

Original Research

Received 10 July 2026

Revised 15 Aug 2026

Accepted 29 Aug 2026

Natural Resources for Human Health 2026, Vol. 6 (18s): 91–98

KEYWORDS:

psychodermatology, psychocutaneous disorders, family medicine, mental health, dermatology.

The Role of Family Physicians in Managing Psychodermatologic Disorders: A Narrative Review

Khitam Al-Refu, Md, PhD

Professor of Dermatology Department of Dermatology, Faculty of Medicine, Mutah University, Karak 61710, Jordan

Email: Alrefukhi@mutah.edu.jo; alrefukhi@yahoo.com

ORCID: 0000-0001-9699-1707

ABSTRACT: Background: Psychodermatologic disorders (PDs) involve interactions between psychological factors and skin disease. Despite their clinical relevance, psychodermatologic disorders are often overlooked in primary care, particularly in resource-limited settings where mental health stigma, limited specialist availability, and inadequate physician training remain important barriers.

Objective: This review examines the classification, diagnosis, and management of PDs from a family medicine perspective, emphasizing practical strategies for primary care.

Methods: PubMed, Scopus, and Google Scholar were searched for relevant English-language publications published between January 2000 and October 2026. Eligible publications were synthesized narratively across the main themes of classification, diagnosis, management, interdisciplinary care, and physician education.

Results: PDs were commonly classified into three groups: primary psychiatric disorders with cutaneous manifestations, such as trichotillomania; psychiatric consequences of chronic skin disease, such as depression associated with psoriasis; and skin conditions exacerbated by psychological stress, such as eczema. Reported barriers to recognition and management included limited consultation time and insufficient professional training. Nevertheless, screening questionnaires, initial counseling, collaborative care, and targeted professional education may improve recognition and management.

Conclusion: Effective management of PDs in primary care requires focused physician education and integration of mental health support with dermatological care. Because family physicians often maintain continuous, trusting relationships with patients, they are well positioned to identify these disorders early, reduce barriers to care, and coordinate comprehensive management. This integrated approach is especially important in resource-limited and culturally diverse settings.

INTRODUCTION

Psychodermatology focuses on the complex relationship between mental health and skin disease, including the ways in which psychological stress may trigger or exacerbate dermatologic conditions. Numerous skin disorders are influenced by psychological factors or may themselves cause considerable psychological distress, underscoring the importance of addressing both dimensions in clinical care. Integrating psychological assessment and support into dermatologic care may contribute to improved clinical outcomes and patient quality of life ^{1,2}. Stress may affect the skin by impairing its protective barrier, disrupting immune regulation, and increasing inflammation. These mechanisms may contribute to exacerbations of chronic skin conditions such as psoriasis ^{3,4}.

A widely accepted classification system divides psychodermatologic disorders into three main categories: (1) primary psychiatric conditions with dermatologic manifestations, such as trichotillomania or delusional infestation; (2) secondary psychiatric conditions arising from chronic or visible skin diseases, such as anxiety associated with acne; and (3) psychophysiological disorders in which psychological stress exacerbates existing skin conditions, such as eczema or urticaria. This classification provides a practical framework for clinicians ⁵.

Advances in psychoneuroimmunology have further clarified how stress-related alterations in immune function and skin integrity may influence dermatologic outcomes. Pharmacologic management may include selective serotonin reuptake inhibitors for selected psychiatric comorbidities or compulsive behaviors, whereas doxepin may be considered in selected cases of pruritus or urticaria because of its antidepressant and antihistaminic properties ⁶.

Despite these advances, psychodermatologic disorders frequently remain unrecognized in primary care settings. Psychological contributors to dermatologic complaints may not be routinely assessed in family practice because of limited training, time constraints, or discomfort in discussing mental health, particularly in settings where psychiatric conditions remain highly stigmatized. This may contribute to delayed recognition, fragmented care, and incomplete management.

