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ARTICLE

An introduction to the assessment and management of psychodermatological disorders

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SUMMARY

Psychodermatology is an emerging field at the interface between psychiatry, psychology and dermatology. There is a strong bidirectional relationship between a number of dermatological disorders and psychiatric disorders. This article provides an overview of psychiatric disorders with dermatological symptoms, and dermatological disorders with secondary psychophysiological consequences. The principles of management and our insights into establishing a psychodermatology service in the UK are discussed.

LEARNING OBJECTIVES

After reading this article you will be able to:

- demonstrate an overview of psychiatric disorders with dermatological symptoms
- demonstrate awareness of dermatological disorders with secondary psychiatric symptoms
- understand the principles of management in psychodermatology.

KEYWORDS

Liaison psychiatry; dermatology; delusional infestation; body dysmorphic disorder; skin picking disorder.

Psychodermatology is an emerging field, focusing on the interaction between 'mind and skin', and involves the interplay between ectoderm-derived brain, cutaneous nerves, immune system and skin (Jafferany 2011). In terms of services, it sits at the interface between psychiatry, psychology and dermatology (Bewley 2014).

The prevalence of psychiatric morbidity in dermatology clinics is high – estimated to be around 25% in an out-patient dermatological clinic (Picardi 2000). There is a range of severity and complexity of psychiatric disorder, from common mental disorders such as anxiety and depression, including those secondary to the underlying dermatological disorder, to more complex and rare disorders, such as delusional infestation or specific manifestations of body dysmorphic disorder that result in dermatological symptoms. Koo & Lee (2003) have outlined a commonly used classification system for psychodermatological diseases:

1 Psychophsyiological disorders – there is a clear and chronological relationship between stress and precipitating or exacerbating a skin disease (e.g. psoriasis, acne).
2 Primary psychiatric disorders with dermatological symptoms – there is no underlying skin disease, instead symptoms are due to pschiatric disorder (e.g. delusional infestation, body dysmorphic disorder, trichotillomania).
3 Secondary psychiatric disorders – where psychological problems arise as a result of skin disease and are more severe than the underlying dermatological disorder (e.g. alopecia areata, acne excoriee).

This article will focus on psychiatric disorders with skin manifestation and dermatological disorders with secondary psychiatric symptoms and how these can exacerbate one another. Some studies estimate that the frequency of medically unexplained symptoms in the dermatology out-patient setting may be around 2% (Reid 2001) and this may be an underestimate. However, it will not be the focus of our article. We aim to provide an overview and approaches to management of psychodermatological disorders, with a particular focus on aspects relevant to those working in general and liaison psychiatry settings, illustrated with fictitious case examples. We will also outline our efforts in establishing an out-patient advice and referral psychodermatology service in the UK.

Psychiatric disorders with dermatological symptoms

A number of psychiatric disorders primarily present with dermatological symptoms, manifesting either through visible clinical signs or the patient's subjective experience. These disorders frequently present to the patient's general practitioner or through specialist dermatology clinics. These patients often have complex needs, which require a collaborative multidisciplinary approach that addresses not only the

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manifest dermatological symptoms, but also the underlying psychological and social factors contributing to their presentation. An open, non-judgemental and attentive listening style should be adopted to establish a therapeutic relationship, in which the patient's symptoms are not dismissed, but explored thoughtfully while placing emphasis on the impact on their social and occupational functioning.

Delusional infestation

Delusional infestation describes an individual's fixed, false and firmly held belief that they are infested with a parasite, despite explanation that there is no medical evidence for this being the case (Freudenmann 2009). Delusional infestation is rare, with an estimated annual prevalence of 17 cases per million population, tending more often to affect females (Freudenmann 2009). It can occur either as a primary delusional disorder or secondary to other mental disorders, such as schizophrenia, dementia or severe depression. Secondary delusional infestation can be associated with medical disorders such as thyroid disorder, HIV, malignancy and nutritional deficiencies (including vitamin B_{12}, vitamin B_3 and folate), prescribed medications (in particular dopaminergic agents) or following substance misuse (mostly associated with amphetamine, cocaine and cannabis use) (Lepping 2014). Where the delusional infestation is secondary to other disorders, it is important that these are addressed appropriately.

