Beneath the Surface: Understanding and Addressing Mental Health Concerns in Patients With Dermatologic Conditions

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Disclosures

- **Dr Fried** has nothing to disclose
- **Dr Jafferany** reports that he receives book royalties from Springer and American Psychiatric Publishing, Inc., and has received speaking fees from Boehringer Ingelheim and La Roche-Posay
- During the course of this lecture, faculty may mention the use of medications for both US Food and Drug Administration (FDA)-approved and non-FDA-approved indications

All relevant financial relationships have been mitigated.

This activity is supported by an educational grant from UCB, Inc.

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Learning Objectives

- Describe disease and treatment factors that negatively impact the mental health of patients with dermatologic conditions
- Implement patient education and clinical discussions to inform patients with dermatologic conditions of potential mental health risks associated with their condition and treatment
- Utilize patient-centered care and multi-disciplinary approaches to appropriately identify and manage mental health concerns in patients with dermatologic conditions and improve quality of life

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Mental Health in Dermatologic Conditions

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Psychocutaneous Disorders

- More than 1/3 of patients with skin conditions have psychological comorbidities
  - More common among patients with psoriasis, atopic dermatitis, eczema, and leg ulcers
- Chronic dermatologic conditions are associated with higher rates of depression, anxiety, and suicidal ideation
- Classification
  - Psychophysiological disorders: Skin conditions exacerbated by stress (eg, psoriasis or acne vulgaris)
  - Primary psychiatric disorders: Self-induced skin manifestations (eg, trichotillomania or body dysmorphic disorder)
  - Secondary psychiatric disorders: Emotional problems from having a visible skin disease (eg, acne or vitiligo)
  - Cutaneous sensory syndromes: Unpleasant cutaneous sensations such as itching and burning, without a clear dermatological or psychiatric diagnosis

Jafferany M. *Psychiatric News*. 2025;60(3) (https://psychiatryonline.org/doi/10.1176/appi.pn.2025.03.3.2). Accessed 3/13/2026. Zagami M, et al. *Skin Health Dis*. 2023;3:e211.

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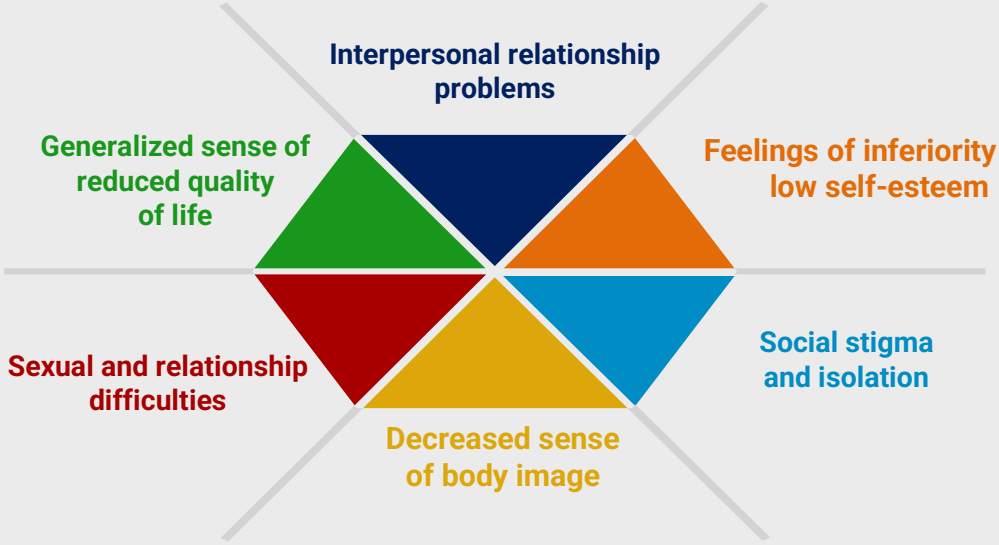
Common Psychosocial Issues in Dermatology



Jafferany M. *Psychiatric News*. 2025;60(3) (https://psychiatryonline.org/doi/10.1176/appi.pn.2025.03.3.2). Accessed 3/13/2026.

