Approaches to Patients

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This chapter will discuss some general considerations and advice on carrying out mental health assessments embedded in dermatology settings. The approach will be different depending on the service model being employed. The following models are commonly employed in the UK and elsewhere in Europe (Boxes 2.1, 2.2, 2.3, and 2.4):

Box 2.1 Joint Psychodermatology Clinics (Currently Still Rare Worldwide)
All patients both new and follow-up are seen jointly by both a psychiatrist and dermatologist at the same time. Typically, 45–60 min for new patients and 30 min for follow-up.

Benefits: Enables delivery of truly holistic care.
- Very acceptable to the vast majority of patients.
- Reduces stigma of being singled out to be 'sent' to see psychiatrist.
- Increases engagement of patient with mental health assessment and treatment.
- Enables true joint management.

Drawbacks: More expensive as it needs two specialists in the clinic, though there is evidence that it can be cost-effective.
- Can be difficult to fund/deliver with administrative boundaries between physical and mental health care providers.
- Need to carefully consider clinical governance and record keeping issues between physical and mental health care providers.

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Box 2.2 Dermatologist with special interest and training in psychodermatology runs specialist psychodermatology clinic

Dermatologist runs specialised psychodermatology clinic with longer new patient and follow-up slots. Typically, 45–60 min for new patients and 30 min for follow-up. Refers to separate liaison psychiatry and psychology sessions that can be run within the same department, either at same time or at another time

Benefits: Easy to engage patients, and patients who would not go to see a psychiatrist can undergo a psychological assessment.

Holistic management of skin and mental health problems treated together.

Drawbacks: Time consuming therefore expensive in specialists' time.

Requires dermatologists with appropriate training and expertise.

No immediate access to psychiatric advice, unless this can be negotiated with liaison psychiatry colleagues. Some barrier to patients seeing mental health professionals as they have to attend a separate appointment, and they may decline to do so.

Box 2.3 Dermatologist does brief screening/psychosocial exploration as part of usual dermatology clinic, then refers patient to liaison psychiatry and/or psychology sessions run within same department

Benefits: Less costly, integrated within usual clinic.

There is a dedicated mental health service for dermatology patients with appropriate expertise.

Enables good liaison communication both ways between dermatologists and mental health specialists.

Drawbacks: Insufficient time to conduct an adequate psychiatric assessment.

Patients may fail to attend further mental health appointment after need for assessment /treatment is identified due to time/logistics/stigma.

Likely to have high rates of non-attendance in mental health sessions.

Dermatologist is not involved in further assessment /treatment, so loses the opportunity to gain skills in this area.

Box 2.4 Dermatologist does brief screening/psychosocial exploration as part of usual dermatology clinic, then refers patient to generic liaison psychiatry services and/or psychology service. This is the standard process in most places
Benefits: None.
Drawbacks: As in Box 2.3.

Introductions and Scene Setting for the Patient

Whatever model is employed, it is important that patients are properly introduced to the professionals who are seeing them, whether this is a dermatologist, a dermatologist with a special interest in psychodermatology, a psychiatrist, a psychologist or a clinical nurse specialist. The patient should understand who they are seeing, what that person's role and area of expertise are, and what the aim of the consultation is to be. It is also helpful for patients to be told in advance how long the consultation will be. Patients will engage much more easily in both a physical and mental health assessment if they are clear what the aim of the assessment is, and that there will be sufficient time to address both their physical and mental health concerns.

Opening Up a Psychosocial Agenda in a Dermatology Consultation

Consultations in dermatology are frequently brief with skin and physical health-focused history and examination. There are usually a lot of people around and in and out of the clinic room. If the clinician plans to open up the agenda to explore mental health issues it is necessary to make some adjustments. It is important to remember that patients will have certain expectations of what their dermatologist will discuss and examine, and they may be surprised by an unexplained change of agenda. Some patients, particularly those who have no insight into their mental health problems and believe their skin disorder to be entirely physical, may not respond well to their dermatologist changing the focus from the skin to psychological health. However, there are certain approaches that can help with the engagement of all patients:

