Psychocutaneous disease

Pharmacotherapy and psychotherapy

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Learning objectives
After completing this learning activity, participants should be able to discuss how to establish a working alliance with the patient who has psychocutaneous disease and most effectively involve the psychiatrist in management; list psychiatric medications used in psychocutaneous disorders; and describe effective psychotherapies for psychocutaneous diseases.

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Building a strong therapeutic alliance with the patient is of utmost importance in the management of psychocutaneous disease. Optimal management of psychocutaneous disease includes both pharmacotherapy and psychotherapy. This article reviews psychotropic medications currently used for psychocutaneous disease, including antidepressants, antipsychotics, mood stabilizers, and anxiolytics, with a discussion of relevant dosing regimens and adverse effects. Pruritus management is addressed. In addition, basic and complex forms of psychotherapy, such as cognitive-behavioral therapy and habit-reversal training, are described. (J Am Acad Dermatol 2017;76:795-808.)

Key words: antidepressant; antipsychotic; cognitive-behavioral therapy; drug; management; pruritus; psychocutaneous; psychotherapy.

Most patients with psychocutaneous disease refuse psychiatric intervention, leaving management exclusively to the dermatologist. A direct and empathic approach helps elicit relevant psychiatric information from the patient to formulate a diagnostically driven management plan. It is important for the dermatologist to identify psychosocial factors and psychiatric comorbidity, and effectively communicate the connection between mind and skin.[1] Rapport develops over the course of several office visits in which the patient feels, with good reason, that the physician is an ally in their struggle to cure the disease.[2] A psychiatry referral approached with sensitivity may be successful.[2] When patient is resistant to pursuing psychiatric treatment, the dermatologist should support the

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Abbreviations used:

AED:	antiepileptic drug
CBT:	cognitive-behavioral therapy
EPS:	extrapyramidal symptoms
FDA:	US Food and Drug Administration
HRT:	habit-reversal training
OCRD:	obsessive-compulsive and related disorder
SSRI:	selective serotonin reuptake inhibitor
TCA:	tricyclic antidepressant

patient with a nonjudgmental stance, provide indicated psychotropic medication (the dermatologist should be aware of commonly used psychotropic agents and their adverse effects),[3] and encourage evaluation with a psychiatrist as a supplement to, and not as a replacement for, the therapeutic relationship.[1]

There are data supporting the effectiveness of psychotherapy in psychocutaneous disease.[4] These therapies are described below.

PHARMACOTHERAPY

Key points

- **Selective serotonin reuptake inhibitors are commonly used to treat anxiety, depression, obsessive-compulsive, and somatic symptom and related disorders**
- **Tricyclic antidepressants can be used in neuropathic pain and obsessive-compulsive and related disorders; doxepin is a potent antipruritic tricyclic antidepressant**

Antidepressants

Antidepressants are approved for the treatment of depression and variants of anxiety including, panic disorder and posttraumatic stress disorder. The onset of effect for all antidepressants, regardless of class, is 4 to 6 weeks at a therapeutic dose.[5] Dosing recommendations include starting low and titrating slowly. As a general guideline, one may consider starting at half the minimum effective dose and titrating upwards every 14 days. Higher dosing does not hasten the effect, but rather puts the patient at greater risk of adverse effects.[6] If there is no improvement after an adequate trial of ≥6 weeks, or if the medication is not tolerated, one should switch to a different medication. If there is partial improvement, titrating the dose is ideal. No class of antidepressant has been shown to be more efficacious than another in the treatment of depression.[7] Of note, no antidepressant carries an indication for a specific psychocutaneous condition. Antidepressants are not addictive, but a discontinuation symptom (eg, flu-like symptoms, insomnia, or imbalance) may occur if they are stopped or tapered too quickly.[7] Treatment should be continued for a minimum of 6 months after therapeutic response.[5] Selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) are the most commonly used classes of antidepressants in psychodermatology.

SSRIs. SSRIs (Table I) are the most common class of antidepressants because of their favorable safety profile.[6] These medications primarily affect serotonin, although this is a simplified version of how they work.[12] Effective dosing for psychocutaneous conditions has not been established. As a general rule, it is typical for obsessive-compulsive and related disorders (OCRD) to require higher dosing.[8] The most common adverse effects include gastrointestinal distress (eg, nausea), insomnia, weight changes, and sexual dysfunction (eg, anorgasmia or reduced libido).[7] When starting an antidepressant of any class in a patient <25 years old, it is important to monitor for suicide-related events because these medications have been found to be associated with thoughts about suicide and suicide attempts but not completed suicide.[13] This is true particularly at the start of treatment (ie, the first 2 months). If the first SSRI fails, a second SSRI option can be instituted before switching to another class of antidepressant.[14]

TCAs. TCAs (Table II) are an older class of antidepressants that act on serotonin and norepinephrine.[5] To a great extent, TCAs have been replaced by SSRIs because TCAs are more sedating and have a broad spectrum of adverse effects. However, they have more antihistaminic properties, which serves useful for pruritic complaints and insomnia.[5] A few of the TCAs are notable for use in psychodermatology. Doxepin carries the most antihistaminergic properties, making it a potent oral and topical antipruritic agent for psychogenic pruritus and prurigo nodularis, respectively.[15] Typically, the dosage of TCA used to treat pruritus is lower than the typical antidepressant dosage. There are case reports of reduction of excoriation and pruritus with doxepin 30 mg/day.[19] Another common TCA used in OCRD, including body dysmorphic disorder, is clomipramine.[20,21] Other TCAs have received approval by the US Food and Drug Administration for indications such as neuropathic pain.[16] When a TCA is used as analgesic, the dosage required tends to be less than the dosage required for its antidepressant effect; amitriptyline (25-50 mg at bedtime) is frequently used for pain control.[3]

Of the TCAs, nortriptyline has the most favorable side effect profile, with mortality rates similar to those of SSRIs, and nortriptyline should be