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Characteristics of Psychocutaneous Disease

Location of skin disease and associated psychosocial distress

Directly visible facial lesions	Genital lesions	Hair and scalp involvement	Lesions of hands and nails	Lesions of trunk and limbs
Greatest concern for distress, anxiety, and depression	Embarrassment and interference with sexual intimacy	Decreased self-confidence and altered social poise	Potentially disabling in certain occupations (eg, banks and retail)	Source of concern in public areas such as the gym or beach

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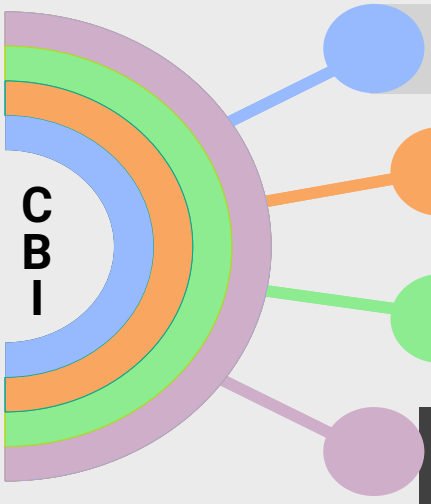
Cutaneous Body Image (CBI)



A subjective measure of a patient's individual psychological perception of their skin, hair, nails, and genitalia

Influenced by developmental, psychosocial, cultural, and psychiatric factors

Individuals with chronic cutaneous disease commonly have lower CBI

Decreased CBI

- Decreased treatment adherence
- Lack of confidence in treatment
- Increased comorbidity
- Decreased quality of life

Gupta MA, Gupta AK. *Clin Dermatol*. 2013;31:72-79.

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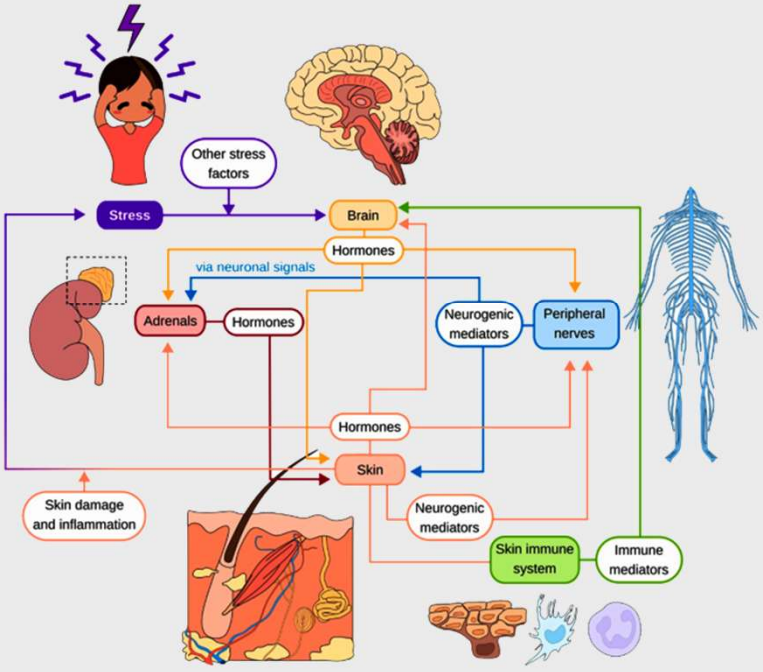
The Brain-Skin Connection



Tan CC, et al. *JAAD Int*. 2025:24:112-123.