Consultation Environment Factors

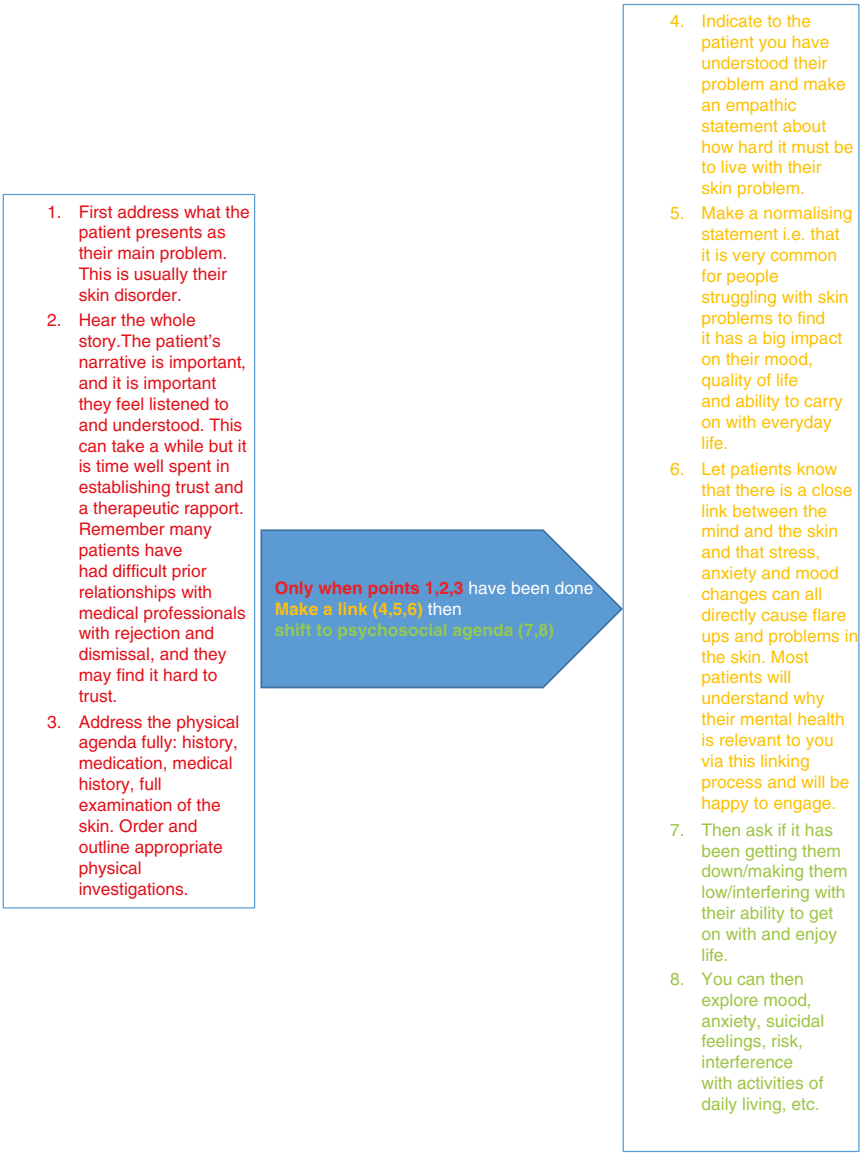
- Consider privacy issues: try to reduce the traffic of staff in and out.
- Safety: ensure the room is set up such that the clinician can exit safely.
- Time: if you are running a specialist psychodermatology clinic you will book longer appointment times, typically 45–60 min for a new patient and 30 min for follow-up. In a general clinic, consider asking a patient to come back and booking two or three clinic slots in order to have time to address psychological health. Inform the patient upfront how long the consultation will last and that follow-up appointments are possible if not all aspects of the patient's problems can be addressed in the initial consultation.

A Note on Record Keeping and Confidentiality Issues

The details of this will depend on the liaison model being used and the legal requirements of the respective country. However, there are some general considerations.

- Mental health information is often more sensitive than physical health information and patients may feel much more sensitive about how the information is recorded and who will have access to it. For example many patients feel uncomfortable with GP reception and administration staff (whom they may know personally in their own communities) potentially reading very sensitive information about their mental health and relationships.
- Patients are much more likely to feel comfortable sharing sensitive details if there has been an explicit discussion of what will be recorded, where, in how much detail, and who will have access to it.
- Staff such as psychologists and psychiatrists seeing patients may be employed by a separate care provider and not the acute general hospital. The mental health care provider may have its own separate record keeping system, activity recording, and clinical governance system. They may be required to keep a full separate medical record including such things as risk assessment. This can pose a problem, and there is not a catch-all solution as it will depend on the local requirements and situation. Any solution to this problem will require negotiation and discussion as to how a record is kept by both the physical health and the mental health care provider without the need for time-wasting and costly duplication.

