How to improve the interface between dermatology and psychiatry: a review and expert suggestion regarding the management of delusional patients

Tory Starzyk[1] and John Koo[2]

Affiliations: [1]Western University of Health Sciences, Lebanon, Oregon, USA, [2]Department of Dermatology, University of California San Francisco, San Francisco, California, USA

Corresponding Author: John, Koo MD, 515 Spruce Street, San Francisco, CA 94118, Email: John.koo2@ucsf.edu

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 difficulty arises, at least partly, from the unavailability of psychiatric knowledge and skillset necessary to properly manage these patients, reflecting that most dermatology residency programs are unable to provide training in psychodermatology. This relates to the lack of faculty available with such expertise. This article reviews various suggestions made in the medical literature to try to improve this current unfortunate situation. However, the more common suggestion regarding organizing a multidisciplinary psychodermatologic clinic may be difficult to achieve as reflected by the scarcity of such clinics in the U.S. The authors offer alternative suggestions beyond the idea of organizing a multidisciplinary clinic.

Keywords: delusional infestation, delusions of parasitosis, Morgellons disease, psychodermatology

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 paper 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.

Methods

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 confirm very few such multispecialty psychodermatology clinics in the U.S. 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 issues may account for the scarcity of such clinics in the U.S.

Clinically, there is a challenge even in naming. By labeling the clinic as a "psychodermatology clinic," delusional patients are likely to be instantly deterred by the implied involvement of mental illness [9]. The stigma associated with mental illness and the patient's firm belief that they have a genuine physical condition will be a formidable barrier for DI patients to attend such a clinic [10]. The patients are less reluctant if the consultations occur within a neutral space (such as a dermatology clinic) without attaching stigmatizing labels like delusional, psychotic, or psychodermatological [11].

Logistically, how do multiple professionals see a single patient together in a cost-effective manner? This concern regarding cost-effectiveness is exacerbated by the fact that DI patients, especially for the initial visit, often do not keep their appointments. Delusional infestation patients are usually wary of being labeled with a psychological problem. They tend to have experienced negative interactions with previous providers, and consequently, it is not unusual that they have some ambivalence toward health care providers, which leads to above-average no-show rates. Although the authors hope that a multidisciplinary psychodermatology clinic will flourish, practical issues, including some stated above, cast doubt on whether implementing such a clinic is a realistic solution in the U.S. 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: 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? Allow us to make suggestions regarding these concerns:

1) Currently, to the authors' knowledge, out of 143 American dermatology residency programs, there are only two that have an attending faculty who is a double-boarded psychodermatologist. Other dermatology faculty members may not be double-boarded but have a track record of passion and expertise in dealing with these patients, but unfortunately, they are also extremely few. A nearly universal lack of faculty expertise in psychodermatology limits the teaching of optimal psychodermatological management to dermatology residents. The most feasible solution is for dermatology programs to incorporate webinars with available psychodermatologists as a regular and periodic feature of their residency lecture series. With the advent of webinars, remote learning is becoming increasingly familiar to residents and lecturers alike

[12]. Virtual instruction allows psychodermatology experts to meet this gap in training from a distance and reach dermatology residents nationwide.

2) Dermatologists may establish rapport with DI patients by first respecting the chief complaint of DI patients. Patients, of course, do not intentionally make complaints up but are genuinely distressed; delusions are an illness first and foremost, so it is important to avoid, even unconsciously, viewing the patient's state with contempt. Holding an empathic and understanding perspective allows the practitioner to accept DI as an unfortunate illness, deserving of the same respect as any other skin disease.

One recent development which might aid dermatologists in viewing DI as a legitimate physical ailment involves the possibility that DI may be organic in origin instead of purely "psychological." There is growing evidence that suggests the causes of primary DI are organic [13]. An interesting question to consider is: why do spontaneous (i.e., primary) cases of DI occur mostly in postmenopausal women? Like other delusional disorders such as schizophrenia, this phenomenon may result from too much dopamine in synaptic space [14]. One interesting theory that has been recently advanced with supportive MRI imaging data is that the DAT (dopamine transporter) system in women keeps dopamine in the synaptic space at an appropriate level. This system prevents excessively high levels of dopamine that can lead to delusions and hallucinations. With menopause, as estrogen decreases, the DAT system becomes less effective related to its dependence on an adequate estrogen level, which results in too much dopamine in intrasynaptic space.

Brain imaging on patients with DI has consistently shown lesions in gray matter (frontal lobe, sensory cortex, and thalamic striatal pathway) linked to the experience of formication [15]. Additionally, a frontal lobe lesion interferes with judgment. Consequently, even when shown evidence against infestation, the patient may be unable to accept this fact. In short, encouraging dermatologists to view DI as an organic condition and practice empathy for the patient's subjective reality may help foster respect for and connection with delusional patients.

