David A. Straker, DO

A specialist discusses the mind/skin connection and addresses the influence of prescription medications.

David A Straker, DO is in private practice on the Upper East Side in Manhattan. He works at Columbia University Medical Center - NY Presbyterian Hospital, Lenox Hill Hospital, Long Island Jewish Medical Center, North Shore University Hospital, and White Plains Hospital. Dr. Straker was the Director of the Psychosomatic Medicine Fellowship at Long Island Jewish Medical Center and North Shore University Hospital from 2008-2014. He is a Fellow of the Academy of Psychosomatic Medicine (FAPM) and a Fellow of the American Psychiatric Association (FAPA). With his unique background, Dr. Straker often assists dermatology colleagues with certain diagnoses and regularly offers counsel on prescription medications, many of which affect the mind and the skin in both positive and negative fashions.

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What do we know about how the mind affects the skin, and vice versa?

Dr. Straker: There is clear evidence that the mind affects the skin. In addition, skin disorders can affect the mind as they can significantly impact one's psychological state. Atopic dermatitis, psoriasis, alopecia areata, urticaria, chronic idiopathic pruritus, body dysmorphic disorder, and delusional parasitosis all are disorders that appear to have both dermatological and psychological manifestations.

What role can a psychiatrist play in treating or preventing some of these co-morbidities?

Dr. Straker: Psychiatrists can play a major role in treating these co-morbid conditions. I have helped many patients with these disorders over the years. Depending on the condition, both psychotherapy and pharmacotherapy can be extremely helpful. Stress/anxiety often plays a major role. Patients with urticaria often have exacerbations under stress as do patients with a number of other conditions. Helping patients decrease stress levels through psychotherapy can be very important. There may be a co-morbidity (anxiety, OCD, delusional disorder, trichotillomania, somatoform disorder) that is playing a role in the dermatological condition. In the hospital setting as well as outpatient, psychiatrists can be very helpful in managing the dermatologic patient.

As a psychopharmacologist, what can you tell us about the interplay between psychiatric and dermatologic medications?

Dr. Straker: Medications such as the more antihistaminic antidepressants and benzodiazepines (in the short term and as needed) can help with many skin disorders. The tricyclic antidepressants have been known for years to be very helpful. In fact, one antidepressant (Doxepin) comes in a cream, and is used to relieve troublesome itching from certain skin condition. On the other side, psychiatric medications, such as Depakote and Lithium, can cause hair loss, Wellbutrin can cause urticaria, Lamictal and Tegretol can cause rashes as well as a Stevens-Johnson Syndrome leading to hospitalization. Lithium also can cause psoriasis.

Any tips on how to rule body dysmorphic disorder (BDD) in or out?

Dr. Straker: There are psychological scales, and a thorough psychiatric exam can help rule out BDD. Up to 12 percent of BDD patients in reports seek dermatological help for concerns about their skin or hair. Risks associated with treating a BDD patient without psychological input can include unnecessary treatments and surgeries, which, of course, can lead to other complications. Trying to get to the root of the underlying psychological issues can help the patient understand their concerns i.e imagined defect. ■