Behaviours and Techniques with Which to Engage Patients in Discussing Their Psychological Health



Useful Interview Techniques

- Be open, empathic, non-judgemental, maintain non-threatening eye contact.
- Use transition statements, e.g. 'Now I have understood a bit about your problem, I am going to ask about your family'. Patients are then not surprised by a change in the line of questioning.
- Use normalising statements. These can be useful if you need to ask about issues that may be stigmatising or where patients may feel defensive and as though the questions imply something undesirable about them (e.g. recreational drug use, alcohol history, cognitive impairment, hallucinations). A normalising statement is something along the lines of 'We have to check certain things with all patients whether it is relevant or not', or 'I need to run through some routine questions about alcohol use', 'I need to ask about use of any non-prescribed drugs' or 'I need to do some brief tests of your memory, we have to check this in everyone'. Other types include normalising for certain problems, e.g. 'many people with similar problems to yours also experience X'.
- Use open questions. E.g. 'How have you been in your mood'? or 'How have you been feeling in yourself?', rather than 'Have you felt depressed'?
- Avoid loaded questions.
- Use summarising and clarifying statements, check you have understood correctly. This has the added advantage of giving the patient an idea of their own problems in a structured way.
- Check patients' comfort zones if they are starting to discuss something difficult, check they are ok with this, let them know they do not need to tell you all the details if they are not comfortable doing so. Indicate that they can talk about it another time or you can refer them to speak with someone else. This is very important if patients have alluded to issues of abuse of any sort. Be aware patients may answer questions as you are an authority figure and they feel they have to answer, but later they may feel very vulnerable and exposed. Being aware of this and using the above technique should avoid the patient feeling uncomfortable afterwards about how much they have shared.

Correspondence and Communication of Mental Health Assessments in the Joint Psychodermatology Setting (Where This Model Is Possible)

- Mental health staff and dermatologists are often working for different health care providers.
- There needs to be service level agreements between providers about who is responsible for funding and providing administrative support: administering the clinic, bookings, patient appointment letters, writing clinic letters, etc.
- Similar considerations apply to letter writing and communicating with the GP and other professionals. The professionals involved need to work out an efficient way of creating relevant correspondence without duplicating one another and

having the right balance of sharing appropriate information whilst avoiding sharing sensitive details unless it is vital.

- Many mental health and acute medical care providers require that all correspondence is copied to patients. In the case of mental health assessments, it is important that anything in the letter will not come as a surprise to the patient. It is also important to check the patient is happy to have a copy of the letter - some patients may decline if they are concerned someone else will open their mail and read sensitive information. If a particular diagnosis or formulation has not yet been shared with the patient it should not be put in a letter. This can be a particularly difficult area when dealing with patients with dermatitis artefacta, factitious disorder or delusional patients such as those with a delusional infestation or the delusional subgroup of body dysmorphic disorder. In those patients, gradual or limited exploration of the diagnosis with the patient is acceptable. See Box 2.5 for some suggestions on how to write GP letters in the psychodermatology clinic.

Box 2.5 Some Suggestions for How to Write GP Letters

Where the patient has a diagnosis, which cannot immediately be shared with them, e.g. dermatitis artefacta, factitious disorder, or they are delusional with no insight, letters to the GP which are also copied to the patient have to be written to avoid saying anything which has not been shared with the patient. Otherwise, any developing trust and therapeutic rapport will be lost the moment the patient reads the letter.

The solution is usually to avoid writing the diagnosis, e.g. factitious disorder, delusional infestation, and simply record in the letter what the patient has told you: e.g. patient believes they have mites burrowing under the skin, the patient feels unhappy that the shape of their nose is triangular, or such like. Patients' behaviour can also be described; e.g. they are throwing away their sheets every week, they check reflective surfaces constantly, they spend 3 hours putting on make-up, etc. The clinician can then make a factual statement of examination findings, record investigations and results when available. It is usually then clear to other professionals that there is a mismatch between the patient's perception of their situation and that of the clinician. In some instances, an additional letter to the GP or referring doctor that is not disclosed to the patient may be feasible. Treatment and its purpose can be recorded, e.g. topical creams to moisturise and containing antibacterial properties, low dose neuroleptics (this term may be preferred to antipsychotics) to reduce crawling and biting sensations in the skin, thus reducing itch and helping sleep. Obviously, all this will also have been discussed with the patient but the letter will serve as a reminder of the treatment rationale, and therefore has potential therapeutic value. It can also be helpful for patients to show to pharmacists as the latter may not dispense neuroleptics unless they understand the rationale for them.