Primary delusional infestation can be classified as a persistent delusional disorder (F22.0) in ICD-10, if present for at least 1 month and cognitive and social functioning is otherwise preserved (World Health Organization 1992). Patients describe the subjective experience of parasites crawling or burrowing into or underneath the surface of the skin. The 'specimen sign' or 'matchbox sign' is a feature in which the patient brings with them to the consultation specimens as 'proof' of infestation – which can be bits of skin or crust stored in a container such as a matchbox, bottle or specimen pot (Freudenmann 2009).

Clinical skin signs are the result of self-inflicted damage to the skin undertaken in an attempt to remove the parasite. These can include excoriations, cuts, erosions or burns secondary to bleaching, and can lead to secondary skin problems as well as reinforcing the belief of infestation (Lepping 2014). Often the symptoms have a specific onset following real experience or an illusion or hallucination.

The primary focus of treatment should be on establishing a therapeutic rapport rather than trying to persuade the patient that they do not have a real infestation (Lepping 2014). It is important that the patient's skin is thoroughly examined from head to toe, helping to build a trusting relationship between the clinician and patient. Often patients are extremely resistant to seeing a psychiatrist, and joint dermatology and psychiatry clinics, or dermatology-led prescribing of antipsychotics under the advice and guidance of a psychiatrist, can be more effective (Lepping 2014).

There is no benefit of established psychological therapy in the treatment of delusional infestations, and the mainstay of treatment is with a low-dose antipsychotic (often risperidone, olanzapine or amisulpride), with reported response rates of 70–80%, although the main difficulty is treatment adherence (Freudenmann 2008; Lepping 2008). Emphasis should be placed on how antipsychotics can reduce distress and significantly improve quality of life. Full insight is not the goal and often is not achieved, with patients instead describing that the symptoms have resolved (Lepping 2014).

Case vignette: delusional infestation

David (58) was referred to dermatology because of distress about an infestation in his skin. He has seen his general practitioner on a number of occasions in the past 8 months and been treated for scabies, but with no improvement. He describes crawling sensations within the skin and brings a small container with him to the dermatology appointment, which he believes contains evidence of the 'bug'. On closer inspection by the dermatologist the evidence appears to be dry skin. When the dermatologist examines David's skin they find excoriations and erosions, with sparing of areas that are difficult to reach (e.g. between the shoulder blades). David says that the infestation became worse after he lost his job as a cleaner. The dermatologist prescribes some emollients and antibacterial wash and sends off the sample to microbiology for analysis, which David is pleased about as he feels he is being taken seriously. The dermatologist also suggests trialling a low-dose antipsychotic to reduce distress by 'switching off the nerve fibres' producing the unpleasant sensations, which David agrees to try. At follow-up 6 months later David reports that his symptoms have resolved and that he has returned to work.

Dermatitis artefacta

Dermatitis artefacta is a type of factitious disorder involving self-induced skin lesions but in which the patient denies responsibility. It may have an underlying internal motive, for example by having physical needs attended to the person can adopt the 'sick role', or it may occur outwith the patient's consciousness, for example during a dissociative state. Patients can be resistant to exploration of their behaviours and underlying psychological or emotional motives. It is important to differentiate dermatitis artefacta from other self-injurious behaviours, including malingering in which skin lesions are self-induced in

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order to satisfy an external motive, such as financial compensation or seeking out medication.

Patients with dermatitis artefacta often have lesions that are within easy reach of the dominant hand, can be bilaterally symmetrical and have bizarre shapes with angular borders (Jafferany 2007). They may also have burn scars, blisters and/or ulcers, with erythema and oedema, and lesions can be induced in a variety of ways, including rubbing, cutting, burning, bleaching, picking or scratching (Jafferany 2007).

Focusing on the possibility that lesions may be self-induced may lead to a break down in the patient–clinician relationship (Millard 2014). Instead the clinician should take time to develop a rapport, identify any stressors and treat underlying psychiatric or psychological disorders. The psychiatric disorders most frequently associated with dermatitis artefacta are personality disorder, adjustment disorder and depression (Millard 2014). Personality disorder is seen in at least one-third of patients (most commonly, emotionally unstable or histrionic personality disorder) and will be suggested by a history consistent with the disorder and/or multiple previous contacts with healthcare services, especially mental health services (Casey 2007: pp. 106–20; Millard 2014). Adjustment disorders follow an identifiable stressor and may or may not resolve, depending on whether the stressor persists.