While much of the existing literature addresses psychodermatologic disorders from dermatologic or psychiatric perspectives, the present review focuses on the role of family physicians. As frontline healthcare providers, family physicians are often the first point of contact for patients with psychocutaneous concerns. By incorporating psychosocial screening, providing initial support, and coordinating appropriate referrals, they may help integrate dermatologic and mental health care. This role is particularly relevant in resource-limited or culturally sensitive settings where access to specialist care may be restricted and patients may be reluctant to seek psychiatric assistance.

Consequently, this review aims to examine psychodermatologic disorders from a family medicine perspective. It highlights relevant clinical presentations, outlines diagnostic and therapeutic challenges, and identifies strategies to improve awareness, early recognition, and interdisciplinary collaboration in primary care settings.

METHODOLOGY

This structured narrative review examined the classification, diagnosis, and management of psychodermatologic disorders from a family medicine perspective. PubMed, Scopus, and Google Scholar were searched for relevant English-language publications published between January 2000 and October 2026. The literature search was last updated in October 2026. Search terms included combinations of “psychodermatology,” “psychocutaneous disorders,” “primary care,” “family medicine,” and “mental health in dermatology,” using the Boolean operators AND and OR.

Publications were eligible for inclusion if they addressed the classification, diagnosis, management, psychosocial impact, or primary care implications of psychodermatologic disorders. Original studies, review articles, relevant book chapters, and authoritative organizational reports were considered. Case reports, non-English publications, publications that did not address the psychosocial aspects of dermatologic disease, and those with no clear relevance to family medicine or primary care were excluded.

Potentially relevant publications were screened by title and abstract, followed by full-text assessment according to the eligibility criteria. Study selection and eligibility assessment were conducted by the author.

The included publications were analyzed thematically across four domains: classification and clinical spectrum, diagnostic and management challenges, the role of family physicians, and integrated multidisciplinary care and educational needs. Findings were synthesized narratively because of the clinical and methodological diversity of the included literature; no quantitative meta-analysis was performed.

As this review involved no direct participation of human subjects and no identifiable or private patient data, institutional ethical approval was not required.

Key findings

Four key thematic domains emerged from the reviewed literature, highlighting practical considerations for family physicians involved in managing psychodermatologic conditions.

1. Classification and Clinical Spectrum of Psychodermatologic Disorders:

A commonly used clinical framework classifies psychodermatologic disorders into three broad and potentially overlapping categories: primary psychiatric disorders with dermatologic manifestations, secondary psychiatric conditions arising from chronic skin disease, and psychophysiologic dermatoses influenced by psychological stress. This framework may help family physicians recognize and manage the range of psychocutaneous presentations encountered in clinical practice. Table 1 summarizes the defining features, psychiatric associations, dermatologic manifestations, and management considerations for each category.

Primary psychiatric disorders are conditions in which an underlying psychiatric disorder produces perceived, self-induced, or behavior-related dermatologic manifestations. Examples include delusional parasitosis, trichotillomania, and body dysmorphic disorder. In these conditions, symptoms such as fixed false beliefs, compulsive behaviors, or distorted perceptions of appearance may lead to dermatologic complaints or self-inflicted skin and hair changes. Early recognition and collaborative management are important for limiting chronic symptoms and further psychological or physical harm ⁷.

Secondary psychiatric conditions arise as emotional or behavioral consequences of chronic, visible, or disfiguring skin disease. Patients with psoriasis, vitiligo, or acne may experience depression, anxiety, reduced self-esteem, or social isolation. Although these symptoms do not always meet the diagnostic criteria for a psychiatric disorder, their psychological burden may adversely affect treatment adherence, quality of life, and dermatologic outcomes ⁸.

Psychophysiologic dermatoses are dermatologic conditions that may be triggered or exacerbated by psychological stress. Atopic dermatitis, psoriasis, and urticaria may worsen during periods of emotional distress. Psychoneuroimmunologic mechanisms, including stress-related immune dysregulation and impairment of the skin barrier, may contribute to this relationship ⁹.