If it is necessary to make the GP aware of suspicion of factitious disorder it may be best to do this by phone or with an additional letter. This diagnosis may need to be discussed with the patient at some point but it is important it is not done too soon, if there is any diagnostic uncertainty, and if there is not a good rapport with the patient.

Different health systems in different countries may have different legal requirements around doctors' letters which obviously need to be taken into account.

Why Are Mental Health Disorders Missed in Dermatology Outpatients?

- Often missed due to context: brief consultations, lots of staff in and out, the focus is on examining skin and brief dermatologically focused history.
- Doctors and nurses may not ask about mood due to fear of opening 'can of worms'.
- Perceived stigma of mental illness limits its discussion by doctors and patients.
- Patient may feel mood symptoms not relevant, 'nothing the doctor can do'. Also patient may be concerned that discussing mental health problems may distract the doctor from addressing physical symptoms thoroughly and physical symptoms will be ignored.
- Staff may feel depressive/anxious reaction is normal and inevitable: 'I would be depressed if that happened to me'; but not all dermatology patients are depressed or anxious!
- Common physical symptoms of depression such as poor sleep, loss of appetite, tiredness can be due to the physical illness.

Factors to Look Out for in Dermatology Patients Which May Suggest There Is an Underlying Psychiatric Disorder

- Distress about skin disease very severe.
- Mood change persistent (>2 weeks) and not responsive to the environment.
- Failure to adjust to illness-exaggerated perception of altered body image, feel ugly and disfigured out of proportion to objective assessment. Difficulty adhering to treatments, overwhelmed.
- Physical function poorer than expected, failure to continue or resume social and work roles.
- Recovery slower than expected, rehabilitation difficult. Patients may be very avoidant of social situations, going out in public, returning to work, etc., even after skin improves.
- Dermatologic non-disease, e.g. burning sensations are frequently associated with depression.

If any of the above are observed there is a need to actively look for an underlying psychiatric disorder.

Approaches to Patient in Specific Clinical Situations: Some Questions to Use and Things to Notice

Assessing Mood

- Subjective: How the patient feels in their own words. Fed up, sad, etc.
- Objective: Observe and record objective indicators of mood during the interview such as body language, behaviour and facial expression, e.g. weeping, sad expression, laughing, irritable, etc. Biological symptoms can be included here.
- Open Question First: 'How have you been feeling in yourself …….or feeling in your mood….. or feeling in your spirits (or try all three) recently'?
- If there is no clear response ask a more closed question: 'Have you been feeling at all low, sad or miserable recently?' or 'Have you been feeling at all depressed'?
- How bad has it been—look for a pervasive low mood. Note variability and reactivity.
- Tearfulness present or not.
- Negative cognitions such as hopelessness, worthlessness, guilt. Yes to all these indicates higher suicide risk.
- Anhedonia (inability to enjoy things one normally enjoys), alexithymia (inability to express one's emotions).
- Diurnal variation of mood (in depression, mood is often lower in the morning).
- Biological symptoms such as poor sleep, early morning wakening, loss of appetite, weight change, loss of libido.
- Assess severity: persistence, lack of variability, limiting social function, diurnal variation of mood and biological symptoms all indicate more severe depression.

Assessing Anxiety

There are two main components of anxiety:

1. *Cognitive: Anxious ruminations*
2. *Autonomic Symptoms of Anxiety*: Palpitations, tachycardia, paraesthesias, dizziness, cold clammy hands, sweating, hot and cold spells, frequency of urine, diarrhoea, nausea and blepharospasm. Increased muscle tone producing shakiness, tremor, trouble swallowing, lump in throat, muscular aches, excessive tiredness. These symptoms can be worsened by hyperventilation, which can also lead to dizziness, perioral and limb paraesthesias and muscular spasm.