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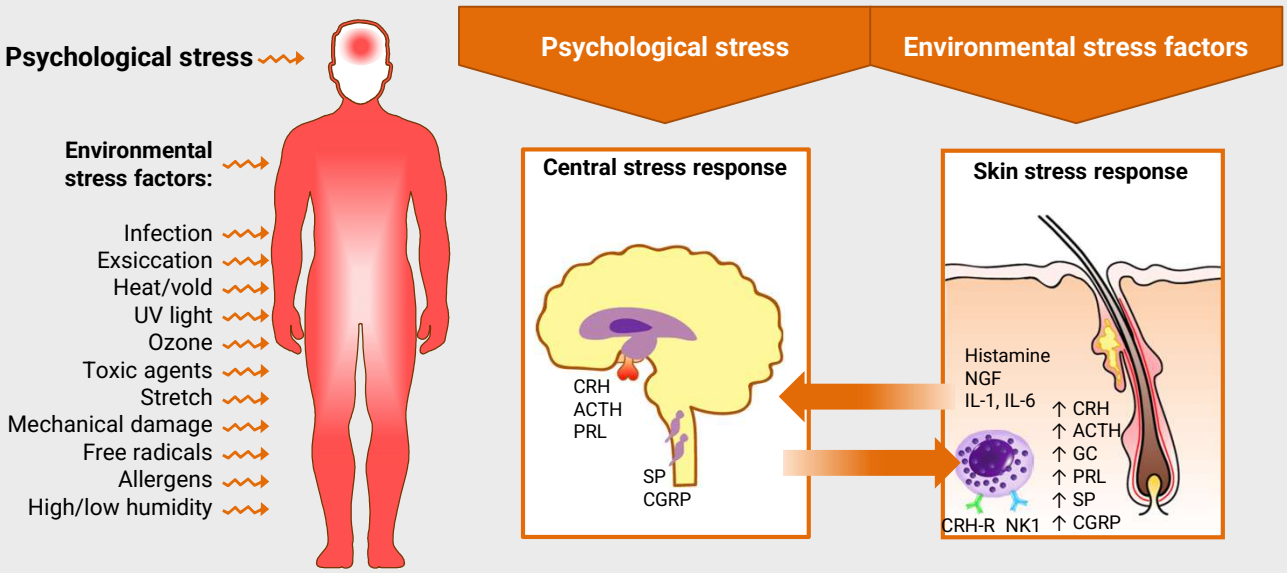
Psychological vs Environmental Stress



ACTH = adrenocorticotropic hormone; CGRP = calcitonin gene-related peptide; CRH = corticotropin-releasing hormone; GC = glucocorticoid; IL = interleukin; NGF = nerve growth factor; NK1 = natural killer 1; PRL = prolactin; SP = substance P; UV = ultraviolet.

Arck PC, et al. *J Invest Dermatol*. 2006;126:1697-1704.

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Stress-Activated NICE System in Skin Diseases

- Skin and brain have shared embryological origin: Neuroecroderm
- Common neurotransmitters, cytokines, hormones, and receptors
- Biologic basis for skin mind interactions
- Skin as both stress perceiver and target of stress response

Psoriasis:
High nerve density, altered neuropeptide activity, amplified T-cell response by stress

Atopic dermatitis:
Epidermal cells interact with neurons via TSLP, activated by stress

Urticaria:
Mast cells degranulation influenced by stress hormones

Acne:
Sebaceous glands responsive to neuroendocrine signals

NICE = neuro-immuno-cutaneous-endocrine; TSLP = thymic stromal lymphopoietin.

Nejati R, et al. *Expert Rev Dermatol*. 2013;8:581-583.

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Scope of Psychodermatology: Common Psychocutaneous Conditions

- Rosacea
- Psoriasis
- Atopic dermatitis
- Eczema
- Acne
- HSV
- Urticaria
- Alopecia
- Hyperhidrosis
- Cutaneous dysesthesias
- Pickers, rubbers, etc
- Delusional syndromes
- Cosmetic benefits
- Life spectrum disorders

HSV = herpes simplex virus.

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Psychodermatology: Obvious Psychiatric Diagnosis

- Obsessive compulsive disorder
- Depressive disorders
- Anxiety disorders
- Body dysmorphic disorder
- Delusions of parasitosis
- Other delusional disorder
- Psychological reactions to aging
- CTSD

CTSD = cosmetic traumatic stress disorder.