Considerable overlap may occur among these categories. For example, a patient with psoriasis may experience stress-related disease exacerbations while also developing depression in response to the visible and chronic nature of the condition. This clinical complexity supports the use of a holistic biopsychosocial approach to assessment and management in family medicine.

2. Diagnostic and Management Challenges in Primary Care

Available evidence indicates gaps in healthcare professionals' knowledge, training, and confidence regarding the recognition and management of psychocutaneous conditions ¹⁰. Similar gaps may affect primary care practice, contributing to under recognition and fragmented care¹¹.

Cultural stigma surrounding mental illness may impede effective care in Middle Eastern settings. A cross-sectional study conducted among healthcare professionals in Qatar identified stigmatizing attitudes toward patients with mental illness, highlighting the need to improve professional awareness and communication ¹².

Structural challenges may also affect the integration of mental health care into primary care settings. In Jordan, WHO initiatives have emphasized strengthening the capacity of healthcare teams through targeted mental health training. These initiatives highlight the importance of equipping primary care professionals with the knowledge and skills needed to recognize mental health concerns and support integrated, community-based care ¹³.

Collectively, these educational, clinical, cultural, and structural barriers may contribute to delayed recognition, insufficient psychosocial support, fragmented care, and poorer outcomes among patients with psychodermatologic disorders.

3. The Role of Family Physicians in Holistic Care

Family physicians are well positioned to contribute to the recognition and management of psychodermatologic disorders because of their accessibility, continuity of care, and biopsychosocial approach. As the first point of contact for many patients with skin complaints, they may identify relevant psychological factors, initiate appropriate assessment and support, monitor patients over time, and coordinate referrals when specialist care is required.

To support the early identification of depressive symptoms, family physicians may use the Patient Health Questionnaire-9 (PHQ-9), a brief and validated instrument for assessing depression severity. Its concise format makes it suitable for use in primary care and may assist physicians in identifying patients who require further psychological assessment or referral ¹⁴.

Beyond screening, family physicians can provide initial support through patient education, reassurance, and appropriate referral. When primary psychiatric disorders manifest through the skin—such as trichotillomania, excoriation disorder, or delusional infestation—recognition of the underlying psychiatric condition is essential. Management should be tailored to the specific disorder and may require psychiatric evaluation and disorder-specific pharmacologic treatment rather than dermatologic treatment alone ¹⁵.

Because psychodermatologic disorders lie at the interface of dermatology, psychiatry, and psychology, collaboration among these disciplines is important, particularly in complex or persistent cases. Family physicians can facilitate appropriate referral to dermatology or mental health specialists while continuing to monitor treatment adherence and provide longitudinal support ¹⁶.

Through these roles, family physicians may help connect dermatologic and mental healthcare and promote comprehensive, stigma-sensitive, and patient-centered management of psychodermatologic disorders.

4. Need for Integrated and Multidisciplinary Approaches

The management of psychodermatologic disorders may require collaboration among family physicians, dermatologists, psychiatrists, and psychologists because these conditions can involve overlapping dermatologic and psychiatric features ^{16,17}. Multidisciplinary care may support more comprehensive assessment, reduce fragmentation between services, and facilitate appropriate management, particularly in complex, persistent, or diagnostically uncertain cases.

Capacity-building initiatives in Jordan have emphasized strengthening the mental health knowledge and skills of healthcare teams. WHO-supported training initiatives highlight the importance of preparing healthcare professionals to recognize mental health concerns and provide appropriate initial support within community and primary care settings ¹³.

Reported gaps in healthcare professionals' knowledge, awareness, and clinical practice highlight the need for continuing medical education in psychodermatology ^{10,11}. Educational initiatives should also address stigmatizing attitudes toward mental illness among healthcare professionals, particularly in regional healthcare settings ¹². Given the interdisciplinary nature of psychodermatology, its basic principles may also provide a useful foundation for educational activities involving family medicine, dermatology, psychiatry, and psychology ¹⁷. Addressing stigma is an important component of integrated psychodermatologic care. Evidence from a regional study conducted among healthcare professionals in Qatar identified stigmatizing attitudes toward patients with mental illness. These findings highlight the importance of promoting respectful, non-stigmatizing communication and improving healthcare professionals' awareness of mental health concerns ¹².