Case vignette: dermatitis artefacta

Meera (16) was referred to the dermatology service by her general practitioner for further assessment of annular (ring-shaped) bullae (blisters) on the inner aspect of her right forearm. On examination the dermatologist noted that the bullae were each the same size and perfectly round. He also noted that Meera is left-handed and the lesions were only on her right forearm. During the consultation Meera said she did not know how the lesions appeared but that they tended to occur at night-time. A biopsy was taken for further investigation, including histology, which revealed non-specific changes. After further consultations and on exploring her psychosocial history, it became apparent that Meera was being bullied at school and about to take examinations in which she felt under a lot of pressure to perform well. Meera was encouraged to tell her parents about the bullying. They subsequently informed her school, which took steps to address the bullying and support Meera. She was also offered counselling with the school counsellor to develop anxiety management techniques. Over the next 3 months her anxiety began to improve and the lesions stopped appearing and began to heal.

Body dysmorphic disorder

Body dysmorphic disorder describes a patient's preoccupation with one or more perceived defects or flaws in their physical appearance that are not observable or appear only slight to others (World Health Organization 1992). This results in repetitive physical acts, such as mirror checking, skin picking or excessive grooming, or mental acts, such as comparing their experience with others, and leads to significant distress or impairment in functioning. Body dysmorphic disorder is relatively common, with a prevalence of around 2% in the general population, occurring equally in males and females (Koran 2008), but a prevalence of 11.9% was recorded in a sample of 268 patients seeking dermatological treatments (Phillips 2000).

The patient may seek specialist input by requesting referrals to dermatologists, plastic surgeons, urologists, gynaecologists or orthodontists to improve their perceived defect (Veale 2015). People with body dysmorphic disorder are often frequent attenders to different specialists and can use a significant amount of National Health Service (NHS) resource. In dermatological settings, perceived defects may include the quantity and quality of the skin appendages (e.g. hair and nails) as well as asymmetry or disproportionality of the lips, teeth, genitalia, pore size, pigmentation, reddening or sweating. They may request dermatological treatments such as medication for acne, antibiotics for perceived skin infections or laser therapy for perceived defects (Veale 2015). Patients less commonly present to mental health services, which may become involved only in a psychiatric liaison setting or where there are additional or resulting comorbidities such as depression or suicidal ideation (Veale 2015).

History taking should be non-judgemental and focus on exploring the patient's own view of the problem, including the impact on their daily functioning, relationships, and social and occupational functioning, as well as exploring for the presence of psychiatric comorbidities. Unless directly asked, people with body dysmorphic disorder often do not reveal the severity of their preoccupation and distress, owing to feelings of shame about their experience (Veale 2015).

The National Institute for Health and Care Excellence provides evidence-based guidelines for the treatment of body dysmorphic disorder in the UK, recommending that patients with moderate dysfunction should be offered the choice of either cognitive–behavioural therapy (CBT) or a selective serotonin reuptake inhibitor (SSRI) (National Institute for Health and Care Excellence 2005). Individuals with severe dysfunction should be offered combination of CBT and an SSRI. There is no evidence to support prescribing antipsychotics, even if delusional symptoms are present (Veale 2010). Retrospective evidence suggest that people

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with body dysmorphic disorder who undertake corrective interventions do not tend to feel resolution of symptoms, and even where they are satisfied with the outcome of a procedure, the preoccupation can subsequently return to the same body part or move to another part of their body (Veale 2006).

Veale & Neziroglu (2010) outline general principles to undertaking CBT for body dysmorphic disorder which revolves around helping patients to develop a different understanding of their problem, with a focus on their distress and worry about their appearance, rather than the appearance itself. The patient's beliefs about their appearance are explored, including past experiences in which these beliefs may have been reinforced, such as bullying or emotional abuse. Learned behaviours are identified that may reinforce distress, such as constant mirror checking or comparison with other people's appearance. Tools include mindfulness to reduce excessive rumination, and behavioural experiments in which the patient enters anxiety-provoking situations but does not undertake previous compensatory behaviours, to try to break the cycle of compensatory repetitive physical acts.

Case vignette: body dysmorphic disorder

Alice (24) was referred to the psychodermatology service owing to distress about an area of pigmented skin on her face. Alice states that she checks her face in the mirror up to 50 times a day and sees an 'ugly person'. She spends several hours trying to conceal the area before leaving the house and feels restless in the company of others through fear that they are also disgusted by her appearance. She reports becoming socially withdrawn owing to fear of being scorned, and she has stopped attending her university course. She has spent hours researching treatment options for her skin and has already spent £400 on laser treatment at a beautician's. She reports low mood and suicidal thoughts over the past few months, but she has never acted on these. The dermatologist notes a few freckles on her face. The dermatologist discusses treatment options, including laser therapy, but emphasises that many people are left unhappy with the results. Instead the dermatologist first recommends trialling antidepressant medication (sertraline) and CBT therapy. It was agreed with Alice that no laser treatments should be pursued while assessing treatment response. At follow-up 4 months later Alice says that her university attendance has improved and she has resumed some social activities.