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Secondary Psychiatric Disorders

Emotional problems as a result of having skin disease

Psychosocial consequences are more severe than the physical symptoms

Not life-threatening but often called *life ruining* because of their visibility

Examples include depression and anxiety related to acne excoriée, vitiligo, alopecia areata, generalized psoriasis, ichthyosis, and others

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Psychodermatology: Worldwide Awareness Gap

Study	Country	N	Participants	Survey conclusions
Jafferany M, et al, 2019	Ukraine and Belarus	396	Dermatologists	Survey results showed that knowledge about the diagnosis and treatment for psychocutaneous disorders is lacking.
Markabayeva A, et al, 2019	Kazakhstan	148	Dermatologists	Results demonstrate dermatologists' lack of experience, skills, and attitude toward psychocutaneous disease.
Osman OT, et al, 2017	Middle East (Arab)	57	Dermatologists	Findings indicate dermatologists lack training and education in psychodermatology and lack of resources for proper patient management.
Ocek T, et al, 2015	Turkey	115	Dermatologists	There is a need for greater collaboration between primary care physicians, dermatologists, and psychiatrists in the proper management of psychocutaneous disease.
Muñoz LU, et al, 2014	Chile	102	Dermatologists	Surveyed dermatologists, overall, do not feel confident in managing patients with psychocutaneous disease and lack proper training in the field.
Gee SN, et al, 2013	United States	59	Dermatologists	The majority of dermatologists surveyed indicate they could successfully diagnose but are not able to treat patients with psychocutaneous disease.
Jafferany M, et al, 2010	United States	223	**Psychiatrists**	Surveyed psychiatrists indicate there is a lack in knowledge and appropriate resources regarding the diagnosis, treatment, and referral in psychodermatology; emphasis on Psychiatry-Dermatology Liaison Clinics
Jafferany M, et al, 2010	United States	102	Dermatologists	Surveyed dermatologists indicate there is a lack in knowledge and appropriate resources regarding the diagnosis, treatment, and referral in psychodermatology.
Kawahara T, et al, 2009	United States	85	Dermatologists	As an underrecognized area in dermatology, greater training and integration of psychocutaneous medicine into dermatology departments are needed.

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Screening Measures

Presence of psychological distress

- Depression
- Anxiety

Measures of HRQoL

- Impact of disease
- Guide treatment

HRQoL = health-related quality of life.

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Screening Tools

Beck Depression Inventory-II (BDI-II)

- 21 items, Mini Sleep Questionnaire (MSQ), self-reported

Generalized Anxiety Disorder-7 (GAD-7))

- 7 items, self-administered

Patient Health Questionnaire (PHQ-9)

- 9 items, self-reported

Bentley KH, et al. *J Affect Disord.* 2021;282:1021-1029. American Psychological Association (APA). Beck Depression Inventory. Updated 6/2020 (https://www.apa.org/pi/about/publications/caregivers/ practice-settings/assessment/tools/beck-depression). Accessed 3/13/2026.

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Tools/Measures (HRQoL)

Cardiff Acne Disability Index (CADI)
Dermatology Life Quality Index (DLQI)
Children's Dermatology Life Quality Index (CDLQI)
Dermatology-Specific Quality of Life Instrument (DSQLI)
Eczema Disability Index (EDI)
Freiburg Life Quality Assessment (FLQA)
Psoriasis Disability Index (PDI)
Recurrent Genital Herpes Quality of Life Questionnaire
Skindex
Hairdex

Both H, et al. *J Invest Dermatol*. 2007;127:2726-2739.

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Legal Liability and Risk Mitigation

It's important to balance respect for the patient's autonomy with the duty to ensure comprehensive, personalized, and compassionate care

- Mild to moderate distress: Dermatology care + supportive counseling and coordination with primary care
- Severe distress: Psychiatric evaluation in coordination with primary care
- Patients with severe aggression or at risk for violence: Collaborate with security or emergency psychiatric services to ensure both patient and staff safety while maintaining professional compassion

Zieneldien T, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03279-7.

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Strategies for Risk Mitigation

While restraint and seclusion during a crisis scenario might seem a safe option, it can negatively impact patients (eg, those with PTSD)

- Mitigation strategies include
  - Early identification of at-risk patients
  - Staff education
  - Administrative review and oversight
  - Self-training in deescalation strategies
  - Drills/simulations
  - Staff and patient debriefing post incidents

Programs based on Six Core Strategies have seen success in reducing the use of restraint and seclusion.

PTSD = posttraumatic stress disorder.

