Although dermatology often does not cross paths clinically with psychology, the two are sometimes not far from each other. Given the prominence of visible diseases in dermatology, the psychological effects can be equally devastating for patients as the conditions themselves. This can often lead to a cyclical effect of the patient’s dermatological condition being worsened by stress or other psychological trauma. Therefore, for dermatologists, monitoring for signs of anxiety, depression and other psychological conditions is paramount, particularly in teens with acne or those with a more debilitating condition. A host of other psychological conditions may be expressed in dermatological settings that dermatologists should look out for, as well. Ahead, Richard G. Fried, MD, PhD, a board-certified dermatologist and clinical psychologist practicing in Yardley, PA, charts the murky terrain of psychodermatoses and provides tips for clinicians on identifying warning signs and counseling patients. Acne is a prime focus.

What are some of the warning markers for depression and other psychological conditions that may occur in patients with acne?

According to Dr. Fried, a range of markers can indicate psychological involvement in the dermatology patient. These include poor eye contact as well as flat or labile affect, such as indifference or irritability. If a patient displays these warning signs it might help to ask about his or her school and/or social life. Dr. Fried observes that sudden changes in these areas can be highly symptomatic of psychological unrest, “such as change in peer group or withdrawal from peers and activities as well as changes in academic performance.” Dermatologists should also be on the lookout for decreased attention to personal care (e.g., dress, grooming, hygiene), as well as obsessive preoccupation with acne lesions or other body concerns, particularly with nose, ears, breasts, weight, etc.

In terms of therapies, are there any agents that may address both the skin condition and the psychological state?

Dr. Fried suggests that a case can be made that any effective acne treatment can theoretically address both. “It is possible that the anti-inflammatory effects of oral antibiotics and anti-inflammatory dose doxycycline can have antidepressant and anxiolytic effects. SSRIs and SNRIs have also recently been demonstrated to have anti-inflammatory effects and thus may be a beneficial addition to standard medical treatment of acne for some patients.”

Take-Home Tips. Given the prominence of visible diseases in dermatology, the psychological effects can be equally devastating for patients as the conditions themselves. A range of markers can indicate psychological involvement. These include poor eye contact, flat or labile affect, or changes in an individual’s personal/social life. Dermatologists should also be on the lookout for decreased attention to personal care (e.g., dress, grooming, hygiene), as well as obsessive preoccupation with acne lesions or other body concerns. The anti-inflammatory effects of oral antibiotics and anti-inflammatory dose doxycycline may also have antidepressant and anxiolytic effects. SSRIs and SNRIs have also recently been demonstrated to have anti-inflammatory effects and thus may be a beneficial addition to standard medical treatment of acne for some patients.
“effects,” notes Dr. Fried. He further suggests that SSRIs and SNRIs have recently been demonstrated to have anti-inflammatory effects and thus may be a beneficial addition to standard medical treatment of acne in certain patients. “Their mood-, attention-, and energy-enhancing effects may dramatically improve compliance,” explains Dr. Fried.

If a clinician identifies a patient as being depressed or anxious, what do you recommend as a course of action? Feelings of helplessness and hopelessness often accompany depression, notes Dr. Fried. “Emphatically telling patients that there are effective and relatively rapidly acting therapies for their acne can alleviate some of their fear and despair that their acne will never abate,” he explains. Dr. Fried also recommends telling them that you understand how difficult it is to live with acne and to promise them that you will continue to provide care until their acne improves.

Are there any other psychodermatoses of which clinicians should be mindful? Can you offer any tips on treating these conditions?

