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Impact of collaboration between psychologists and dermatologists: UK hospital system example[☆]

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ABSTRACT

There is a strong known link between the mind and the skin, with studies indicating that some individuals who live with skin disorders can exhibit high levels of psychological distress. Historically, the psychological impact of skin conditions has often been disregarded by health professionals, friends, and family members. However, more recently, clinicians are becoming aware of the benefits of combining medical and psychological treatment for these patients. Within the United Kingdom, this is becoming more popular within dermatology due to a recent study that measured clinical utility and cost savings. Understanding the theory behind psychocutaneous medicine enables dermatologists to work alongside psychologists to provide holistic treatment by meeting the medical and psychological needs of our patients.

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Contents

Background and psychological impact of skin disorders	0
Psychodermatology services	0
Influence on treatment outcomes	0
Discussion	0
References	0

Background and psychological impact of skin disorders

Why is it imperative for psychologists and dermatologists to work collaboratively? The skin represents an external barrier between an individual's internal being and the outside world. The concept of psychodermatology has been recognized since as early as the 17th century with Richard Burton's book *Anatomy of Melancholy*, where pruritus was noted to be associated with depression. Fortunately today, the importance of psychological factors in dermatology is

well recognized in the United Kingdom and has been studied extensively in patients with psoriasis, eczema, acne, and vitiligo.

Society often perceives unblemished skin as a sign of beauty and this enhances individuals' self-esteem and identity, which is arguably perpetuated by the media (Shah, 2012). The stigmatization of imperfect skin is a huge problem within our society, and being visibly different can cause stress and often perpetuate psychological difficulties, which can affect social activities, relationships, and overall quality of life (QoL; Thompson and Kent, 2001).

Unfortunately, there is often no cure, but having a skin condition can be life changing. From the initial diagnosis to coping with the day-to-day regimen of skincare, skin conditions can create many challenges. Anything from a small blemish on the face to a widespread skin disorder (e.g., eczema, psoriasis, or vitiligo) can lead to embarrassment, humiliation, and other negative body image

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experiences. These negative experiences, together with the influence of others and society's expectations, can diminish self-esteem and self-confidence, increase self-consciousness, and create a loss of sense-of-self and isolation (Shah, 2012; 2014).

These feelings have the potential to lead to psychological problems such as depression and anxiety, with some studies indicating that approximately 30% of dermatology patients have clinically significant levels of psychological distress (Gupta and Gupta, 2003). High rates of suicidal ideation have also been reported, in 8.6% of outpatients with skin conditions (Picardi et al., 2006) and, in particular, 7.2% of those with psoriasis and 5.6% of those with acne, which is higher than in the general medical population (Gupta and Gupta, 2003).

Stress can interfere with the immune system and affect the skin's capacity to heal. Research indicates a strong biological link between stress and the exacerbation of skin disorders (Al'Abadie et al., 1994; Shah et al., 2014). For example, patients with eczema have reported flare-ups when stressed, and those with vitiligo have noticed new patches when stressed. Gouin and Kiecolt-Glaser (2011) looked at stress levels preoperatively and found that patients who were less stressed had a high level of a specific type of molecule that promotes healing. Postoperatively, these patients had a faster recovery and shorter hospital stay. Chronic stress is also known to disrupt the barrier function of the skin (Altemus et al., 2001) and thus affect conditions such as eczema. Furthermore, embryological cutaneous nerve endings influence the skin's immune cells through neuropeptides (Chen and Lyga, 2014).

It is often difficult to ascertain which factor comes first, the physical or the psychological. The most widely cited difficulties are those around social anxiety, social skills, and self-concept. People report difficulty with social interactions due to body image concerns and in using effective coping mechanisms (Rumsey and Harcourt, 2005). Patients with skin disorders can have relationship difficulties within friendships, couples, sexual partners, and family relationships. Some people with skin conditions report becoming preoccupied with covering their skin and often avoid activities where it might be on display.

