

Original Research Article

Psychodermatology Liaison Clinic at a Tertiary Care Centre in North India

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Abstract: Psychodermatology is a sub speciality in dermatology which deals with the interactions between the mind and the skin. Psychocutaneous diseases can be either primary psychiatric or primary cutaneous, with various degrees of associations between the psyche and the skin. The aim is to study the psychodermatology liaison clinic established at GGS Medical College, Faridkot, Punjab and study briefly the type of cases attended to Hospital. A total of 50 patients with primary psychocutaneous diseases recruited by the dermatologists were referred to liaison clinic consisting of psychiatrist and psychologist. In our study, neurotic excoriations were seen in 20 (40%) patients, trichotillomania in 13 (26%) patients, followed by delusional parasitosis in 12 (24%) patients, body dysmorphism in 1(2%) patients, obsessive compulsory disease in 3(6%) patients and dermatitis artefacta in 1(2%) patients. Unless the dermatologist cultivates a special interest in this field, many an invisible mental disorder may be missed leading to sub optimal treatment of the visible skin condition.

Keywords: Psychodermatology; clinic; liaison; dermatology; treatment; morbidity

INTRODUCTION

Psychodermatology is an emerging speciality of dermatology which studies the interactions between mind and skin [1, 2]. The dermatology psychiatry liaison clinic was originated in Europe and slowly spreading to the west. The basis of the psychocutaneous disorders is that the brain and skin have a common ectodermal origin. The bidirectional brain and skin influences are mediated by neurotransmitters, hormones and neuropeptides [3, 4]. Nearly 30% of dermatology patients have associated psychiatric comorbidity. Dermatologists should be aware of the various psych dermatological disorders and their treatment in association with psychiatric counseling can lead to a better response to treatment. There are two types of psychodermatoses:

- **Primary** – It includes dermatitis artefacta, delusions of parasitosis, body dysmorphism and trichotillomania.
- **Secondary** – It includes depression, anxiety, social phobia, psoriasis, and alopecia areata and acne vulgaris.

In the primary psychodermatosis, the diagnosis is usually straight forward while in the secondary group, with diseases like psoriasis and atopic dermatitis,

associated psychiatric co morbidity may be missed or overlooked [5].

AIMS AND OBJECTIVES

- To study the psychodermatology liaison clinic established at GGS Medical College, Faridkot, Punjab and study briefly the type of cases attended to.
- To discuss and advise psychopharmacological and psychological interventions.

MATERIAL AND METHODS

The period of study was from January to October 2013. A total of 50 patients with primary psychocutaneous diseases recruited by the dermatologists were referred to liaison clinic consisting of psychiatrist and psychologist. Both specialists discussed the case with the dermatologist and the standard dermatological treatment with or without psychopharmacologic agents and/or psychological interventions were advised. All the patients were followed up at regular intervals. Psychological interventions were carried out in the clinical psychology department.

RESULTS

The data was collected, tabulated and the results were analyzed statistically. Majority of the

patients were females (Male: Female ratio - 6.1:1). Commonest age group of patients was between 20 – 40 years of age.

Table 1: Table Showing Primary Psychiatry Diseases

SR NO	PRIMARY PSTCHIATRIC CASES	FEMALES	MALES	TOTAL
1	Neurotic excoriations	17	3	20 (40%)
2	Delusional parasitosis	8	4	12 (24%)
3	Trichotillomania	11	2	13 (26%)
4	Body dysmorphobia	1	0	1 (2%)
5	Obscensive compulsory disease (OCD)	3	0	3 (6%)
6	Dermatitis artefacta	1	0	1 (2%)

Table 2: Table Showing Psychological Techniques Taught

SR NO	PSYCHOLOGICAL TECHNOQUES TAUGHT	TOTAL
1	Habit awareness and reversal	7
2	Relaxation technique	3
3	Distraction technique	5
4	Cognitive behavioural therapy	15
5	Interpersonal therapy	8

