# Chapter 6
# Screening Questionnaires, Scales and Approach to Patients with Psychodermatologic Disorders


## Introduction to the Relevance of Questionnaires in Dermatology

As quoted by the physicist Lord Kelvin, in the nineteenth century, "to measure is to know" and "when you can measure what you are speaking about, and can express it in numbers, you know something about it" [1]. This concept is of unquestionable importance in medicine, both in the field of research and in the clinical practice. Moreover, in psychodermatology, characterized by the relative subjectivity of the description of the mental processes and the psychopathology connected with the skin symptoms, screening tools help to guide the objective description of the mental health impairment and the impact on the quality of life in clinical practice and research.

For example, concerning the usefulness of screening questionnaires and scales in research, in psychodermatology, a multicenter study conducted in Columbia, in 2017 [2], to assess the impact of dermatoses, using the Skindex-29 score, a score that was conceived to assess the impact on quality of life [3], documented that psoriasis, contact dermatitis, atopic dermatitis, urticaria, hair disorders, Hansen's disease, scars, hyperhidrosis and genital human papillomavirus were the skin disorders that presented the highest impact. However, interestingly, subtle and asymptomatic skin lesions also showed a significant impact on quality of life, stressing the importance of psychometric measures to exactly know the typology of symptoms and lesions that can actually bother the patients [2]. Indeed, the clinical severity of a disease is not always a faithful representative of the psychological impact of the diseases as well as the impact on the quality of life [3]. Thus, there are screening questionnaires and scales that are preferred in the setting of research. They are needed to understand the global dynamic of the impact on mental health and quality of life of the different dermatoses and skin illnesses, to assess patients' perspectives concerning the characteristics and the distribution of the lesions, including the extent of the skin involvement, the most uncomfortable symptoms as well as the



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satisfaction with the treatments. This may then support the evidence for some systemic treatments considering all this, as it happens, for instance, in the context of psoriasis [4, 5].

In the clinical practice, however, some questionnaires and scales could disturb the doctor-patient relationship as they include a larger number of questions and are also more time-consuming. Thereby, they should not replace the clinical interview and examination, even though they may provide valuable information for the diagnosis and the management. Scales and questionnaires, in turn, should be used to complement the mental state examination, providing additional information or reinforce the conclusions that are given by the clinical assessment. For this purpose, some tools can be more practical, such as, the "Hospital Anxiety and Depression Scale" (HADS), to assess symptoms of depression and anxiety, and the "Dermatology Life Quality Index" (DLQI), to assess the impact on quality of life [6, 7].

## How to Approach a Patient with a Psychodermatologic Disorder

As explained in Chap. 5, there is a wide spectrum of psychodermatologic disorders and the assessment of these patients should take into account the main group where the disorder that the patient present is placed: primary psychopathology focused on the skin (with or without secondary dermatologic lesions); psychophysiological dermatoses with important psychological component; cutaneous sensory disorders; dermatosis or disfiguring skin condition and secondary psychiatric or social comorbidity.

Table 6.1 exposes the main topics to follow while performing a clinical history of a patient that has a psychodermatologic disorder. The examination should start by identifying whether there is or not a dermatosis and whether it is a primary dermatosis or whether the patient presents secondary dermatologic lesions or whether there are not skin lesions; at the same time, the presence of pruritus or dysesthesia should be excluded as well as the severity of these symptoms, taking into account all the clinical presentation, namely, the eventual presence of primary or secondary skin lesions [8]. Afterwards, other relevant topics include to know whether, for the patient, the stress is a triggering factor for the symptoms, a topic that is frequently forgotten in the approach of psychophysiological dermatoses [9], and the current medication, which, on the one hand, can be linked with the onset of pruritus [8], and, on the other hand, can point out to the underlying psychiatric comorbidities or even the presence of sleep problems, commonly seen in patients suffering from psychodermatologic disorders [9].

Furthermore, as illustrated in Table 6.2, a brief mental state examination can be performed to identify the most important aspects of mental health linked with the skin disease or illness. For example, this will allow to identify the presence of insight for the clinical symptoms, a complex concept that presumes the recognition by the patient that he has a psychiatric disorder that needs a treatment [10]. The

**Table 6.1** How to organize a clinical history in psychodermatology, proposed by Ferreira, Jafferany & Patel

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|---|---|
| **Main topics to organize a clinical history in psychodermatology** | Presence of skin lesions, their distribution and whether they are primary or secondary skin lesions |
| | Presence of pruritus or dysesthesia |
| | Duration of the skin symptoms and antecedents of previous episodes |
| | Presence of factors that can trigger or worsen the skin symptoms - are they triggered by stress? |
| | Personal medical history: is there a previous diagnosis of a skin disease, psychiatric disorders, sleep difficulties or other medical problem? |
| | Family antecedents: are there antecedents of psychiatric disorders and chronic skin diseases? |
| | Is the patient under medication for the skin symptoms? And for psychiatric symptoms? And to sleep? What kind of medication? And since when? |
| | Description of the social context: since childhood up to the current situation (occupation, relationships, family context) |