Hence, people with skin disorders may take various steps to maintain a sense-of-self. This may be due to the belief that other people may stigmatize or reject them because of how they look, and they may anticipate experiencing embarrassment and/or shame (Kellet and Gilbert, 2001). It is also important to note that those with nonvisual skin conditions also show high levels of psychological distress. For example, those with vulvodinia have shown significantly high levels of anxiety, depression, obsessive-compulsive and phobic symptoms, somatization, and interpersonal sensitivity, hostility, and paranoia compared with controls (Wylie et al., 2004).

It is important to recognize that the severity of the psychological distress and dysfunction that is experienced does not correlate with the severity of the skin condition (Rumsey et al., 2004). Individuals' perception of their skin disease is key to gauge. For example, someone with a small patch of vitiligo or mild acne may be traumatized, affecting all aspects of QoL, versus someone with eczema all over their body who is coping well. Hence, when conducting a psychological assessment, highlighting patients' key issues is crucial (Shah, 2014).

Over the last few years, work has been done to promote and increase people's awareness of the psychological impact of skin disorders (e.g., All Party Parliamentary Group on Skin, 2013), which has helped support changes in clinical practice and service developments (Lowry et al., 2014). It is key for clinicians to appreciate the research in psychodermatology and to acknowledge the psychological impact of living with a skin condition. This can ensure a holistic service (i.e., treating the mind and skin concurrently), which has shown higher rates of treatment success. In time, this way of

collaboration between dermatologists and psychologists would start to reduce the stigma of mental health in dermatology.

Psychodermatology services

Historically in the health care system of the United Kingdom, the treatment of physical and mental health conditions has been divided. However, over the last 20 years, there has been an increase in services that combine care to provide holistic treatment packages. This has become prominent within dermatology with an increase in psychiatrists and psychologists who work alongside dermatologists within one department to create a truly multidisciplinary team.

For example, at the Royal London Hospital, a psychiatrist and dermatologist created a Psychodermatology Clinic, and a psychologist joined the team years later. This is a tertiary service, receiving referrals from all over the U.K offering a holistic treatment package. Over time, the model of stepped provisions for psychodermatology services (see Fig. 1) was developed by the British Association of Dermatologists [BAD] (BAD, 2012; Bewley et al 2013) which now informs gold standard service provision.

This model highlights a stepped care pathway that is helpful to evaluate the level of psychological assessment that is required and by whom by ascertaining the level of distress based on two standardized measures: the Dermatology Life Questionnaire (DLQI; Finlay and Khan, 1994) and the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983). The results of the measures then facilitate the level of psychological support that is offered (i.e., by nurse specialists or psychologists).

However, there are limitations to this model. The measures proposed are self-reported and only look at general QoL, anxiety, and depression. Often, people with skin disorders have a range of psychological difficulties, which may not be highlighted with these measures (e.g., relationship problems, obsessive compulsive disorder, or stress). There are also limitations to the DLQI for certain skin conditions due to the type of problems patients may have; therefore, the psychological assessment interview is key to inform the pathway for the patient.

At our clinic, in addition to a thorough psychological assessment conducted by the psychologist, we adapted the BAD model and included the use of alternative measures, depending on the patient's presenting difficulties. This enabled us to be person-centred and cater to the individual needs of the patient. All clinicians provide some psychological input, which may vary per skillset. Importantly, psychological supervision is also offered to all staff.

With respect to treatment, we enhanced the model at our clinic by adding level 4 skills, whereby complex cases were referred from the Regional Psychodermatology Service directly to the specialist psychologist, who offered complex assessments (e.g., risk assessments for suicide) and psychological therapies (e.g., cognitive behavioral therapy, systemic family therapy, and trauma-focused work). The psychologist also offered habit reversal therapy (i.e., individual and group sessions), mainly for those individuals who scratched and/or picked at their skin repeatedly.

Influence on treatment outcomes

Through this process of collaboration, the relationship among the dermatologist, psychiatrist, and psychologist has a positive outcome as a multidisciplinary team. This affects the perception of dermatology and highlights to clinicians and individuals how working together can positively influence the treatment of patients. Having joint sessions shows how we believe in the importance of holistic treatment and reduces the stigma for patients. Feedback from patients suggests that this

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