DISCUSSION

Psychodermatologic disorders are clinically relevant to primary care but may remain underrecognized despite their potential effects on patients' quality of life and healthcare use. This review identified several barriers to their recognition and management, including gaps in professional knowledge and training, stigmatizing attitudes toward mental illness, and limited integration between dermatologic and mental health care. Strengthening the capacity of family physicians in psychodermatology may support earlier recognition, appropriate initial management, patient education, and timely referral when specialist care is required.

Studies conducted in international and regional settings have identified gaps in healthcare professionals' knowledge, awareness, and clinical practice regarding psychodermatology ^{10,11}. Such gaps may hinder the recognition of psychological factors associated with dermatologic presentations. In addition, a regional study conducted among healthcare professionals in Qatar identified stigmatizing attitudes toward patients with mental illness ¹². Together, these findings highlight the need for structured education and culturally sensitive training for healthcare professionals involved in the care of patients with psychodermatologic conditions.

The continuity and comprehensive nature of family medicine may place family physicians in a favorable position to recognize psychodermatologic disorders at an early stage. Conditions involving self-inflicted lesions or psychocutaneous symptoms, including trichotillomania and delusional infestation, require timely recognition, appropriate assessment, and referral when necessary ^{18,19}. The substantial psychological burden reported among dermatology patients further supports the importance of considering mental health symptoms during clinical assessment ²⁰. The PHQ-9 may assist in identifying depressive symptoms; however, its results should complement rather than replace a comprehensive clinical assessment ¹⁴.

Family physicians may also provide patient education, supportive counseling, and initial management according to the patient's diagnosis and clinical needs. Pharmacologic treatment should be individualized rather than directed broadly at psychodermatologic symptoms. SSRIs may be considered for appropriate coexisting depressive, anxiety, or selected compulsive symptoms, whereas doxepin may be considered in selected cases of pruritus because of its antidepressant and antihistaminic properties ^{6,21}. Incorporating psychological assessment into dermatologic care may help reduce stigma, support treatment adherence, and facilitate timely referral to appropriate multidisciplinary services.

The interaction between psychological stress and skin health is well recognized²², while unmet educational and training needs in psychodermatology have also been reported ²³. Studies involving healthcare professionals have identified gaps in knowledge, awareness, and clinical practice related to psychodermatology ²⁴⁻²⁶. These findings support the inclusion of relevant psychodermatologic principles in undergraduate, postgraduate, and continuing medical education. Psychological and educational interventions have also been evaluated in the management of chronic skin conditions, particularly eczema, further illustrating the clinical relevance of addressing psychosocial factors in dermatologic care ²⁵. Such educational efforts may be particularly valuable in settings where mental health stigma and limited specialist availability place greater responsibility on primary care providers.

Psychodermatologic conditions may impose a substantial emotional and social burden. Individuals with visible chronic skin diseases, including vitiligo, psoriasis, and acne, may experience shame, social withdrawal, and perceived stigma. In patients with psoriasis, perceived stigmatization has been associated with greater disease-related disability²⁷. Health-belief-based education combined with behavior-modification strategies has also been shown to improve adherence to skin-moisturizing care among patients with psoriasis ²⁸. Psychiatric comorbidity has been associated with reduced quality of life among patients with dermatologic diseases ²⁹. These findings support a holistic, patient-centered approach that combines appropriate medical treatment with empathetic communication, patient education, and psychosocial support.