Trichotillomania and skin picking disorder

In trichotillomania the person repeatedly pulls at their hair, resulting in noticeable hair loss. Skin picking disorder (or neurotic excoriation) involves repetitive skin picking, resulting in noticeable skin lesions, typically weeping, crusted or lichenified lesions with hypo- or hyperpigmentation (Jafferany 2011). There is significant overlap between both trichotillomania and skin picking disorder, with similar demographics (young female with a history of emotional trauma), psychiatric comorbidities (including depression, obsessive–compulsive disorder and anxiety-related disorders, eating disorder, personality disorder and body dysmorphic disorder) and personality traits (in particular, perfectionist traits) (Gupta 1996; Lochner 2002; Jafferany 2011).

Trichotillomania is often precipitated by an increase in feelings of tension before hair pulling and can include attempts to resist. Hair pulling can lead to feelings of relief, gratification or even pleasure afterwards (Enos 2001). The disorder tends to affect females more than males, and has been found to have a lifetime prevalence of around 1.7% in a large sample of community adults (Grant 2020).

Skin picking disorder often follows specific situational cues, such as looking in the mirror or noticing a blemish, or more general triggers, such as feelings of agitation, boredom or distress, and it is often associated with subsequent feelings of relief or pleasure (Odlaug 2011). Acne excoriée (or skin picker's acne) can result when someone with acne picks at their skin, resulting in a vicious cycle in which the person becomes more likely to pick at blemishes (either because of concerns about appearance or the satisfying sensation of picking), thus making them worse (Jafferany 2007). Repetitive skin picking can result in multiple lesions, scarring or skin infections and, in extreme cases, can result in exposure of underlying tissues, such as muscles and arteries (Abramowitz 2014).

Case vignette: Skin picking disorder

Mary (28) was referred to the psychodermatology clinic with multiple lesions across her shins that failed to heal. An organic dermatology cause had been excluded, including undertaking a skin biopsy. After establishing a rapport over three consultations, the dermatologist is able to explore their suspicions that Mary is picking at the lesions. Mary says the compulsive thoughts occur daily and often immediately on waking. She describes feelings of relief and gratification immediately on picking the scabs, but these then give way to feelings of guilt and shame. Mary has had anxiety since her teenage years and thinks she has had scabs on her legs for a similar length of time. Mary undertook habit reversal training and psychoeducation with the psychodermatology therapist. This included keeping a diary of her picking, along with associated emotions and potential triggers (e.g. immediately after waking), allowing her to develop strategies such as alternative distraction methods and covering the area at which she picks. She also identified work stress as a trigger and learned relaxation techniques to manage this. At follow-up 4 months later, there had been some improvement in

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TABLE 1 Components of cognitive–behavioural therapy for trichotillomania and skin picking disorder

Component	Description	Example
Stimulus control	Using measures such as reducing cues in the environment or making the response more difficult	Having a short hairstyle in trichotillomania
Habit reversal therapy	Developing an understanding of triggers or situational cues, and using competing responses until the urge passes	Making a tight fist when passing a mirror that would normally trigger skin picking at blemishes
Cognitive interventions	Challenging the beliefs that maintain the cycles, such as rationalising the behaviours or believing they can control the amount of picking	Challenging the belief that 'after picking my face for 5 min I will stop and be able to relax'

Source: Abramowitz & Jacoby (2014).

her scabs and Mary was agreeing to continue with further therapy.

Similar treatment approaches are used for both trichotillomania and skin picking disorder, and they should include thorough exploration for comorbid psychological and psychiatric disorder. CBT is the mainstay of treatment, but there is also a role for pharmacological therapy with SSRIs either where psychotherapy is inappropriate or combination treatment is required (Jafferany 2011; Abramowitz 2014). CBT for trichotillomania and skin picking disorder has three components: stimulus control, habit reversal therapy and cognitive therapy (Abramowitz 2014) (Table 1).

