psychosocial aspects of their skin disease are a major component of their illness;
- patients with psychocutaneous disease have a significant mortality from suicide and other causes.

These findings are not unusual and are mirrored throughout Europe, North America and globally.

The psychodermatology multidisciplinary team

Though patients often present to dermatologists, dermatologists are not usually able, in isolation, to manage patients with psychocutaneous disease. For these patients, there is increasing evidence that a psychodermatology
multidisciplinary team (pMDT) can improve outcomes [4]. Specialists who make up a pMDT require dedicated training in the management of patients with psychocutaneous disease, though such training is difficult to obtain (Box 1.1). This book, then, is aimed at being a practical, hands-on guide to the management of psychodermatological diseases by all healthcare professionals. We are not saying that each patient with a psychocutaneous problem needs to be reviewed by a pMDT as that would be impractical and probably unnecessary. We are saying that for some

Figure 1.1 Psychodermatology interfaces (courtesy of Trevor Romain).

Table 1.1 Psychocutaneous disease

<table>
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<tr>
<th>Primary dermatological disorders caused by or associated with psychiatric co-morbidity (Figure 1.2)</th>
<th>Primary psychiatric disorders that present with skin disease (Figure 1.3)</th>
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<tr>
<td>Psoriasis, eczema, alopecia areata, acne, rosacea, urticaria, vitiligo</td>
<td>Delusional infestation</td>
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<td>Visible differences (disfigurements)</td>
<td>Body dysmorphic disorder</td>
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<td>Inherited skin conditions (e.g. ichthyosis)</td>
<td>Dermatitis artefacta</td>
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<td>May be caused, exacerbated by or associated with: Depression, anxiety, body image disorder, social anxiety, suicidal ideation, somatization, psychosexual dysfunction, schema, alexithymia, changes in brain functioning</td>
<td>Obsessive-compulsive disorders</td>
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<td>Trichotillomania</td>
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