In Middle Eastern settings, mental health stigma and gaps in professional knowledge may complicate the recognition and management of psychodermatologic disorders. Evidence concerning adolescents in Jordan indicates that stigma influences perceptions of depression and mental health treatment; however, receiving treatment was viewed positively and was not associated with increased perceived stigma ³⁰. WHO-supported initiatives in Jordan have also emphasized mental health training and capacity building among healthcare teams ¹³. In addition, a Jordanian study involving patients with chronic dermatologic diseases reported clinically significant anxiety in 52% and depression in 49% of participants ³¹. Research among dermatologists in Turkey similarly identified gaps in psychodermatology-related knowledge, awareness, and practice patterns ³². Collectively, these findings support culturally sensitive patient communication and structured professional education in psychodermatology across regional healthcare settings.

Collectively, these findings support the need for culturally sensitive communication, clearer referral pathways, and practical psychodermatology training for healthcare professionals.

These findings support an integrated and multidisciplinary approach to psychodermatologic disorders in primary care. The substantial global burden of skin disease underscores the need for accessible and scalable approaches to dermatologic care ³³. Clinical guidance, clear referral pathways, and collaboration among primary care, dermatology, and mental health services may facilitate more coordinated management. In resource-constrained settings, appropriately supervised task-sharing may offer a practical means of expanding access to selected first-line psychological interventions ³⁴. Psychodermatologic principles may also be incorporated into medical curricula and continuing professional education. Consistent with person-centered care, closer integration of dermatologic and mental health services may support more comprehensive and equitable management.

This review has several limitations. As a narrative review, it was not designed to provide a systematic or quantitative synthesis of the available evidence. Restricting the search to English-language publications may have excluded relevant regional evidence. In addition, much of the available literature focuses on dermatology or psychiatry rather than specifically on family medicine, and evidence from Jordan and other Middle Eastern primary care settings remains limited. The findings should therefore be interpreted in light of these limitations.

Psychodermatologic disorders represent an important but potentially underrecognized challenge in family medicine. Their management is influenced not only by clinical manifestations but also by educational, cultural, and healthcare-system factors,

particularly in resource-limited settings. Strengthening professional education, reducing mental health stigma, improving interdisciplinary collaboration, and adapting services to local contexts may improve recognition, continuity of care, and patient-centered management. Family physicians can contribute to this process through early assessment, appropriate initial support, longitudinal follow-up, and coordination with dermatology and mental health services.