Eating disorders

Eating disorders can result in a wide range of dermatological signs and symptoms, which are the result of starvation, malnutrition, self-induced vomiting or the misuse of weight-loss supplements (e.g. laxatives and diuretics) (Jafferany 2007). These include lanugo (fine facial hair), erythrocyanosis (cold intolerance, swelling and blistering of extremities), poor wound healing, gingivitis (gum disease), cheilitis (swelling of the lips), acne, alopecia and Russell's sign (calluses on the back of the hand or knuckles due to repeated acts of self-induced vomiting). Patients with an eating disorder should be referred to a community-based, age-appropriate eating disorder service for further assessment and treatment (National Institute for Health and Care Excellence 2017).

Dermatological disorders with psychiatric comorbidities

There is a strong association between dermatological disorders with psychological distress and psychiatric disorders such as depression and anxiety (Kurd 2010; Sampogna 2012). Routine or targeted screening for patients attending dermatology out-patient clinics can offer an effective means of identifying those who may benefit from further assessment and intervention if required (Henkel 2002; Picardi 2004). Although a variety of screening measures have been suggested, including the Hospital Anxiety and Depression Scale (HADS) and the 12-item General Health Questionnaire (GHQ-12) (Lamb 2017), we have found that using both the two-item Patient Health Questionnaire (PHQ-2) and the two-item Generalized Anxiety Disorder scale (GAD-2) have been effective at screening for evidence of common psychiatric comorbidities.

In so-called psychophysiological disorders, stress often plays a key role in the aetiology of the disorder and can either precipitate or exacerbate dermatological disorders (Table 2). These are thought to be mediated through immunological mechanisms, for example through an increased ability of T-cells and natural killer cells to target the skin when patients with psoriasis are in psychological distress (Schmid-Ott 2009).

Other dermatological disorders associated with psychological problems include vitiligo (in which there is destruction of melanin, leading to light patches of skin), with around one-third of affected individuals thought to have a psychiatric disorder (Papadopoulos 1998). Alopecia areata is an autoimmune condition resulting in significant hair loss and it can itself be triggered by psychological factors (Jafferany 2007). Psychiatric comorbidity is common in alopecia areata, including depression, generalised anxiety disorder and social phobia (Koo 1994).

Psychological distress has been identified as a key predictor of successful response and adherence to treatment (Fortune 2003; Richards 2006). Treatment with psychological intervention alone has been shown to improve dermatological disorder (Papadopoulos 1999) and maintain behavioural change in long-term dermatological conditions (Lavda 2012). The 'combined approach to atopic dermatitis' combines patient education, optimal topical treatment and habit reversal therapy, and has been shown to successfully treat chronic atopic

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TABLE 2 **Psychophysiological dermatological disorders**

Disorder	Description	Psychiatric associations
Psoriasis	Scaling plaques largely on extensor surfaces (the skin on the outside of joints)	Stress has been reported by 44% before initial flare and up to 80% in recurrent flares (Al'Abadie 1994; Griffiths 2001). Associated with body image disturbance and impaired social functioning (Gupta 1987)
Atopic dermatitis (eczema)	Chronic and recurrent skin disease characterised by severe pruritus. Skin becomes dry, itchy and cracked	Stressful life events, such as partner bereavement, have been found to increase the risk of eczema (Wong 2020) and symptom severity has been associated with interpersonal and family stress (Gil 1987)
Acne excoriée	Habitual act of picking that is localised to the face and there is minimal acne	Psychological factors, including perfectionist and compulsive traits and poor self-image are associated with perpetuation of excoriation (Gupta 1996)
Urticaria (hives)	Wheals (superficial skin-coloured swellings with surrounding redness) appear on skin due to allergies or autoimmune response; may also be idiopathic	Stress is a well-recognised triggering factor for urticaria (Curto-Barredo 2019)
Herpes simplex	Viral infection characterised by painful erosions and blisters most commonly occurring around the mouth and genitals	Evidence to suggest that stress can induce reactivation of the herpes simplex virus (Sainz 2001)
Hyperhidrosis	Persistent and excessive sweating	Often brought on by emotional stimuli, and can lead to social phobias and avoidance symptoms (Jafferany 2007)

dermatitis (Bridgett 2019). The habit reversal element aims to reduce habitual scratching that leads to lichenification of the skin, and hence exacerbates the condition. Habit reversal therapy works through keeping a diary of scratching, identifying triggers (such as stress or changing clothes) and developing alternative strategies (e.g. closing hands into fists), with follow-up appointments to reinforce behaviours and monitor progress (Norén 1995).

