How to improve the interface between dermatology and psychiatry: A review and commentary regarding the management of delusional patients

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ABSTRACT

Psychodermatological problems are prevalent in dermatology practices. Among those, delusional infestation (DI) is the subject of one of the most challenging patient encounters practicing dermatologists may experience. This article examines this problem and reviews suggestions made in the medical literature to try to improve this current unfortunate situation. A major challenge is that dermatology residency programs are unable to provide training in psychodermatology due to the lack of faculty available with such expertise. The authors conclude that this difficulty arises, at least partly, from the unavailability of psychiatric knowledge and skillset necessary to properly manage these patients. In further review of the medical literature, the authors confirmed that dermatologists, rather than psychiatrists, are often designated by DI patients to address their condition. Some authors suggest that managing patients in a dedicated psychodermatology clinic is the most cost-effective treatment method. However, the authors could confirm very few such multispecialty psychodermatology clinics in the US where the patient is seen simultaneously by both a dermatologist and mental health professional. Based on the results of this review, the authors offer alternative suggestions beyond the idea of organizing a multidisciplinary clinic.

OBJECTIVE

The objective of this study is to review suggestions for the management of delusional infestation in the medical literature and make informed suggestions that build upon prior research.

INTRODUCTION

Psychodermatological problems are prevalent in standard dermatology practices [1]. Even though psychodermatology is a broad field involving many different aspects, delusional infestation (DI) or Morgellons Disease is used in this discussion as a prototype because it is among the most challenging situations for dermatologists to manage. This poster is a review and an expert suggestion on improving the interface between dermatology and psychiatry, focused on the management of delusional patients because this is one area of significant unmet need within our specialty.

STUDY DESIGN

This review identified literature up until January 16, 2021, using the PubMed and Google Scholar databases. We used the following search strategy: *psychodermatology clinic OR psychodermatology practice OR psychocutaneous clinic OR psychiatry dermatology combined OR psychiatry dermatology clinic OR delusions of parasitosis OR delusional parasitosis OR delusional infestation OR Morgellons Disease OR delusions dermatology combined*. We primarily focused on English language literature in our search.

RESULTS

Through a review of the medical literature, we confirmed that dermatologists, rather than psychiatrists, are often designated by DI patients to address their condition [2]. Unfortunately, most dermatologists have substantial gaps in knowledge and training in managing these patients [3]. One obvious idea to remedy this is to make referrals to mental health professionals [4]. However**,** DI patients typically resist referral to any mental health professionals [5]. The literature also suggests that a solution to this dilemma is to organize psychodermatology clinics that involve psychiatrists and dermatologists [6]. Moreover, some authors suggest that managing patients in a dedicated psychodermatology clinic is the most cost-effective treatment method [7]. However, the authors could not confirm the existence in the US of even one such multispecialty psychodermatology clinic where the patient is seen simultaneously by both a dermatologist and mental health professional.

DISCUSSION

How can the care of DI patients be improved in practice? In the literature, a predominant suggestion is to organize an interdisciplinary psychodermatology clinic staffed by both dermatologists and psychiatrists [8]. There could be a clinic in the US where patients are seen together by a dermatologist and psychiatrist/psychologist, but the number of such clinics is likely to be extremely few. Although the concept of a psychodermatology clinic is logical, several clinical and logistical concerns may account for the scarcity of such clinics in the US. These concerns include the stigma associated with labeling the clinic as a “psychodermatology clinic” and the cost-effectiveness of running such a clinic.

Practical issues cast doubt on whether implementing such a clinic is a realistic solution in the US. More importantly, even if such multidisciplinary clinics exist, they are likely to be very few, limiting the reach of improving DI patient care nationwide.

An alternative to organizing a multidisciplinary clinic is to help individual dermatology providers manage these patients more effectively since they will likely encounter these patients in their own practice. However, with this option, there are also several problems to overcome.