To develop a trusting relationship with the patient, dermatologists may find it most helpful to, within reason, diplomatically accommodate the delusional patient's way of thinking rather than expecting them to entirely accept the physician's logic. The dermatologist should never endorse the patient's delusional ideation because such appeasement can make the ideation much more rigid. However, there is also no need for instant invalidation that can lead to antagonism. Instead, the dermatologist can sympathetically validate the patient's suffering and possibly even use it to motivate the patient to focus on therapy rather than etiology, even if therapy was offered on a "trial and error basis."

3) Dermatologists should become familiar with the medications useful for DI, such as pimozide, risperidone, olanzapine, and aripiprazole [2,16]. These antipsychotics often work well in low doses in dermatology, and because of this, there are rarely side effects [17]. Tardive dyskinesia is also rare, with only one case ever reported in the dermatology setting [18]. Delusional infestation is highly responsive to antipsychotic treatment compared to other delusional disorders. Unlike the chronic antipsychotic pharmaceutical management of schizophrenia, which is typically lifelong, the treatment of dermatological delusions is usually shorter-term; upon adequate treatment, the dermatologist can usually taper these medications. However, no matter how efficacious the therapeutic agents available, the patients will not benefit if detailed instruction regarding their use is not taught in dermatology residency programs. Therefore, there is a need for instructional lectures on this topic, possibly through webinars as recommended in item 1) above.

Even with the addition of psychodermatology lectures during residency, dermatologists may feel unsure about prescribing antipsychotic agents. This lack of familiarity with prescribing this definitive treatment is further exacerbated by the fact that, after residency, a practicing dermatologist has very few opportunities to learn about psychodermatology. Sessions on the topic of

psychodermatology are rarely offered in dermatology Continuing Medical Education (CME) symposiums. For example, at the 2019 American Academy of Dermatology meeting, the largest meeting of our specialty, only one CME session out of 343 covered topics in psychodermatology [19].

An emerging possible treatment solution for the future is that patients can access care outside their state of residence through telemedicine. One of the issues with access to care is that many states have no experts in psychodermatology. Telemedicine can help improve care for patients with DI in states where there are no practicing psychodermatologists. With the COVID-19 pandemic, telemedicine's growth has led to a reexamination of medical licensure state requirements [20]. This new potential for extending licensure across states offers an opportunity to provide direct access to the very few psychodermatologists available in the entire U.S.

4) Psychodermatological patients do not have to be a financial loss to private practices if their appointments are managed appropriately. It is critical to avoid scheduling these patients as haphazardly interspersed visits throughout the day lest the patient flow become disrupted. Instead, aim to schedule these patients at the end of the day. Suppose a patient with DI appears unexpectedly in the middle of a clinic day; the dermatologist may 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. The dermatologist may help this transition by letting the patient know that their story is important and deserves more time than available within the already packed schedule.

Dr. Koo implements this strategy in practice by asking these patients to inform the front desk that they are a "VIP patient" and request an appointment at the end of the clinic day. This "VIP" designation unfailingly makes the patient very happy and willing to return for a dedicated visit while also indicating to Dr. Koo's staff that this is a psychodermatological visit. The visits can be billed for time and do not typically require procedures or additional staff (RN, MA, front desk), so there is no additional overhead as long as the provider is willing to spend time with the patient beyond the usual closing time. With the ability to charge for time spent, these appointments can be a financial gain. After the initial lengthy visit, follow-up visits need not be necessarily lengthy once good rapport is established. For a subset of patients with chronic emotional needs, multiple short appointments are a good strategy to adequately address these needs while maintaining the dermatologist's usual schedule. Seeing psychodermatological patients monthly for fifteen minutes provides the opportunity to maintain supportive patient-physician relationships without financial loss or disruption.

5) A primary contributor to malpractice lawsuits and medical board complaints is a lack of connection with the patient. In this regard, the dermatologist's mindset in genuinely respecting and welcoming the patient may be even more foundational than knowing how to prescribe antipsychotic medication. Patients with a primary DI disease are typically older women [21]. In contrast to chronic mental illness in which the patient's functioning has been compromised for decades, DI patients present as highly functioning members of society except for the "encapsulated" delusion and tactile hallucination compatible with the delusion. In the authors' experience, when respect and proper attention are given to DI patients, they generally respond positively in kind. Moreover, the senior author (JK) notes that DI patients can be the most appreciative, especially if they view the current dermatologist as different from previous practitioners with whom they have not connected.

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 very few such clinics exist in the U.S., it raises the question of whether such an idea is practical and financially solvent in its application, especially in the U.S. where private fee-for-service models of care may

complicate and disincentivize collaborative care by multiple specialists in a single office visit. Although a multidisciplinary clinic is highly desirable, the authors' opinion is that a more realistic solution may involve empowering the "rank-and-file" dermatology practitioners to handle DI patients more effectively in their practice. Dermatologists can manage DI cases with some financial gain and without compromising patient flow. 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.

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Potential conflicts of interest

The authors declare no conflicts of interest.

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