Soliman L, et al. *Focus (Am Psychiatr Publ)*. 2023;21:46-51. Huckshorn KA. *J Psychosoc Nurs Ment Health Serv*. 2004;42(9):22-33.

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Case Study 1

- A 35-year-old female with Fitzpatrick II Skin presents with refractory erythrotelangiectatic rosacea: Her symptoms include persistent, erythema, accompanied by intermittent, burning and hypersensitivity; she also experiences extremely uncomfortable and visible blush, and flush when under stress or when precipitated by heat, hot drinks, exertion, or public speaking; and she has experienced a little benefit from topical ivermectin cream, azelaic acid, metronidazole, and dietary restriction

Discussion and potential evaluation and treatment

- Briefly assess psychosocial impact
- Medication review including prescription medications, vitamins, herbal medicines, recreational drug use
- Physical exam and lab tests to rule out collagen vascular process, thyroid disease, hormonal dysregulation, etc
- Consider low-dose propranolol, low-dose doxycycline, pulse dye laser/intense pulsed light (IPL), low-dose selective serotonin reuptake inhibitor (SSRI), low-dose naltrexone
- Discuss concept of self-perpetuating blush/flush with sympathetic/adrenergic activation
- We sell and give control methods (pharmaceutical and cognitive behavioral therapy [CBT])

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Patient Education and Counseling

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Pearls of Management

- High suspicion of underlying psychopathology
- Strong physician–patient alliance
- Neutral, nonjudgmental, and nonconfrontational interview
- Screening tools for anxiety and depression: BDI-II, GAD-7, PHQ-9
- Psychotherapy and pharmacologic interventions
- Motivational interviewing

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Management

Problem recognition

- Clinical interview
- Screening tool

Appropriate referral

- Patient declines psychiatric referral

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Reasons for Declining Psychiatric Referral

- Poor insight
- Lack of motivation
- Lack of judgment
- Lack of financial ability
- Stigmatization

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Personalized Patient Care

- Understanding the patient's background and cultural sensitivity
- Addressing low health literacy
- Informed consent and patient understanding of treatment risks

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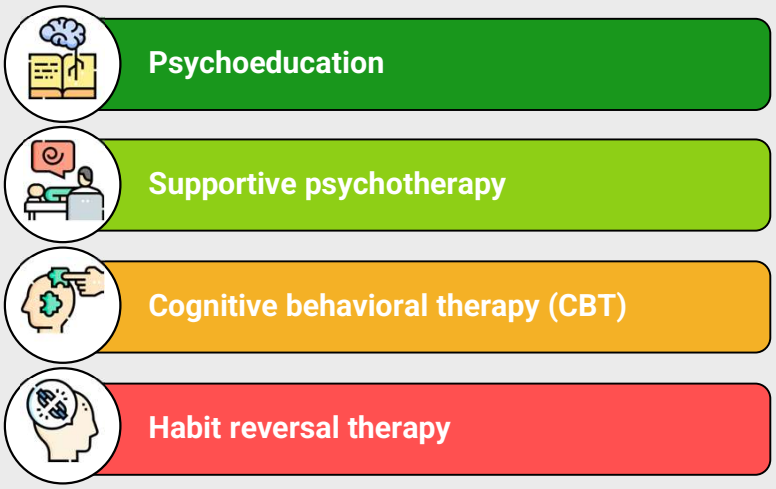
Psychological Counseling



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The Psychologist's Role

Psychoeducation

- Normalize symptoms and reduce fears of cancer or any irreversible damage
- Explain modulation and central sensitization in simple terms

CBT- and ACT-based approaches

- Address catastrophic thoughts, pain, and hypervigilance
- Encourage value-based living despite discomfort

Mind-body interventions

- Relaxation training, mindfulness, guided imagery
- Reduce sympathetic arousal and enhance interoceptive tolerance

ACT = acceptance and commitment therapy.