**Table 6.2** How to briefly assess psychopathology for a patient with a skin disease or illness, elaborated by Ferreira, Jafferany & Patel

| | |
|---|---|
| **Basic psychological assessment in psychodermatology** | To analyze the appearance (posture, clothes) and the behaviour (psychomotor activity, eye contact, compulsions) |
| | To ask about the experience of having the current skin symptoms - the disease or the illness |
| | To ask about biological functions, namely, appetite and sleep: are they changed? How? And since when? |
| | To ask about the most relevant current and past relationships |
| | To know the copings strategies used by the patient |
| | To assess risk - are there suicidal tendencies, attempts, thoughts, plans? |
| | To put the open-ended question: what and how would you like to change (concerning the skin, the social context, the family, the job)? |
| | Aspects to analyze during the clinical interview: mood, insight, cognitive functions, perception, thought (form and content) and speech (volume, fluency and rhythm) |

most paradigmatic example in psychodermatology is that of delusional infestation, which is characterized by the fix, unwavering belief that there is a real infestation (by a parasite or an inanimate matter), and these patients will rarely present to specialists in psychiatry or psychodermatology. Thus, all clinicians should be taught about this diagnosis to avoid superfluous examinations and the reinforcement of the delusion; actually, they could collaborate to perform a first approach to control the skin symptoms and introduce the need for the assessment by a specialist in

psychodermatology [11, 12]. Interestingly, disorders traditionally placed in the obsessive-compulsive spectrum, then presenting intellectual insight, can also exhibit psychotic symptoms, during the evolution of the disorder, and exhibit the co existence of delusion. For instance, this could be observed in the context of body dysmorphic disorder, a condition of very difficult management that is under-recognized by medical professionals and that is connected with a high suicide attempt rate. In the approach of these patients, primary care physicians could have a very important role to avoid to postpone the adequate management, which could have disastrous consequences. Their collaboration may include psychoeducation about the condition, avoiding to reinforce the desire of the patient to keep on looking for more surgical or cosmetic treatments; for patients with lack of insight, it is also ineffective trying to convince the patient that the beliefs are irrational and the best strategy should be to put the focus on the distress caused by the illness, in order to introduce the need to referral to a specialist in psychiatry or psychodermatology [13]. Another important point described in Tables 6.1 and 6.2 is the current and the past family and social context and relevant relationships. For instance, this is especially important in the setting of factitious disorders, where a troubled childhood or family context or occupational issues can be a precipitant [14, 15]. These topics could be explored by the family physician, who knows very well the family dynamics, introducing, then, the need for a multidisciplinary approach, ideally a team with expertise in psychodermatology: to explore the subtleties of the troubled psychosocial background by psychological intervention, to exclude a primary dermatosis and to treat psychiatric comorbidities [14].

Moreover, some screening questionnaires were developed to improve the accuracy to diagnose specific mental health problems connected with the skin disease or illness, as illustrated in Fig. 6.1 [16–20]. The spectrum of anxiety and depression are common comorbidities of psychodermatologic disorders and the HADS is a practical and useful tool in routine clinical practice, that can be answered in few minutes, to determine whether the patient would benefit of a more specialized approach, a pharmacological treatment or a psychological intervention, depending on the severity of the symptoms. It was developed by Zigmond and Snaith [6], and includes seven items to assess the severity of depression and seven items to assess the severity of anxiety; for either anxiety and depression, there is the possibility of a score between 0 and 21 (normal, mild, moderate or severe levels of anxiety and/or depression). Additionally, other questionnaires and scales were developed to

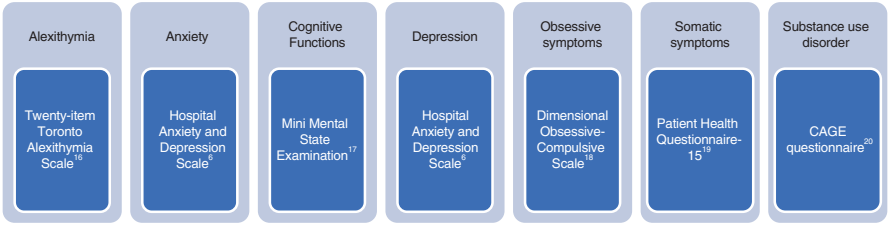


**Fig. 6.1** Useful questionnaires and scales to assess psychopathology in psychodermatology

facilitate the description of the impact on quality of life of specific skin conditions or the severity of its clinical presentation, as mentioned in Fig. 6.2 [21–27]. Globally, to assess the impact on quality of life linked with skin diseases, DLQI [7] is a useful tool for adults and, in pediatrics, the Children's Dermatology Life Quality Index (CDLQI) is recommended [28].