REFERENCES

- [1] Koo J, Lebwohl A. Psychodermatology: The mind and skin connection. *Am Fam Physician*. 2001;64(11):1873-8.
- [2] Jafferany M. Psychodermatology: A guide to understanding common psychocutaneous disorders. *Prim Care Companion J Clin Psychiatry*. 2007;9(3):203–213. doi:10.4088/PCC.v09n0306.
- [3] Georgieva F. Psychoneuroimmunology and impact of stress in chronic skin conditions. *Scripta Sci Med*. 2017;49(2):9–16. doi:10.14748/ssm.v49i2.2194.
- [4] Picardi A, Abeni D. Stressful life events and skin diseases: Disentangling evidence from myth. *Psychother Psychosom*. 2001;70(3):118–36.
- [5] Koo JY, Lee CS. General Approach to Evaluating Psychodermatological Disorders. In: Koo JY, Lee CS, editors. *Psychocutaneous Medicine*. New York: Marcel Dekker Inc; 2003. p.1–29.
- [6] Gupta MA, Gupta AK. The use of antidepressant drugs in dermatology. *J Eur Acad Dermatol Venereol*. 2001;15(6):512–8.
- [7] Kuhn H, Mennella C, Magid M, Stamu-O'Brien C, Kroumpouzou G. Psychocutaneous disease: clinical perspectives. *J Am Acad Dermatol*. 2017;76(5):779–791. doi: 10.1016/j.jaad.2016.11.013.
- [8] Gupta MA, Gupta AK. Psychiatric and psychological co-morbidity in patients with dermatologic disorders: epidemiology and management. *Am J Clin Dermatol*. 2003;4(12):833–842.
- [9] Reich A, Wójcik-Maciejewicz A, Slominski AT. Stress and the skin. *G Ital Dermatol Venereol*. 2010 Apr;145(2):213–9. PMID: 20467395.
- [10] Christensen R, Jafferany M. Global awareness, knowledge, and practice patterns of psychocutaneous medicine: A primary care perspective. *Prim Care Companion CNS Disord*. 2022;24(4). doi:10.4088/PCC.21r03175.
- [11] Altaba L, Jafferany M, Khan A. Psychocutaneous medicine in Iraq: current status and recommendations. *Prim Care Companion CNS Disord*. 2022;24(2):21m03077. doi:10.4088/PCC.21m03077.
- [12] Ghuloum S, Mahfoud ZR, Al-Amin H, Marji T, Kehyayan V. Healthcare professionals' attitudes toward patients with mental illness: a cross-sectional study in Qatar. *Front Psychiatry*. 2022 May 16; 13:884947. doi:10.3389/fpsy.2022.884947.
- [13] World Health Organization (WHO). WHO Jordan's mental health team leads successful training [Internet]. Amman: WHO EMRO; [updated 2024 Jul; cited 2025 Aug 3].
- [14] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606–13.
- [15] Tohid H, Shenefelt PD, Burney WA, Aqeel N. Psychodermatology: an association of primary psychiatric disorders with skin. *Rev Colomb Psiquiatr*. 2019;48(1):50–57. doi:10.1016/j.rcp.2017.07.002.
- [16] Makowska I, Gmitrowicz A. Psychodermatology – the interface between dermatology, psychiatry and psychology. *Psychiatr Psychol Klin*. 2014;14(2):100–105.
- [17] Jafferany M, França K. Psychodermatology: basic concepts. *Acta Derm Venereol*. 2016;96(Suppl 217):35–37. doi:10.2340/00015555-2378.
- [18] Gieler U, Consoli SG, Tomás-Aragónés L, Linder DM, Jemec GBE, Poot F, et al. Self-inflicted lesions in dermatology: terminology and classification—a position paper from the European Society for Dermatology and Psychiatry (ESDaP). *Acta Derm Venereol*. 2013;93(1):4–12. doi:10.2340/00015555-1506.