Aims for treatment in psychodermatological disorders should include the reduction of pruritus and scratching and improvement of sleep or psychological distress, such as anger, embarrassment and social withdrawal (Jafferany 2007). Should comorbid psychiatric disorder be identified (such as anxiety or depression), established guidance should be followed (National Institute for Health and Care Excellence 2009), ideally led by a multidisciplinary approach.

Establishing a psychodermatology clinic

There is evidence that delivering integrated care in the dermatology setting involving a multidisciplinary team of dermatologists, nursing staff, psychiatrists and psychologists can result in high-quality and cost-effective care (Akhtar 2012; Bewley 2012). Despite this compelling argument, many NHS trusts and health boards in the UK are reluctant to prioritise the resources required to establish such a service.

A number of integrated services have instead relied on a higher trainee clinic model involving the input of psychiatry and dermatology trainees supervised by

BOX 1 Developing a psychodermatology service

Service design

- Consider using a stepped-care approach: patients receive treatment in steps and the intensity of treatment is increased if they fail to benefit from the previous step (Richards 2012).
- One proposed model for this stepped-care approach was set out by the British Association of Dermatologists' Psychodermatology Working Party (Bewley 2012). This suggests at least regional psychodermatology services with clinical psychologist support and named lead dermatologists with expertise in psychodermatology.
- Aim to make use of existing services wherever possible. Locally, we have developed strong links with improving access to psychological therapy (IAPT) services, including providing space for a therapist providing high-intensity cognitive–behavioural therapy to see referrals in the dermatology out-patient setting. We regularly meet with the therapist to review the quality and number of referrals received.

Training and education

- Make use of existing dermatology multidisciplinary meetings to offer support to dermatology colleagues for complex cases, to provide informal training and to develop links between the psychiatry and dermatology departments.
- Consider how you can support the dermatology department to better recognise people presenting with psychiatric comorbidity. In our clinic we encourage and support dermatology doctors and nurses to use the PHQ-2 and GAD-2 screening tools.

Joint dermatology and psychiatry clinics

- Offer joint assessment appointments with a senior dermatologist (higher specialist trainee or consultant) and senior liaison psychiatrist.
- These appointments should be dedicated and extended (45 min for new joint assessments) to allow for detailed psychosocial assessment.
- Ideally, facilities for providing assessments and psychological intervention should be within the dermatology out-patient clinic.
- Encourage the referring dermatologist to attend in order to increase their own skills in managing psychodermatology presentations.

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consultants. This has the potential to work particularly well in psychiatry, where trainees often have protected time for special interest work. In Box 1 we have outlined some of our own learning from developing a local psychodermatology service, initially involving a higher specialist psychiatry trainee (J.H.).

Conclusions

There is a high prevalence of psychiatric illness in patients presenting to dermatology clinics and a strong bidirectional relationship between dermatological disorder and psychological distress and, at its extreme, psychiatric disorder. This relationship points to the value of a multidisciplinary approach to treatment, involving dermatology, psychiatry and psychology. In our own experience, such integrated care can be clinically and cost-effective, although this service model is still uncommon in the UK's NHS.

Author contributions

R.G. conceived and wrote the article. P.W. and J.H. provided the fictitious clinical vignettes and made contributions to writing of the article.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bja.2020.66.

MCQ answers
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MCQs

Select the single best option for each question stem

1 Which of the following statements about delusional infestation is correct?

a it is always classified in ICD-10 as persistent delusional disorder
b it has an estimated annual prevalence of around 17 per million population
c there is always an absence of any dermatological clinical signs
d psychiatrists are best placed to treat the disorder
e full insight into the disorder is an aim of treatment.

2 Which of the following statements about dermatitis artefacta is correct?

a the patient is always aware that the skin lesions are self-induced
b it is more common in males
c it is often associated with emotionally unstable and histrionic personality disorder
d it is suggested by an absence of previous contact with mental health services
e it is an example of malingering.

3 Which of the following statements about body dysmorphic disorder is false?

a it involves repetitive physical or mental acts
b it leads to clinically significant distress or impairment in functioning
c patients with severe dysfunction should be offered combination CBT and SSRI
d corrective interventions tend to lead to resolution of symptoms
e it is equally common in males and females.

4 Which of the following is not a psychophysiological dermatological disorder?

a urticaria
b neurotic excoriation
c hyperhidrosis
d atopic dermatitis
e herpes simplex.

5 The combined approach to atopic dermatitis involves:

a patient education
b optimal topical treatment
c habit reversal therapy
d follow-up to monitor and reinforce progress
e all of the above.

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