In Fig. 6.3, the differential diagnoses of generalized pruritus are highlighted, a very important topic to consider in the absence of a primary dermatosis [29]. Even

| Acne vulgaris | Atopic dermatitis | Body Dysmorphic Disorder | Hidradenitis suppurativa | Psoriasis | Skin cancer | Skin Picking |
|---|---|---|---|---|---|---|
| • Cardiff acne disability index[21] | • Infants' Dermatitis Quality of Life Index[22] | • Body Dysmorphic Disorder Symptom Scale[23] | • HIDRAdisk[24] | • Psoriasis Disability Index[25] | • Skin cancer index[26] | • Skin Picking Scale[27] |

**Fig. 6.2** Examples of specific questionnaires and scales with interest in psychodermatology

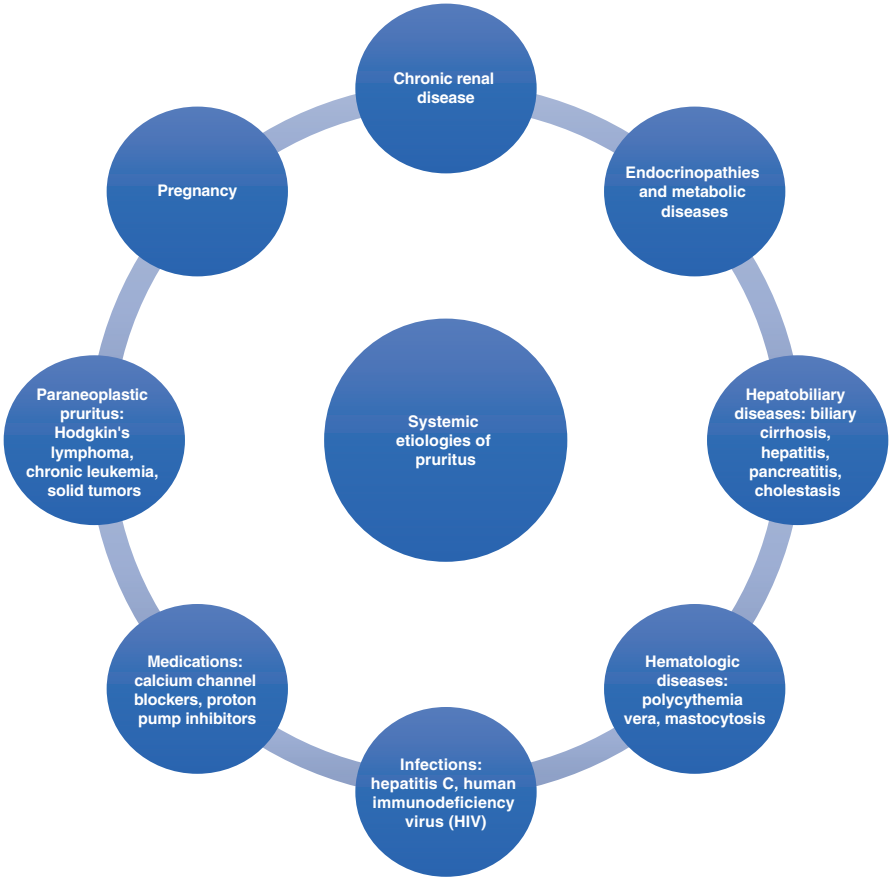


**Fig. 6.3** Conditions to rule out in the setting of a patient with pruritus without a primary dermatosis

though not rarely correlated with psychiatric comorbidities, especially, anxiety and depression, secondary etiologies should also be remembered in dysesthesia syndromes with a normal clinical examination, namely, in burning mouth syndrome, some vitamin deficiencies (especially B vitamins and folate) and Sjögren's syndrome. Furthermore, scalp dysesthesia without a primary dermatosis may eventually be linked with a primary neurologic disorder, such as multiple sclerosis, and, in dysesthetic anogenital syndromes without specific dermatologic findings, a lumbosacral radiculopathy should be considered, as well. Finally, a small fiber polyneuropathy should be suspected in the setting of chronic pruritus or dysesthesia, bilaterally, in the feet, legs and hands; a neurological examination and a immunohistochemical staining of a distal leg skin biopsy confirm the diagnosis and possible etiologies should be ruled out, including, diabetes mellitus, vitamin B12 deficiency and hematologic neoplasms [8].

## Final Reflections: The Need for Medical Education in Psychodermatology

Even though 30% of the patients in dermatology have a psychiatric comorbidity and 85% of the patients with skin symptoms confirm that there is a very important psychosocial component linked with the disease or illness, there are very few specialized services in psychodermatology and most of these patients will be approached by clinicians without medical education in psychodermatology [31, 32]. The relatively subjective aspects of dermatology, the psychosocial issues, are still undervalued and poorly approached globally [9, 33]. This is true not only in the context of dermatology and psychiatry, but also in other branches of medicine, in general, and decreases the patient's quality of life and may be a factor to worsen the disease and the illness [34]. Thereby, even if there are some specialized clinics or specialists in psychodermatology, most of the patients will not be referred [9, 35]. Thus, basic knowledge in psychodermatology should be implemented and spread in medical courses, in general medicine and in family medicine. General practitioners could also have a very important role in the approach of patients suffering from psychodermatologic disorders, considering that they provide a continuity of care and they have a closer contact with the patients and their families, having, thus, a pivotal role in the prevention of disease and illness and in the promotion of health [36].

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