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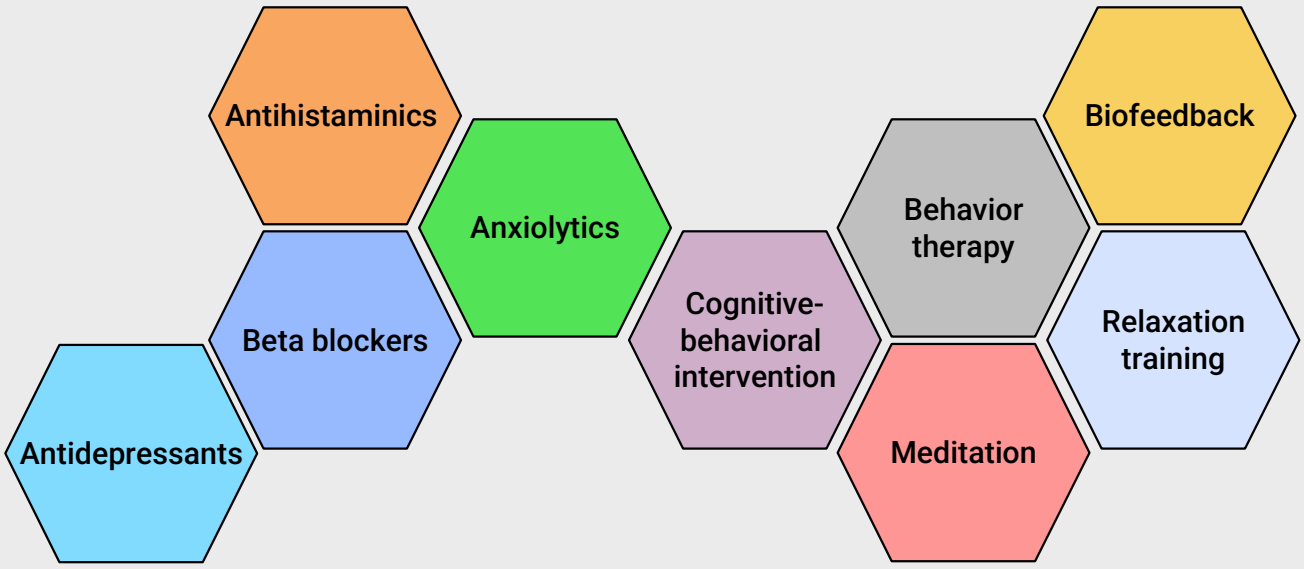
Psychocutaneous Cascade: Interventions to Break the Cycle



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SSRI as a Model

- Reduce depression and anxiety
- Decrease in compulsive behaviors such as skin picking, rubbing, washing, pulling, etc
- Increase focus and compliance
- Allow for a happier patient and family

Net result: Decreased psychosocial stress

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Side Effects: Pharmacologic Treatments

Drug class	Common side effects
SSRIs (fluoxetine, paroxetine, sertraline, citalopram, etc)	Nausea, insomnia, gastrointestinal (GI) changes, abdominal pain, weight change, and sexual dysfunction
Tricyclic antidepressants (nortriptyline, amitriptyline, doxepin, clomipramine)	Dry mouth, constipation, dizziness, blurred vision, tachycardia, and urinary retention; use with caution in patients with cardiac conditions; contraindicated in first trimester
Other antidepressants	
Mitrazapine	Sedative, weight gain, anticholinergic effects
Buproprion	Insomnia, agitation, constipation, headache, dry mouth, nausea, and tremors
Venlafaxine	Insomnia, anxiety; blood pressure (BP) should be monitored at high dose
Antipsychotics (pimozide, risperidone, olanzapine, haloperidol, etc)	Weight gain, orthostatic hypotension, constipation, xerostomia, increased risk of myocardial infarction and transient ischemic events in elder patients
Anxiolytics	
Benzodiazepines (triazolam, midazolam, lorazepam, diazepam, etc)	Learning difficulties, amnesia, aggressiveness, confusion, respiratory depression (patients with chronic lung disease or concomitant use of central nervous system [CNS] depressants); contraindicated in first trimester
Nonbenzodiazepines (buspirone, zolpidem)	Zolpidem can cause mental confusion and tolerance
Psychiatric drugs can trigger skin reactions such as pruritus, rash, urticaria and angioedema, photosensitivity, skin discoloration, alopecia, acneiform rashes, psoriasiform reactions, seborrheic dermatitis, and others.	