Other conditions besides acne that are tied to psychodermatoses

A new study in the International Journal of Dermatology examined the agreement and correlation of self-assessed and objective severity measure in 108 patients with acne, psoriasis, or atopic dermatitis to better understand the psychological associations of these diseases. Investigators noted a modest correlation (of ρ=0.46) and similarly very modest agreement of 0.35 (weighted kappa) of self-assessed and clinician-assessed disease severity. Furthermore, self-assessed (but not clinician-assessed) severity was statistically associated with psychological morbidity in this study; i.e. depression, anxiety, and overall psychological morbidity. The researchers concluded that clinicians should consider psychological sequelae of skin disease, not only in those with objectively more severe disease but also in patients across the severity spectrum. Moreover, they noted, both observational and interventional studies of skin disease should include both clinician-assessed and self-assessed measures of severity among assessed variables. [Int J Dermatol. 2011 Dec;50(12):1486-90]

A qualitative study recently examined the relationship of skin disease with societal ideals of beauty, as well as the role of the media in this relationship. According to investigators, the theme or the ideal of perfect skin and the role of the media in generating this ideal arose via an inductive study methodology and was explored in the context of respondents’ psychological morbidity. The researchers conducted 62 semi-structured interviews with individuals with acne, eczema, or psoriasis in an Australian regional city. Interviews were audiotaped, transcribed and subjected to thematic analysis employing a process of constant comparison in which data collection and analysis were cumulative and concurrent. The themes of perfect skin, societal ideals, and media influence emerged from this iterative process, according to researchers. Moreover, respondents identified a societal ideal of flawless skin, largely mediated by media portrayals of perfection. Failure to meet this ideal precipitated psychological morbidity, particularly in female respondents. The investigators concluded that an appreciation of the pervasive pressures of society and media upon females with skin disease may inform management strategies, particularly psychological management strategies, in patients with skin disease. [Aust J Prim Health. 2011;17(2):181-5]

Finally, researchers in a recent study assessed coping strategies and the psychological distress due to anxiety and depression and concluded that evaluating the mental health of patients might help to provide optimal treatment. In the recent study, self-administered questionnaires (HADS, COPE) were given to 603 dermatological patients. Out of 567 participants, 149 (26.2 percent) scored positive for anxiety, and 52 (9.2 percent) scored positive for depression. The investigators noted that multivariate analysis, adjusting for gender, age, socio-economic status, and disease, showed that both anxiety and depression are associated with a less frequent use of positive attitude coping. The researchers concluded that since coping ability was found to be important for mental health status, policy implications could include emphasis on social programs to assist individuals to manage stress, as well as psychological support. [J Eur Acad Dermatol Venereol. 2011 Jun 28.]
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Dr. Fried also points to several psychological conditions that may present in dermatological settings that clinicians should be aware of. According to Dr. Fried, these include telogen effluvium, body dysmorphic disorder, trichotillomania, HSV, and disorders of formication. In these cases, Dr. Fried emphasizes the importance of offering hope, noting that medical therapy can offer control of symptoms and control of anxiety and improve bedtime sedation for enhanced sleep.

In terms of therapy, clinicians can prescribe any number of agents, including antihistamines, anti-inflammatory antibiotics, propranolol, anxiolytics, SSRIs, SNRIs, antiseizure and neuromodulators (i.e., gabapentin, pregabalin), and Orap (pi,ozide) for possible anti-opiate activity. He also advises that clinicians concomitantly remain vigilant for paraneoplastic etiologies.

Conclusion

Although the treatment of psychological conditions does not fall within dermatologists’ typical clinical output, the connection between the skin and mental well-being necessitates that dermatologists are educated and prepared to treat a variety of psychological conditions. As more research clarifies the link, it is incumbent upon dermatologists to monitor patients’ psyche as well as their skin.

Dr. Fried has no relevant disclosures.

Richard G. Fried, MD, PhD, is an internationally recognized clinician, researcher, and teacher. He practices in Yardley, PA.

For more on monitoring patients for stress, anxiety, and depression (SAD), see Joseph Bikowski MD’s feature article in the November issue, available at practicaldermatology.com. You can also watch Dr. Bikowski discuss the SAD evaluation at DermTube.com: http://bitly.com/rZrE6W or scan the QR code at right with your smartphone.