Psychodermatology can be broadly defined as anything that lies between the fields of psychiatry and dermatology. Psychodermatological problems are frequently encountered in dermatological clinical practice. They range from patients with real skin disorders such as psoriasis or eczema who experience exacerbation of their skin disease in response to emotional stress to those with no real skin disorders but with serious underlying psychopathology who self-induce their own skin conditions, such as trichotillomania, delusions of parasitosis or neurotic excoriations. Since skin disease is visible, disfigurement resulting from skin conditions can also have significant psychological impact resulting in various psychological morbidity such as anxiety, depression and social phobia. Moreover, there are also some patients who only present with cutaneous sensory complaints such as burning, stinging, or itching without any visible skin lesions. Lastly, in some selected dermatological conditions such as post-herpetic neuralgia or chronic urticaria, psychopharmacological medications such as Doxepin may turn out to work better that the usual antihistamines that dermatologists use.

Classification. Because of the varied presentations of psychodermatological problems, it is useful for the clinician to classify them into different categories so that one can better formulate an approach to the patient and, if applicable, select appropriate psychopharmacological agents which may be of benefit. There are two broad ways to categorize psychodermatological disorders. First, they can be categorized by the broad category of psychodermatological conditions involved. Secondly, the disorders can be categorized by the underlying nature of the psychotherapy.

Types of psychodermatological conditions. Most psychodermatological conditions can be categorized into the following five categories:

1. Psychophysiological Conditions. These are real skin conditions with demonstrable physical pathologies which can be exacerbated by emotional factors such as stress. 2. Primary Psychiatric Disorders. These are patients with no real skin disorders. All of the skin manifestations observed are self-inflicted. These include conditions such as delusions of parasitosis, trichotillomania, neurotic excoriations etc. 3. Secondary Psychiatric Disorders. These are patients who develop emotional problems secondary to disfigurement associated with real skin disorders. 4. Cutaneous Sensory Disorder. These are patients who only present with sensory complaints without visible rash or diagnosable underlying medical condition, such as uremic pruritus, to account for their sensory complaint. 5. The Use of Psychopharmacological Agents to Treat Real Skin Disease. This is when psychiatric medications have more efficacy in treating real skin conditions than the usual dermatological therapies. Examples include the use of Doxepin, an antidepressant, for the control of pruritus or urticaria. The use of amitriptyline, and antidepressant, for the treatment of post-hepatic neuralgia.

It is useful to distinguish these broad categories of psychodermatological cases so that one has a better idea of the therapeutic strategies that are available. For example, if the patient has a psychophysiological disorder, frequently, the efficacy of the usual dermatological remedies can be enhanced by addressing the psychological factors either pharmacologically or non-pharmacologically (such as relaxation techniques, meditation, yoga etc.) The decision regarding the aggressiveness of the treatment option chosen may hinge upon the intensity of the secondary psychiatric problem induced by the skin disease. For example, the decision to treat a patient with isotretinoin (Accutane)
rather than antibiotics may be reached due to the intense psychological distress that the patient feels with regard to his or her acne. To properly manage patients with primary psychiatric disorder, ascertaining the nature of the underlying psychopathology is critical. The patients with chronic cutaneous sensory disorders frequently respond to management strategies modeled after the management of chronic pain syndrome in other specialties. Therefore, the broad approach to the problem at hand frequently depends upon the type of psychodermatological condition involved.

The nature of the underlying psychopathology. The second way to classify psychodermatological cases is by the nature of the underlying psychopathology involved. This is most critical when dealing with patients with primary psychiatric disorders. On the other hand, this is almost irrelevant when dealing with patients in the last category, which are patients who are treated with psychiatric medications for real skin disorders just because psychiatric medications work better that the usual dermatological remedies. In these cases, no psychopathology is implicated.

Even though the Diagnostic and Statistical Manual, 4th Edition, contains numerous psychiatric diagnoses ranging from borderline personality disorder to hyperactive child syndrome, in the practice of dermatology, the types of psychodermatological conditions that are so blatantly psychiatric that dermatologists have no difficulty recognizing these cases as "psychodermatologic" generally involve four types of psychopathology. These are anxiety, depression, psychosis and obsessive-compulsive disorder. If the dermatologist can recognize the distinction between these four types, it will not only enhance the capacity of the dermatologist to effectively deal with these patients by being able to select the proper approach to the patient, but also the ability to make such a distinction will guide the dermatologist in the proper use of psychopharmacologic agents. Needless to say, if the underlying psychopathology is anxiety, anti-anxiety agents should be tried first rather than antipsychotics or antidepressants. However, if the underlying psychopathology is depression, antidepressants are indicated. If delusion is involved (i.e. the patient is psychotic), antipsychotic agents are called for. Lastly, if obsessive-compulsive is the main pathology, antipsychotic-compulsive agents such as fluoxetine (Prozac), clomipramine (Anafranil), or fluvoxamine (Luvox) should be used.

Psychophysiological disorders. With regard to non-pharmacological approaches to stress, a referral to a counselor for possible solutions may be helpful. However, if no real-life solution exists for the patient's stress, a non-pharmacologic, non-specific approach to reducing stress such as exercise, meditation, biofeedback, hypnosis and other popular techniques of stress management can be effective. However, the patient's responsiveness to these techniques vary. Therefore, it is important to encourage the patient to find a particular technique that works for him/her.