   Asking About Anxiety:

- Have you had problems with feeling anxious/scared/ nervous/fearful? Try different words.
- Have you found yourself worrying constantly? Having thoughts and worries which go round and round in your head?
- If they say yes, ask how it makes them feel in their body? (open question). If no useful response, go on to ask if they have any of the specific autonomic symptoms of anxiety listed above.
- Ask if they have panic attacks; if they say yes, ask them to describe them. If they do not know what they are, describe a panic attack as a sudden feeling of fear or anxiety where they may feel they cannot breathe, the heart is racing, they feel sweaty or shaky and as though they may pass out or collapse, and they may feel they have to get out of the situation they are in.
- If they do have anxiety, ask if this is constant which hints towards generalised anxiety, or in relation to a specific situation which is phobic anxiety (fear of spiders, etc.).

Assessing Obsessional Symptoms

Features of Obsessional Phenomena

- Obsessional thoughts are repeated stereotyped intrusive thoughts or images which cannot be stopped, though they may be resisted.
- Recognised as patients' own thoughts.
- The motor act often accompanying an obsession is called a compulsion, e.g. handwashing, checking locks.
- Obsessional Rumination: repeating the same stereotyped thought over and over.
- Magical Thinking: The patient links two events, knowing that the connection is senseless (e.g. If I do not see three red cars today, my children will come to harm).
- Obsessional Images: repeated similar image in mind.
- Obsessional thoughts are often egodystonic, e.g. the religious person who has blasphemous thoughts. They are recognised as irrational by the patient, the patient usually tries to resist them, and the resistance causes anxiety, which is relieved by a ritualistic act.

Asking About Obsessional Symptoms:

- Before asking about unusual symptoms like obsessional symptoms you may want to make an orientating statement like 'you may find some of these questions a bit unusual and they don't apply to everyone, but I need to ask them just to check whether you have had any of these experiences'.
- 'Sometimes people find they have to keep checking everyday things even though they know they have done them, for example checking light switches, gas taps, locks. Do you ever have problems like this'?
- 'Are you someone who is unusually tidy and orderly and you find you have to keep things in a special order for example ornaments, clothes or papers'?

- 'What about being unusually clean and finding that you have to either wash your hands very frequently or clean things in your house excessively'?
- If present, check frequency severity and impact on function.

Obsessional Disorders in the Skin Clinic

Skin picking disorders and trichotillomania: these can be driven by obsessional thoughts, e.g. repeated thought that something needs extracting from under the skin before the area will heal. The picking or plucking can be a compulsion: there will be a strong compulsion to pick driven by ideas that this is needed for healing or to relieve the compulsive drive. The patient experiences anxiety when the compulsion is resisted, then relief immediately afterward, though they will often then experience shame and guilt about having picked.

Body dysmorphic disorder is thought to lie on the obsessive-compulsive disorder spectrum. The patient may experience repeated obsessional thoughts about the appearance of a part of their body with a strong drive to repeat behaviours such as checking in a mirror or trying to alter a part of the body, e.g. arranging the hair, covering blemishes, etc.

Assessing Psychosis in the Skin Clinic

What is psychosis?

The defining symptoms of psychosis are:

- Loss of contact with reality.
- Hallucinations: auditory, visual, tactile, olfactory or gustatory.
- Delusions: These are fixed, usually false, unshakeable beliefs held with subjective conviction and usually despite evidence to the contrary. They are not explained by a patient's usual cultural or religious concepts. The intensity of the delusional belief can be variable.
- Loss of insight.

Types of Psychotic Illness

- Schizophrenia.
- Mania.
- Psychotic depression.
- Schizoaffective disorder.
- Organic psychosis.
- Delusional disorder.

Any of the above can be seen but the commonest psychotic presentation in skin clinics is *delusional disorder*. The ICD 11 criteria for this disorder is that the main features include non-bizarre delusions, the criteria for schizophrenia are not met, there is no auditory or visual hallucination, though olfactory and tactile

Box 2.6 Some Common Psychoses Seen in Skin Clinics

- Delusional infestation.
- Morgellons: Disorder often suggested by patients following research on internet. Patient sees hairs often coloured on or growing out of the skin, and there may be a variety of non-specific neuropsychiatric symptoms, e.g. fatigue, headache, poor concentration. Not scientifically accepted as a diagnostic entity. The new term suggested in Morgellons is 'unexplained dermopathy'.
- Body dysmorphic disorder (psychotic subtype). Patient has delusions about abnormalities of appearance in a particular part of their body, e.g. believes there are big scars, pores, or swelling of nose, eyes, chin, etc, when no such abnormality is objectively apparent or if it exists it is very minimal.
- The belief of abnormal smell (cachosmia).

hallucinations can occur, mood episodes may occur but are brief compared to the duration of the delusion, the disturbance is not secondary to drugs, alcohol or any general medical condition. There can be a variety of types of delusion, e.g. erotomanic, grandiose, jealous, persecutory or somatic such as infestation. In the skin clinic, somatic delusional disorders are commonly seen. The delusions remain focused around the main somatic theme, and the rest of the personality can be remarkably intact in comparison to schizophrenia, where there is often a general deterioration of cognition, affect and personality. See Box 2.6 for common psychoses seen in skin clinics.

