COMMENTARY

'Psychodermatology': The present standing and a path forward

Commentary on 'perceived stress in four inflammatory skin diseases: An analysis of data taken from 7273 adult subjects with acne, psoriasis, atopic dermatitis, or hidradenitis suppurativa' by Misery *et al*.

Psychocutaneous medicine, also known as psychodermatology, is a branch of psychiatry and dermatology that uses the biopsychosocial model for skin diseases. Unfortunately, psychodermatology is still not integrated into dermatology programmes. Without training, dermatologists are not well-equipped to identify mental illnesses manifesting in patients with skin problems, nor can they care for the mental disorders that skin diseases cause.[1] Surveys have shown that increasing the collaboration between dermatologists and psychologists/psychiatrists allows patients to return to fewer consultations and increases patient satisfaction overall.[2]

In a recently published article by Mostaghimi, L,[3] 808 cases seen at the University of Wisconsin (UW) weekly Psychocutaneous clinic were reviewed. Skin picking, intractable itch and delusional disorders were found to be the highest causes of referral from dermatologists. Upon meeting with a board-certified psychiatrist in the psychocutaneous clinic, the most common diagnoses were skin picking, followed by depressive disorders (in nearly 40% of patients) and anxiety disorders (in nearly 30% of patients). Major findings showed that while dermatologists were able to accurately identify skin picking disorder in their patients, they often missed depressive and anxiety disorders.

The nature of being a tertiary referral clinic may explain the high number of major mental health issues. Regardless, the lack of referrals for depressive and anxiety disorders is concerning. A formal psychiatric evaluation comes with proper treatment of the patients: an undeniable benefit.

Having a psychocutaneous clinic in a dermatology department presents multiple challenges. The most pressing challenges of integration include the cost of the programme, different expectations for dermatology *versus* psychiatry visits and the stigma of mental illness.

It may not be cost-effective for hospitals and outpatient clinics to hire a psychiatrist or therapist to be available for dermatology patients. At the same time, we cannot assign dermatologists the role of mental health providers. If having a psychocutaneous clinic is not possible, then collaboration between the two specialities is vital. There is an increase in healthcare spending by patients with untreated mood disorders; therefore, providing the correct diagnosis and treatment may save healthcare dollars.[4]

Another issue with integrating is the bias against mental illness. Patients in dermatology clinics are not usually looking for mental health advice or referral, and many get upset if the dermatologist proposes a mental health referral. Furthermore, physicians have their own biases about mental illness. In the UW Psychocutaneous Clinic, dermatology residents appreciated having the clinic to refer patients to, but many were unenthusiastic about training to treat these patients independently. This was associated with perceived irrelevance to their board examinations and disinterest in what they perceived as psychiatry rather than dermatology training.

Misery *et al* showed that 66.3% of patients with inflammatory skin disease (acne, atopic dermatitis, psoriasis or hidradenitis suppurativa (HS)) self-reported high levels of stress. Only 15% of these patients were offered psychological support. HS patients showed the highest impact on quality of life, and 74.1% of respondents had a DLQI score over 10. Interestingly, only in HS the severity of the disease did not translate to more severe perceived stress.[5]

Research has shown that physicians' attitude improves with increased exposure and education.[6]

Associations such as the American Association for Psychoneurocutaneous Medicine of North America (APMNA), the European Academy for Dermatology and Psychiatry (ESDaP) and the European Academy of Dermatology and Venereology (EADV) psychodermatology task force have been investing time and effort in advancing research, teaching and training in psychodermatology, but this is clearly not enough. Potential solutions include increasing psychodermatology training opportunities, adding more psychodermatology questions to the board examination and adding anti-stigma training to medical students' and residents' curricula. Furthermore, educating dermatologists in screenings and referrals is vital. Dermatology clinics could use screening questionnaires such as PHQ-2 (Patient Health Questionnaire-2) and GAD-7 (Generalized Anxiety Disorder-7) in all their patients to identify patients in need of mental health help.

The issue of overlooking mental illness in dermatology patients must be addressed. We know that 30% - 40% of dermatology patients suffer from psychological issues.[1] By investing in psychocutaneous teaching and research, hospitals can better equip their dermatologists to take care of both mind and body.

Funding sources
None.

Acknowledgement
Open access funding enabled and organized by ProjektDEAL.

Conflicts of interest
The authors did not have any potential conflict of interest during the time of initial conception and planning to present.

Data availability statement
The data that support the findings of this study are openly available in reference # 3 Mostaghimi and reference #5 Misery et al.

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Linked article: L. Misery *et al*. *J Eur Acad Dermatol Venereol* 2022; **36**: e623–e626. https://doi.org/10.1111/jdv.18016.

References
1 Roberts JE, Smith AM, Wilkerson AH *et al*. "Psychodermatology" knowledge, attitudes, and practice among health care professionals. *Arch Dermatol Res* 2020; **312**: 545–558.
2 Shah RB. Impact of collaboration between psychologists and dermatologists: UK hospital system example. *Int J Womens Dermatol* 2018; **4**: 8–11.
3 Mostaghimi L. Psychocutaneous Medicine Clinic; Wisconsin experience. *J Acad Consult Liaison Psychiatry 2021* 2021; **62**: 522–527.
4 Katzelnick DJ, Simon GE, Pearson SD *et al*. Randomized trial of a depression management program in high utilizers of medical care. *Arch Fam Med* 2000; **9**: 345–351.
5 Misery L, Chesnais M, Merhand S *et al*. Perceived stress in four inflammatory skin diseases: an analysis of data taken from 7273 adult subjects with acne, atopic dermatitis, psoriasis or hidradenitis suppurativa. *J Eur Acad Dermatol Venereol* 2022; **36**: e623–e626.
6 Sandhu HS, Arora A, Brasch J, Streiner DL. Mental health stigma: explicit and implicit attitudes of Canadian undergraduate students, medical school students, and psychiatrists. *Can J Psychiatry* 2019; **64**: 209–217.

DOI: 10.1111/jdv.18278