Even though conditions such as eczema, psoriasis, urticaria, etc. are frequently noted to be exacerbated by emotional stress, not every patient reports this association. The antianxiety medications are available in two types, mainly the benzodiazepines that are neither sedating nor addictive but which are much slower in their onset of action. A prototypical quick-acting benzodiazepine which is widely used in the U.S. is alprazolam (Xanax). These agents are most effective and appropriate for short-term anxiety, such as situational stress. If the anxiety is chronic, buspirone (BuSpar) is more appropriate. However, BuSpar cannot be prescribed on an as-needed basis; it has to be taken regularly in order to manifest therapeutic benefit. The onset of action can be delayed anywhere from two to four weeks.

In short, for patients who are "stress-responders" with respect to their real skin disease, a combined approach of aggressive dermatological therapy and an effective approach to the management of emotional stress may provide the optimal solution for the patient.

Primary psychiatric disorder. Neurotic excoriations. Neurotic excoriations can be broadly defined as the use of a patient's fingernails to create skin lesions though scratching, picking, rubbing, etc. This is in contrast to patients with factitial dermatitis, where they actually use something other than their fingernails to self-induce a skin lesion, such as a knife, cigarette butt, caustic chemical etc. Even though the term neurotic excoriations has the word "neurotic" in it, this is essentially a dermatological term with no psychiatric implication. The clinician still has to determine whether the excoriation results from anxiety, depression, obsessive-compulsive disorder or some other underlying psychopathology before one can effectively initiate psychological intervention. Doxepin (Sinequan) is an antidepressant with very powerful antipruritic effects due to its powerful histaminic property. If the patient can tolerate its sedative side effects, it is often used as a first-line treatment for anxious or depressed patients with neurotic excoriations.

Delusions of parasitosis. The treatment of choice for delusions of parasitosis is the antipsychotic medication pimozide (Orap). By definition, delusional patients cannot be talked out of their delusion. However, some patients who present with a complaint of infestation without physical evidence of infestation are not necessarily delusional; some may only have formication (i.e., crawling and biting sensations). Pimozide also works for patients with only formication but without ideation of infestation. If a patient is truly delusional, one has to be very

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patient and diplomatic, as well as pragmatic, in winning their confidence and their agreement to give pimozone a therapeutic trial.

**Trichotillomania.** Most patients with trichotillomania have an underlying psychopathology similar to that of obsessive-compulsive disorder. Consequently, many of them are successfully treated with antiobsessive-compulsive agents such as clomipramine, fluoxetine or fluvoxamine. Behavioural therapy can also be effective. There are some rare patients for whom the underlying psychopathology turns out to be something other than obsessive-compulsive disorder. For example, there is a rare condition called trichophobia where the patient pulls his or her hair out due to their delusional ideation with regard to their hair. If such is the case, an antipsychotic medication rather than and antiobsessive-compulsive medication may be indicated.

**Secondary psychiatric disorder.** The disfigurement of skin disease can result in significant psychological impact, whether the patient happens to be a teenager with bad acne or a dark-skinned patient with vitiligo. In the U.S., there are many patient support groups such as the National Psoriasis Foundation, the National Alopecia Areata Foundation, etc. to provide support for patients with those types of chronic skin disorders. However, if the psychopathology becomes intense enough, a referral to a mental health professional may be warranted.

**Cutaneous sensory syndrome.** If a patient presents with itching, burning, stinging or other sensations without visible rash or diagnosable underlying medical disorder, and if such a patient fails to respond to the usual dermatological remedies such as topical steroids, the patient may be suffering from neurologically mediated chronic cutaneous sensory disorder. For those patients, one possible solution is to use psychotropic medications such as analgesics, just the way patients with chronic pain syndrome in other specialties are empirically treated. The “older” tertiary antidepressants such as amitriptyline and doxepin have the most documentation regarding their efficacy as analgesics. If the primary complaint is pain, amitriptyline is used. If the primary complaint is pruritus, doxepin may be more effective. If the patient fails to respond to or cannot tolerate these “older” tricyclic antidepressants, a newer tricyclic antidepressant such as desipramine or imipramine may be tried. The last choice would be the “non-tricyclic” antidepressants such as fluvoxamine (Prozac). This is because there is the least amount of documentation scientifically regarding their efficacy as analgesics, despite the fact that there are case reports attesting to their positive therapeutic effects in some patients.

**The use of psychopharmacological medications to treat real skin disease.** The antidepressant doxepin (Sinequan) is known to be one of the most powerful antihistamines available orally. It has affinity for the histamine, receptor approximately 775 times that of diphenhydramine (Benadryl). Moreover, it has histamine, blocking effect, which may be needed in the treatment of some cases of chronic urticaria. Doxepin can also be a more effective antipuritic agent than the usual antihistamines. Because of this, doxepin is now available as a cream (Zonalon) in the U.S. Likewise, amitriptyline (Elavil) is the treatment of choice for post-hepatic neuralgia, once again because of its analgesic effect. Opiate antagonists such as naltrixone (Trexan) can also be effective in the treatment of some cases of chronic, idiopathic, intractable pruritus.

The use of psychiatric medications to treat skin disease is a field that is well-worth further investigation.

In conclusion, psychodermatological conditions are frequently encountered in dermatological practice. It is also a common experience in all corners of the world that many of these patients are resistant to being referred to a psychiatrist. In view of this, it is possible for dermatologists to treat these cases more effectively by learning some fundamentals of psychodermatologic diagnosis, differential diagnosis and the use of selected psychopharmacologic agents. Dermatology as a field has expanded its capability tremendously in the last few decades by incorporating the knowledge and therapeutic armamentaria of other specialties. For example, dermatologists today in the United States take it for granted that such endeavors as dermatological surgery, evaluation of allergies, management of pediatric patients, etc. rightly belong in the field of dermatology. There is no reason why psychiatric knowledge and therapeutic options cannot be incorporated into dermatological practice to make dermatologists more complete physicians in the care of skin disorders.

**Further reading**