- [19] Marshall C, Taylor R, Bewley A. Psychodermatology in clinical practice: main principles. *Acta Derm Venereol.* 2016;96(Suppl 217):30–34. doi:10.2340/00015555-2370.
- [20] Dalgard FJ, Gieler U, Tomas-Aragones L, Lien L, Poot F, Jemec GBE, et al. The psychological burden of skin diseases: a cross-sectional multicenter study among dermatological out-patients in 13 European countries. *J Invest Dermatol.* 2015;135(4):984–991. doi:10.1038/jid.2014.530.
- [21] Kouwenhoven TA, van de Kerkhof PCM, Kamsteeg M. Use of oral antidepressants in patients with chronic pruritus: a systematic review. *J Am Acad Dermatol.* 2017;77(6):1068–1073.e7. doi:10.1016/j.jaad.2017.08.025.
- [22] Sun MD, Rieder EA. Psychosocial stress and mechanisms of skin health: a comprehensive update. *J Drugs Dermatol.* 2021;20(1):62–69. doi:10.36849/JDD.5608.
- [23] Christensen RE, Jafferany M. Unmet needs in psychodermatology: a narrative review. *CNS Drugs.* 2024;38(3):193–204. doi:10.1007/s40263-024-01068-1.
- [24] Elsaie ML, Hanafy NS, Zaky MS, Hasan MS, Jafferany M. Psychodermatology knowledge and awareness: a cross-sectional Egyptian perspective. *Dermatol Ther.* 2020;33(6):e14239. doi:10.1111/dth.14239.
- [25] Singleton H, Hodder A, Almilaji O, Ersser SJ, Heaslip V, O'Meara S, et al. Educational and psychological interventions for managing atopic dermatitis (eczema). *Cochrane Database Syst Rev.* 2024;8(8):CD014932. doi:10.1002/14651858.CD014932.
- [26] Roberts JE, Smith AM, Wilkerson AH, Chandra A, Patel V, Quadri SSA, et al. “Psychodermatology” knowledge, attitudes, and practice among health care professionals. *Arch Dermatol Res.* 2020;312(8):545–558. doi:10.1007/s00403-020-02050-9.
- [27] Richards HL, Fortune DG, Griffiths CEM, Main CJ. The contribution of perceptions of stigmatisation to disability in patients with psoriasis. *J Psychosom Res.* 2001;50(1):11–15. doi:10.1016/S0022-3999(00)00210-5.
- [28] Tian L, Weng Y, Xu A, Chen Y, Tang J. Effect of behavior modification combined with health belief model education on adherence to skin moisturizing care in patients with psoriasis vulgaris. *Sci Rep.* 2024;14:31997. doi:10.1038/s41598-024-83647-2.
- [29] Arbabi M, Zhand N, Samadi Z, Ghaninejad H, Golestan B. Psychiatric comorbidity and quality of life in patients with dermatologic diseases. *Iran J Psychiatry.* 2009;4(3):102–6.
- [30] Gearing RE, MacKenzie MJ, Ibrahim RW, Brewer KB, Batayneh JS, Schwalbe CSJ. Stigma and mental health treatment of adolescents with depression in Jordan. *Community Ment Health J.* 2015;51(1):111–117. doi:10.1007/s10597-014-9756-1.
- [31] Al-Refu K. Anxiety and depression in patients with chronic dermatologic diseases in Jordan: a cross-sectional study. *Int J Res Dermatol.* 2026;12(3):197–204. doi:10.18203/issn.2455-4529.IntJResDermatol20261095.
- [32] Ocek T, Sakalli Kani A, Baş A, Yalcin M, Turan S, Emul M, Jafferany M. Psychodermatology: Knowledge, awareness, practicing patterns, and attitudes of dermatologists in Turkey. *Prim Care Companion CNS Disord.* 2015 Apr 30;17(2):10.4088/PCC.14m01628.
- [33] Hay RJ, Johns NE, Williams HC, et al. The global burden of skin disease in 2010: an analysis of the prevalence and impact of skin conditions. *J Invest Dermatol.* 2014;134(6):1527–1534. doi:10.1038/jid.2013.446.
- [34] Patel V, Chowdhary N, Rahman A, Verdeli H. Improving access to psychological treatments: Lessons from developing countries. *Behav Res Ther.* 2011;49(9):523–8.

Legends of tables

Table 1. Classification of psychodermatologic disorders, with key psychiatric features, dermatologic presentations, and management considerations. Adapted from references 5, 7, and 8.

Category	Definition	Examples	Psychiatric Features	Dermatologic Presentation	Management Focus
Primary Psychiatric Disorders	Psychiatric disorder is primary, and dermatologic symptoms are physical expressions of the mental illness.	Delusional parasitosis, Trichotillomania, Body dysmorphic disorder	Delusions, compulsive behavior, distorted body image	Excoriations, alopecia, self-inflicted lesions	Psychiatric evaluation, pharmacotherapy (e.g., SSRIs, antipsychotics)
Secondary Psychiatric Disorders	Emotional or psychiatric symptoms arise as a reaction to the distress caused by chronic dermatologic diseases.	Depression in acne, Anxiety in vitiligo or psoriasis	Mood disturbances, low self-esteem, and social withdrawal	Visible inflammation, chronic lesions, psychosomatic complaints	Psychological support, dermatologic treatment, and patient education
Psychophysiological Disorders	Psychological stress triggers or worsens skin conditions through neuroimmunological pathways.	Stress-induced flares in atopic dermatitis, psoriasis, or urticaria	Anxiety, anger, grief preceding or worsening dermatologic symptoms	Flare-ups, itching, redness exacerbated by emotional stress	Stress reduction techniques, lifestyle interventions, combined care