Article:
Montgomery, K. and Thompson, A.R. orcid.org/0000-0001-6788-7222 (2018) Developing sensitivity to the psychological burden associated with skin conditions: a call for training. British Journal of Dermatology, 179 (2). pp. 237-238. ISSN 0007-0963

https://doi.org/10.1111/bjd.16817

Developing sensitivity to the psychological burden associated with skin conditions: a call for training

Kerry Montgomery and Andrew Thompson

Considering the range of physical, social and emotional consequences that can arise as a result of living with a skin condition it is unsurprising that dermatology patients report higher levels of anxiety and depression than the general population (1). With the objective severity of skin conditions not providing an accurate picture of psychological distress (2), and psychological morbidity being strongly associated with poorer quality of life,(2) it is disappointing that access to psychological treatment remains limited.(3) While efforts have been made to increase access to psychological therapies (3) there is a critical task that needs to take place within the dermatology clinics before patients can begin to consider the options of support, namely, the identification of psychological distress.

While interest in 'psychodermatology' has grown exponentially in recent years, studies have shown that despite a significant number of dermatology patients experiencing psychological distress, this is not identified in routine clinical practice.(4,5) Indeed, in the current issue of the *BJD* Dalgard *et al*. (4) present the findings of a cross-sectional multicentre European study which highlights that dermatologists in Europe significantly underestimate levels of anxiety and depression.(4) An analysis of 3635 consultations found that the agreement between patients and dermatologists was poor to fair, with dermatologists failing to identify depression and/or anxiety in over half their patients (56% depression and 64·4% anxiety).(4) The underestimation of depression and anxiety was particularly evident in patients with chronic conditions (e.g. hand eczema and psoriasis). Dalgard *et al*.(4) conclude that further training for dermatologists is needed to increase the likelihood that patient distress will be identified and treated.

These findings are sadly not new, and lend weight to an earlier study of patients with psoriasis,(6) in which the level of agreement between patient-reported and clinician-reported anxiety and depression was low (kappa statistic 0·24 and 0·26, respectively).(6) In addition, when distress was actually identified in patients with psoriasis they were rarely offered appropriate psychological treatment.(6) Further, a number of qualitative studies have indicated that some patients report that distress and stigma associated with their skin condition is not acknowledged by clinicians.(7,8) On a positive note, good concordance between patients and clinicians has been reported on quality of life measures in some studies;(7) however, this concordance is related to functional impact rather than affective distress, which clinicians are seemingly less familiar with and on occasion may consider as outside their remit.

As outlined by Dalgard *et al*.(4) in this current issue of the *BJD*, the recognition of psychological distress is crucial given the influence of mood on the course of the skin condition and adherence to treatment.(4) One potentially useful strategy to assist clinicians in identifying psychological distress is to use brief psychological screening tools in routine clinical practice. Psychological screening tools (e.g. the Patient Health Questionnaire 9(9) and the Generalized Anxiety Disorder Questionnaire 7(10)) can assist dermatologists in identifying common mental health problems (e.g. anxiety and depression).(11) Screening

tools(9,10) provide an opportunity for dermatologists to begin a conversation with the patient about how they are feeling, and, if used appropriately, can assist clinicians in acknowledging patient distress. In addition, psychometric measures of affective distress can not only act as a valuable tool in indicating levels of distress but also form part of the assessment of risk. There is now sufficient evidence to suggest that improving mood can improve health outcomes for dermatology patients, and this forms an additional rationale for the routine assessment of distress to be included within dermatology consultations.

Training on brief psychological assessment and management of risk may provide reassurance and encouragement to dermatologists; however, it is no small ask for dermatologists to make time within demanding and busy schedules for training. However, despite these legitimate barriers it is crucial that dermatologists do not miss out on an opportunity to support patients by identifying distress. Simply asking patients about the emotional impact of their skin condition can be hugely valued by and beneficial to patients. The growing field of psychodermatology offers an opportunity to support dermatologists with the necessary training and development opportunities to enhance the holistic care of dermatology patients.

Conflicts of interest

K.M. has no conflicts of interest to declare. A.R.T. is an advisor to the Katie Piper Foundation, and a Scientific Advisor to the Vitiligo Society, and has been an advisor to the All Party Parliamentary Group on Skin. He has received research funding from the British Skin Foundation, Medical Research Council, Psoriasis and Psoriatic Arthritis Alliance, and Galderma.

References

1 Dalgard FJ, Gieler U, Tomas-Aragones L *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; 135:984–91.

2 Sampogna F, Picardi A, Abeni D et al. Association between poorer quality of life and psychiatric morbidity in patients with different dermatological conditions. Psychosom Med 2004; 66:620–4.

3 Bewley A, Affleck A, Bundy C et al. Psychodermatology services guidance: the report of the British Association of Dermatologists' Psychodermatology Working Party. Br J Dermatol 2013; 168:1149–50.

4 Dalgard FJ, Svensson Å, Gieler U et al. Dermatologists across Europe underestimate depression and anxiety: results from 3635 dermatological consultations. Br J Dermatol 2018; 179:464–70.

5 Sampogna F, Sera F, Mazzotti E et al. Performance of the self-administered Psoriasis Area and Severity Index in evaluating clinical and sociodemographic subgroups of patients with psoriasis. Arch Dermatol 2003; 139:353–8.

6 Richards HL, Fortune DG, Weidmann A et al. Detection of psychological distress in patients with psoriasis: low consensus between dermatologist and patient. Br J Dermatol 2004; 151:1227–33.

7 Nelson PA, Chew-Graham CA, Griffiths CE, Cordingley L. Recognition of need in health care consultations: a qualitative study of people with psoriasis. Br J Dermatol 2013; 168:354–61.
8 Johnston SA, Krasuska M, Millings A et al. Experiences of rosacea and its treatment: an interpretative phenomenological analysis. Br J Dermatol 2018; 178:154–60.
9 Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med 2001; 16:606–13.
10 Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Int Med 2006; 166:1092–7.
11 Lamb RC, Matcham F, Turner MA et al. Screening for anxiety and depression in people with psoriasis: a cross-sectional study in a tertiary referral setting. Br J Dermatol 2017; 176:1028–34.