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Correspondence

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PSYCHIATRIC SYMPTOMS IN DERMATOLOGY PATIENTS

DEAR SIR,

The recent contribution from Dr J. E. Hughes and colleagues in Southampton (*Journal,* July 1983, **143,** 51–54) highlights the well-known relationship between some dermatological disorders and various types of pathological, personal or psychological functioning. The authors clearly describe the differing patterns of association which may occur, including that of primary psychiatric disturbance leading to requests for dermatological remedy. This pattern, however, was identified in only two patients out of the study population of 236 and we would venture to suggest that this may be an atypical finding, under-representing the existence of this type of association in general dermatological practice. Previous reports by Dr Joan Sneddon (1980), a psychiatrist, and Dr Ian Sneddon (1978), a dermatologist, lend support to our contention.

The syndrome of delusional parasitosis (Ekbom, 1938; Skott, 1978), in particular, does not appear in the study data, yet increasing recognition by dermatologists of this disorder is demonstrated by Dr Alan Lyell's recent major publication (1983) and by other contributions (*BMJ* Leader, 1977; *Lancet* Leader, 1983). Lyell wrote personally to 374 dermatologists throughout the country and received reports of 282 patients with this disorder from 216 of his colleagues.

We, too, (data to be published) have recently sought detailed information in questionnaire form from 386 dermatologists—consultants, senior registrars, and clinical assistants, in the United Kingdom and Eire. That 215 were kind enough to reply may reflect the high level of current awareness of this disorder among dermatologists. One hundred and forty four of the doctors mailed had seen at least one such patient in the past 5 years, and they collectively identified at least 365 patients 78 of whom were currently under treatment.

Surprisingly, the distribution of recognition of these patients was markedly uneven. Several centres, including some of the larger departments, could recall no patient with this disorder while individual consultants in district general hospitals identified as many as 15. A leading centre for dermatological referrals reports that approximately 50 such patients had been seen there within the past 5 years. Lyell, too, (1983) commented on the same apparently random geographical variation in reported incidence and suggested as a possible explanation a differential level of interest in the syndrome, with some dermatologists therefore, collecting a disproportionate number of patients. This factor appears relevant in the light of the pattern of response to our own questionnaire survey. One dermatologist commented, for example: "I tell them there is nothing I can do for them and send them back to their own doctor", yet others recounted case histories in considerable detail, revealing an empathic involvement with their patients' suffering and curiosity in respect of the bizarre nature of the disorder. It is to be hoped that detailed analysis of these responses may suggest some additional hypotheses to explain the variable pattern of reporting. For example, in different geographical areas the relative distribution of these patients between the dermatological and psychiatric services may vary greatly according to several factors. The degree of recognition of and interest in the disorder may fluctuate as widely among psychiatrists as we suggest it may do among dermatologists. We intend exploring this hypothesis, and others, by mounting a parallel postal survey directed towards psychiatrists throughout the country as the next stage in our epidemiological enquiry.

The principal purpose of this communication is to counter the inference—readily made from a study of the paper by Hughes *et al*—that delusional parasitosis is not one of the established modes of presentation of psychiatric disorder to the dermatologist. This point is not merely academic, since the outlook for patients with this increasingly recognised disorder has improved considerably in the past seven years for two main reasons. Increased awareness has led to more accurate diagnosis and effective treatment of "secondary" forms of the condition, especially those occurring in the context of an affective, schizophrenic or organic psychosis. Secondly, a growing body of evidence (Reilly, 1978; Munro, 1978; Hamann and Avnstorp, 1982) supports the efficacy of the diphenylbutylpiperi-dine pimozide in the treatment of the "primary" form of the disorder, now described as

monosymptomatic hypochondriacal psychosis—of which "pure" delusional parasitosis may be but one manifestation (Reilly, 1977; Munro, 1980).

TERENCE M. REILLY

The Retreat,
York YO1 5BN

DAVID H. BATCHELOR

Janssen Pharmaceutical Limited,
Marlow, Bucks

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SEVERE DEPRESSION: ANOTHER PATIENT

DEAR SIR,

I should like to make a few points in response to Dr Gray's interesting article, *Journal,* October, 1983, **143,** 319–22. During the last ten years I have suffered bouts of depression diagnosed as severe. A spell in hospital, a few sessions of ECT, a fortnight in a nursing home, and continuous drug- and psychotherapy have made me familiar with much of the medical care available to depressive patients. Acceptable drugs, now, include Parnate, Surmontil, lithium carbonate, Eltroxin for thyroid problems, Mogadon as an aid to sleep and, occasionally, Serenid for acute anxiety.

Identity: In depression, loss of a sense of identity is paramount. "I am not what I used to be when not depressed, therefore I am nobody", or "I do not know who I am". Dr Gray does not mention feelings of guilt about depression, of moral failure as well as loss of identity. Depression is still "unacceptable" to the ordinary world; it is still easier to say ". . . seems to be a virus" or "just a bit under the weather, I'm afraid". "I am depressed, clinically depressed" is an alienating response to general enquiries about health. I wholly endorse Dr Gray's point that the patient feels physically ill, but she may also feel guilty and cut off from general comforting remarks: "Better in a day or two" etc. The patient knows she is most unlikely to get better quickly, and meantime a job has somehow got to be got on with and daily life continued. The psychiatrist's task must be to re-establish the patient's sense of identity, not with false promises, but by reinforcing an identity known from past experience of the patient or elicited from early interviews. "Despite your present condition, you have not disintegrated totally as a personality: you are still you". If the vital link of trust has been established between psychiatrist and patient—the patient, even on a monthly visit, may be greatly helped by a positive reminder that her identity, as a person functioning in a family and in society, has not been totally impaired.

Feeling ill: The depressed patient is likely to take a grim view of all her activities and of her non-activity. If she is capable of functioning at all, the outside world may see no more than someone suffering from the after-effects of a bout of influenza. The patient has to put up with continuous tiredness, lethargy, inability to concentrate, to generate ideas and to make (even small) decisions. A stomach-churning anxiety may sometimes preclude rest. As Dr Gray makes clear: the patient feels ill. She also feels guilty about failing to conquer her illness, but is eventually forced to realise that "strong-mindedness" cannot, alone, overcome the mind's disease. It is a help if family, friends and GP can get the patient to see that it is not surprising she feels ill and is functioning at a very low level. The depressed person needs to be allowed to feel ill, and at times to give up, to become "inert" as Dr Gray explains.

Activity: If the patient is not in hospital and is attempting to continue a job, it may not be practical to stay "inert" for long. She may have convinced doctors and those close to her how bad she feels, and along with drugs and psychotherapy, many ideas for changing her condition may have been suggested. But changing a life-situation is quite impossible when to walk out of the front door is a frightening and burdensome decision. Doing a job, while in this condition, must rely on repetition, on known routine, not on anything new. Dr Gray speaks of "optimistic self-grooming", but a stage before this can start to happen may be, not the repetition of "looked forward