PROBLEMS

1) How do we address the need to teach psychodermatological knowledge and skills in dermatology residencies?
2) How can we teach dermatologists to connect with delusional patients interpersonally?
3) How can dermatologists learn to be comfortable using selected psychopharmacological agents proven useful for DI patients?
4) How can we decrease the financial disincentive for dermatologists to manage these patients in their practice?
5) How can we overcome the aversion to treating psychodermatological concerns out of fear of conflict with DI patients*?*

SUGGESTIONS

1) Incorporate webinars with available psychodermatologists as a regular and periodic feature of residency lecture series in order to improve skills.
2) Without endorsing the patient's delusional ideation, the dermatologist may sympathetically validate the patient's suffering and possibly even use it to motivate the patient to focus on therapy rather than etiology.
3) Webinars may help dermatologist become more familiar with the medications useful for DI, such as pimozide, risperidone, and olanzapine. Utilize telemedicine when available.
4) Initiate a "temporizing strategy" by deliberately and intently listening to the patient's concerns for no more than five minutes and then offering the opportunity for the patient to return for a dedicated visit. Utilize the ability to charge for time spent.
5) Acknowledge that DI patients present as highly functioning members of society except for the "encapsulated" delusion and tactile hallucination compatible with the delusion.

CONCLUSION

In reviewing the literature, the suggestions for improving the dermatology and psychiatry interface, including DI patients, mainly involve organizing a multidisciplinary psychodermatology clinic. Theoretically, this is a logical solution. However, since no such clinic exists in the US, it raises the question of whether such an idea is practical and financially solvent in its application, especially in the US, where private fee-for-service models of care may complicate and disincentivize collaborative care by multiple specialists in a single office visit. While a multidisciplinary clinic is highly desirable, the authors find that a more realistic solution may involve empowering the "rank-and-file" dermatology practitioners to handle DI patients more effectively in their practice. Connecting with these patients is a prerequisite to having a positive route forward and avoiding malpractice or other problems.

Most importantly, the skill set needed to connect with DI patients can be taught to dermatology residents and practitioners. The key obstacle in residency education regarding psychodermatology is the dearth of psychodermatology experts, which can now be overcome by deliberately scheduling remote learning opportunities in dermatology residency programs. It is important to start a discussion about improving the interface between dermatology and psychiatry so our specialty can meaningfully address one of the greatest unmet needs in dermatology.

REFERENCES

1.Tracey EH. Challenges of treating primary psychiatric disease in dermatology. *Cutis*. 2019;104:E12-E14. [PMID: 31603969].
2. Laidler N. Delusions of parasitosis: a brief review of the literature and pathway for diagnosis and treatment. *Dermatol Online J*. 2018;24. [PMID: 29469757].
3. Roberts JE, Smith AM, Wilkerson AH, et al. "Psychodermatology" knowledge, attitudes, and practice among health care professionals. *Arch Dermatol Res*. 2020;312:545-558. [PMID: 32100098].
4. Tran A, Desir AK, Okafor LC, et al. Psychodermatology in clinical practice: an examination of physician attitudes, beliefs, and interventions toward psychocutaneous disease. *Dermatol Ther*. 2020;33:13612. [PMID: 32421212].
5. Jafferany M. Psychodermatology: a guide to understanding common psychocutaneous disorders. *Prim Care Companion J Clin Psychiatry*. 2007;9:203-13. [PMCID: PMC1911167].
6. Patel A, Jafferany M. Multidisciplinary and holistic models of care for patients with dermatologic disease and psychosocial comorbidity: a systematic review. *JAMA Dermatol*. 2020;156:686-694. [PMID: 32347896].
7. Marshall C, Taylor R, Bewley A. Psychodermatology in clinical practice: main principles. *Acta Derm Venereol*. 2016;96:30-4. [PMID: 27283859].
8. Magid M, Reichenberg JS. An evidence-based approach to starting a psychodermatology clinic. *JAMA Dermatol*. 2020;156:617-618. [PMID: 32347892].