DISCUSSION

The leading primary psychiatric disease was neurotic excoriations seen in 20 (40%) patients, trichotillomania (Fig 1) in 13 (26%) patients, followed by delusional parasitosis in 12 (24%) patients, body dysmorphobia in 1(2%) patients ,obscensive compulsory disease in 3(6%) patients and dermatitis artefacta (Fig 2) in 1(2%) patients. In neurotic excoriations, there were 10 patients of neurodermatitis, 5 patients of prurigo nodularis and 5 patients of acne excoriee. All the patients underwent psychological interventions and psychopharmacotherapy. The need for

a liaison psychodermatology clinic has been well established. The major advantage of a combined clinic is the prompt availabalist of a psychiatrist, dermatologist and a clinical psychologist at a single visit [6]. Quite often the patients express their displeasure whenever a psychiatric referral is made. Although, the stigma of visiting psychiatry department has lessened in recent times, but still it exists. By liasoning, the patient can be treated in a holistic fashion thereby addressing both the psychological and the physical needs [7].



Fig 1: Showing trichotillomania in a 21 years old female



Fig 2: Showing dermatitis artefacta in a 25 years old male



Fig 3: Showing acne excoriee in a 19 years old female

Amongst the primary psychodermatoses, delusion of parasitosis usually occurs in the middle aged or elderly persons. It is one of the commonest delusional disorders in which the patients develop a delusional belief that his/ her body is infested with parasites [8]. Some of the patients go to the extent of bringing the infected material in some box. In our study, there was a 18 years old male patient of post herpetic neuralgia, who pulled his hairs and was labelled as a case of pseudo trichotillomania. Family history of psychiatric disorders was present in one of

the family members. Dermatitis artefacta is a deliberate self inflicted injury on accessible sites including skin, especially face and hands being the commonest site [9, 10]. Its main purpose is to have some economic gain or sympathy. Neurotic excoriations occur more in females and in this there is an irresistible urge to scratch the skin with tissue damage [11, 12]. Psychosocial stress makes the patient pick his or her skin. Acne excoriee (Fig 3) which comes under neurotic excoriations was seen in 5 patients and it was seen that in our study that all the patients of acne excoriee were females having

underlying anxiety neurosis. In body dysmorphobia, there is a defect in which the person is excessively preoccupied with his or her appearance and repeatedly goes to doctors to find solution to their appearance and are usually unsatisfied [13, 14]. In our study we had a young beautiful girl with body dysmorphic disorder, who had a visible vein over the periorbital area and she confused it with bluish pigmentation. In trichotillomania, the patient has an impulsive desire to pull out his hairs. The patient has increased tension before pulling out his hairs and a sense of gratification after pulling out his hair [15, 16]. In acne excorée, the patients have only facial involvement and the majority of patients have no lesions at all [17].

In our study, initially the patients were noncompliant with the psychological interventions. Probably, they did not realize the benefit or were not keen on attending the clinical psychology department. The above study underscores the need for dermatologists to master selected psychological techniques which can easily be taught to patients in the OPD.

CONCLUSIONS

It is imperative to treat the invisible mental disease in addition to the visible skin disease which is impossible unless the dermatologist has a special interest in mental health. Therefore should liaise. Dermatologists should familiarize with the selected psychopharmacological drugs and simple nonpharmacology interventions. The patient should first be treated of the underlying condition by a dermatologist and then the patient can be referred to a psychiatrist after a rapport is build with the patient. This is because the patients are sometimes reluctant to go to the psychiatry OPD and in such cases; the dermatologist can go with the patient to the psychodermatology clinic and discuss the possible options along with the psychiatrist and a clinical psychologist. Screening for common psychiatric conditions such as anxiety and depression should be objectively done using standard questionnaires improving the quality of life is the ultimate aim of a psychodermatology liaison clinic.

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