Weber MB, et al. *An Bras Dermatol*. 2020;95:133-143. Jafferany M. *Psychiatric News*. 2025;60(3) (https://psychiatryonline.org/doi/epub/10.1176/appi.pn.2025.03.3.2). Accessed 3/13/2026.

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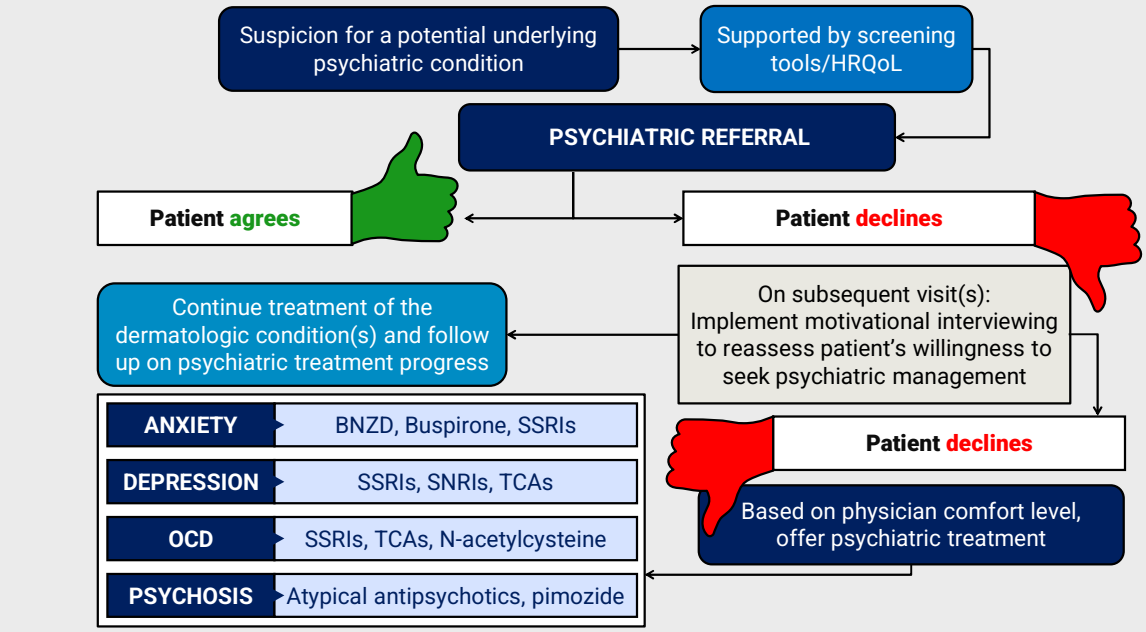
Psychodermatology Patient Management Approach



BNZD = benzodiazepines; OCD = obsessive compulsive disorder; SSRIs = selective serotonin reuptake inhibitors; SNRIs = serotonin and norepinephrine reuptake inhibitors; TCAs = tricyclic antidepressants.

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Case Study 2

- A 34-year-old male with 4-year history of plaque psoriasis, mostly limited to elbows, knees, and lower back; his symptoms were well controlled with topical treatments until about 6 months ago, at which time his psoriasis progressively worsened spreading to the scalp, ears, and glans penis with substantial associated pruritus
- His effect was mildly blunted as he vocalized distress regarding the extent and discomfort of his current psoriasis

Treatment discussion

- How quickly should his treatment regimen be modified?
- Would biologic treatment be an option, in addition to DMARDs such as methotrexate?
- How to best address fears of systemic side effects?
- What agents can be considered for control of pruritus?
  - Nonsedating antihistamine, hydroxyzine, doxepin, mirtazapine, SSRI/SNRI?

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Patient-Centered and Multidisciplinary Care

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Importance of Patient Participation

- Understanding patient priorities and integrating their preferences and values in care are important
  - Integrative and culturally attuned approach
  - Present psychological support as essential to comprehensive dermatologic care and holistic skin care management
- Patients may resist referral for counseling or psychological support dues to stigma, prior negative experiences, or limited access
- Patient participation and acceptance can be encouraged via
  - Gradual engagement
  - Empathetic dialogue
  - Normalizing mind-skin connection

Zieneldien T, et al. *J Am Acad Dermatol*. 2025:S0190-9622(25)03279-7.