Risk Assessment

- Always consider the risk to self, others and of neglect.
- Must always do a risk assessment: two main forms of risk to consider.
  1. Risk of patients harming themselves. This can include:
     (a) Suicide risk in patient.
     (b) Risk of other self-harm: e.g. damage to skin driven by abnormal beliefs or picking. There may be a risk of self-mutilation in patients with body dysmorphic disorder.
  2. Risk of patient harming others, e.g. risk to children in their care, inability to adequately parent, shared delusional beliefs involving children, for example in delusional infestation patient may expose the child to harmful 'treatment', e.g. with bleach or disinfectant (be aware of child protection guidelines), very rarely *Münchausen by proxy*. Consider the risk to other clinicians in patients with delusional disorders. Patients may threaten the plastic surgeon to obtain a cosmetic procedure.

Box 2.7 Statistical Population Risk Factors for Suicide

Older age (any sex)
Middle-aged and young men
Male
Previous attempts, especially with violent methods
Psychiatric history
Family history of suicide or suicide in close other
Unemployment
Poor physical health, especially chronic pain
Recent loss/bereavement
Living alone
Alcohol/drug misuse

Assessment of Suicide Risk

- You must ask about thoughts of suicide and self-harm.
- There is no evidence that asking about suicidal ideas increases the risk of suicide; in fact the opposite is the case. You will reduce the risk of suicide by asking patients about suicidal ideas.
- Be aware of the risk factors for suicide (Box 2.7) and assess the patient for these risk factors.

How to Ask About Suicidal Ideas?

- Begin with an enquiry about mood and move stepwise into more specific enquiry as appropriate.
- Having established there is low mood or distress, move into enquiry about suicidal feelings: Ask about the future and feelings of hopelessness. 'How do you feel about the future'? 'Do you feel hopeless or do you feel things will improve'?
- Ask about passive suicidal thoughts: 'Has it ever got so bad that you have felt you did not want to carry on'? 'Have you felt that life was not worth living'? 'Have you ever wished you would not wake up in the morning'?
- 'Have you ever thought about acting on those sorts of feelings'? 'Have you thought about doing something to harm yourself'?
- 'What sort of things have you thought about doing'? 'How close have you got to carrying out these thoughts'? 'Have you done anything to harm yourself'?
- If you get affirmatives to the above, spend time exploring the intensity and frequency of the thoughts, the detail of the plans, whether plans have been put in place to say goodbye to others (letters, etc.), organising affairs, e.g. making a will. Detailed plans and preparations increase the risk.

- If there are suicidal feelings, it is important to understand what is keeping the person going, and preventing them from acting on these feelings: 'What has stopped you from acting on these thoughts/feelings'.

Practice Points

- Carefully consider the model of service delivery which is feasible in your service. The optimal model for seeing patients with a primary psychiatric disorder which presents via the skin is joint consultation with a psychiatrist and dermatologist.
- When setting up psychodermatology services, consider issues such as appropriate space, and how to deal with clinical correspondence.
- Patients attending psychodermatology clinics should understand who they are seeing, what the role of each professional is, and should understand how records will be kept and how information sharing with GP and others will function.
- Engagement of patients with the biopsychosocial model is crucial to their management. This engagement is achieved by fully understanding the patient's presenting problem, hearing their story and carrying out a thorough physical assessment BEFORE then moving to the psychosocial agenda. This move can be facilitated by using normalising and empathic statements to encourage patients to see the link between their skin and their emotional state.
- Clinicians running psychodermatology clinics must be trained in psychological assessment and learn appropriate communication skills which maximise their ability to elicit psychological symptoms and so understand their patients holistically.
- Clinicians seeing psychodermatology patients must always carry out risk assessments and be skilled in how to do this.