

Mental health and dermatology practice in the COVID-19 pandemic

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The current COVID-19 pandemic highlights the inextricable link between mental health and chronic skin disease. Furthermore, it is crucial that patients are aware of the potential mental health impact of the pandemic, and have clear guidance about how to maintain their wellbeing and seek help in case of distress.

Chronic skin disease is linked to psychological distress and psychiatric comorbidities, which significantly increase disability in these patients. Atopic dermatitis and chronic urticaria are strongly associated with anxiety and depressive symptoms. In psoriasis, up to one in five patients have clinically significant depression, and social isolation is high. Up to 17% of people with psoriasis and 9.3% of people with eczema report suicidal thoughts, and evidence suggests that these skin diseases pose higher suicide risks.¹

Immediate stressors during the COVID-19 pandemic such as statutory shielding and social distancing are likely to have a direct effect on patients' mental health. There is evidence that the pandemic may also constitute a traumatic or stigmatizing event, with long-lasting consequences such as post-traumatic stress disorder (PTSD). The further likely severe socio-economic impact is likely to contribute to the psychological burden of the population, including suicidality.²

Given that people with chronic skin disease are at higher risk for mental health disease and many (especially those on immunosuppressant medications) have been advised to shield and self-isolate, the psychological impact of the pandemic on these patients is particularly important. We expect these patients to experience higher rates of health anxiety and social

isolation and probably low mood during the shielding and social distancing period, as well as reduced physical attendance at medical services. Some patients may experience changes in their immunosuppression therapy subject to infection risk, leading to acute flares and creating a vicious cycle with further worsening of their mental health. The psychosocial stress of the pandemic may itself present a trigger for inflammatory skin conditions. Notably, individuals who develop stress-related disorders such as PTSD after traumatic or other stressful events are at increased risk of subsequently developing autoimmune diseases, including psoriasis.³

It is therefore crucial that sufficient prevention and management measures are in place for people with dermatological disease. Patients need to be educated about the importance of taking active steps to promote their wellbeing. Basic wellbeing and self-care advice with emphasis on social connectedness should be available to all. Maintaining a balance between work and personal time is important, along with a daily structure and good sleep hygiene practices. People with existing physical and mental comorbidities should be strongly encouraged to look after their physical health and should be given information, including online resources, with exercise and diet advice. Reinforcement and activation of positive social and personal life resources increases resilience and is highly relevant in populations with psoriasis and eczema, for which the rates of alcohol abuse and other maladaptive coping strategies are increased.⁴

For this reason, we and others have made available simple signposting and other resources available.⁵ These resources are particularly relevant to COVID-19 and complement the resources already available through many national organizations (<http://www.skincare.org.uk>). Clinicians should make sure that all patients have adequate and clear information about what steps to take and who to contact if they need medical help for their skin and mental health and

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wellbeing. Feelings of guilt and worthlessness are common in depression and may inhibit help-seeking behaviour. Patients with affective disorders or acute distress often experience avolition, psychomotor retardation and cognitive disorders, including impaired concentration, memory or decision-making. It is therefore important that comorbid or at-risk populations have direct access to readily available information about key clinical contacts without having to utilize significant cognitive resources. Written contact information in times of crisis, including 24-hour accessible contacts, is an essential component of safety plans used in mental health care. While it may not be possible to create personalized documents, key information and advice (e.g. signposting to General Practitioner emergency appointments, 24-hour helpline numbers such as the Samaritans' charity, accident and emergency services information, local mental health crisis team numbers, and weblinks to specialist societies' and government wellbeing guidance) could be disseminated to patients or integrated into either face-to-face or telephone consultations. Our resources have therefore signposted patients and healthcare professionals (HCPs) to already established mental health support networks, which have, themselves, developed COVID-19 pandemic orientated advice.

It is equally important that there are well-defined clinical management protocols for people who present with distress and psychiatric comorbidity either in the dermatology clinic or during virtual consultations. Among concerns over the potential increase of suicides, clinicians should be aware of patients at high suicidality risk and should alert primary care and mental health services, where appropriate. Previous mental disorders or suicidal behaviour, substance abuse and other addictions, chronic painful comorbidities, loneliness and socio-economic factors (unemployment, financial difficulties, recent bereavement) are recognized risk factors for suicidality. Efforts should be made to arrange follow-ups for those patients, particularly if they are socially withdrawn or repeatedly miss appointments. Proactively asking at-risk patients about suicidality (thoughts, plans, attempts) could help them share feelings that would otherwise remain unexpressed and access appropriate care.

The pandemic has changed dermatology practice, altering the way care is delivered and influencing treatment decisions. During this challenging time, patients' mental health, which is integral to their quality of life, should be a clinical priority. High-risk populations, particularly patients with chronic inflammatory skin disease, should be made aware of the importance of

maintaining wellbeing and the central role of social networks. Establishing prevention and management pathways for mental health can help significantly improve outcomes of dermatology patients not only during the crisis, but also in its wake.

Finally, we are very much aware of the impact of COVID-19-related mental health consequences for HCPs in both general dermatology and psychodermatology. We have established a link for HCPs to access and be signposted to advice and support, which is tailored for them rather than for patients.⁶ We are in the process of establishing a virtual network for HCPs working in general dermatology and psychodermatology to further support our colleagues in these challenging times.

Conflict of interest

PST has received a consultancy fee for serving as an Advisory Board member for LivaNova UK Ltd in the past 3 years. AB has received travel bursaries and ad hoc consultancy payments from Abbvie, Almirall, Eli Lilly, Galderma, Janssen, Leo Pharma, Novartis, Sanofi and UCB. CEK has received honoraria/ad hoc consultancy payments from Janssen, Eli Lilly, LEO, Novartis, Abbvie, UCB and Almirall as well as research funding from Pfizer, Novartis, Janssen and Eli Lilly.

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