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Shared Decision-Making (SDM)

- Patients with cutaneous ailments and psychological issues have complex needs
- Shared decisions with their healthcare providers must consider
  - Interdisciplinary care
  - Intersectionality
  - Trust in their healthcare provider and the healthcare system
- Ensure seamless communication among the care team to prevent adverse health outcomes
- The following modulations can support SDM processes
  - Components of needs and decisions regarding outcomes assessment so they recognize the influence of multiple decisions and options faced by patients
  - Components used to evaluate the decision-making support required and key actors in the process to ensure adequate communication
  - Components used to assess organizational policies and procedures

Perron ME, et al. *BMC Prim Care*. 2024;25:390.

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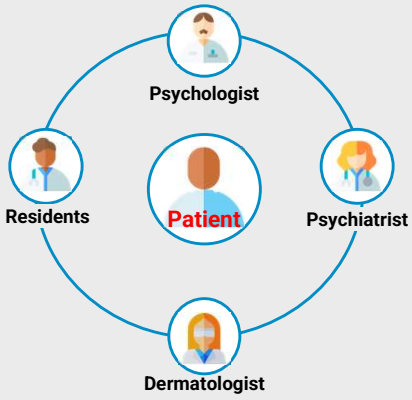
Multidisciplinary Care

- Treating the patient as a whole and not a specific disease/condition
- Ideal members of the team
  - Dermatologist
  - Psychologist
  - Psychiatrist
  - Residents
- Team-based care can avoid
  - Inaccurate diagnoses
  - Ineffective treatments
  - Unnecessary referrals



- Encourage joint appointments with dermatologist and psychiatrist
- Holistic treatment with pharmacologic and nonpharmacologic therapies can improve patient satisfaction and outcomes

Patel A, Jafferany M. *JAMA Dermatol*. 2020;156:686-694.

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Case Study 3

- A 41-year-old female presents with a 3-year history of worsening skin picking; patient related episodic periods of picking during her teenage years, especially when under stress, and her skin excoriations were largely limited to areas of active acne vulgaris
- Pair of picking behavior returned 3 years ago after significant marital difficulties culminating in divorce; her picking at presentation includes her face, neck, chest, and back, and she reports persistent skin dysesthesia, including itch, burning, and occasional biting sensations; review of systems is noncontributory
- On physical examination, there is no evidence of an affection, infestation, or primary skin lesions other than extensive, imperialized linear excoriations; patient appears motivated for treatment but is extremely frustrated by admonitions of "don't pick" from friends, family, coworkers, and healthcare professionals; she denies any known medical history, takes no medications, denies any history of attention-deficit/hyperactivity disorder (ADHD), and denies use of illicit drugs

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Case Study 3: Treatment Discussion

It is extremely important to know why the patient is picking. She believes that her picking is provoked by her dysesthetic symptoms but does find herself autonomously picking at her skin throughout the day and more intensely at night. She mentally denies any purposeful self-injurious behavior.

Treatment should involve

- Offering a biologic explanation for her dysesthesias, including the role of neuropeptides, potentially histamine, etc
- Initiation or continuation of nonsedating antihistamines in morning or 2 times a day (BID)
- Initiation of a low-dose SSRI, such as paroxetine or sertraline, can be very beneficial; consideration of low-dose naltrexone may be helpful
- For patients with extensive picking and scarring, very low dose pimozide 0.5 to 2.0 mg at bedtime (hs) can be helpful in diminishing dysesthesias and concomitantly diminishing functionally autonomous picking behavior; topical or oral antibiotic for impetigenized areas often decreases dysesthesias; low-dose gabapentin or pregabalin can be considered
- Simultaneous CBT psychotherapeutic intervention is often helpful
- Finally, vigilance for other organic or paraneoplastic process is always advised

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Key Takeaways

- Psychodermatology is part of every patient encounter
- a reciprocal interaction exists between skin and emotion
- Anxiety, depression, OCD, fear, and anger are common—for both patients and providers
- Psychocutaneous interventions are effective
  - They can be incorporated without increased time commitment or liability

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Thank you!

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