7 Cognitive Behavioural Therapy for Skin Conditions

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Introduction

What Is CBT?

Cognitive behavioural therapy (CBT) is an umbrella term used to cover a variety of different therapies that focus on alleviating distress by working to change both internal cognitive processes and external behaviours. Like other approaches to psychological intervention, formal CBT psychotherapy requires the application of empathy and other 'non-specific' therapeutic skills such as active listening and the ability to build a therapeutic alliance with the patient. Indeed, CBT has at its heart the goal of the practitioner/therapist working in collaboration with the patient, usually in such a way as to foster both parties making guided discoveries of changeable factors that may be serving to maintain distress. For example, during CBT, the person living with psoriasis and experiencing low mood will explore how their mood interacts with specific thoughts and behaviours. This guided discovery occurs not just during the therapy session or whilst reading the self-help materials provided, but, crucially, also during guided exercises and practices. For example, Fig. 7.1 shows an excerpt from a typical diary used to identify the relationship between thoughts, feelings and behaviours.

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Situation Where were you, what was going on?	Emotion What did you feel?	Unhelpful thoughts and thinking patterns –be specific
Saw my psoriasis in the mirror	**anxious**	**What if people at work notice**

Fig. 7.1 Example of a thought record

CBT Protocols

CBT has developed such that there are now evidence-based 'protocols' involving specified techniques and procedures for treating many types of psychological presenting problems or disorders. Such protocols typically incorporate behavioural interventions that draw heavily on learning theory (such as exposure and response prevention) but also use insight-based approaches that focus on drawing an individual's attention to the role played by cognitive and affective factors such as thought content, cognitive processes, attentional biases and emotional states.

CBT and Skin Conditions

For people with skin conditions experiencing psychological distress, a variety of CBT approaches can be used as valuable additions to dermatology treatment. In this chapter, we will briefly outline the impact that skin conditions can have on psychosocial functioning, differentiate between CBT offered at different steps of mental health treatment, and detail how a range of specific CBT-based approaches can be used to treat the psychological distress associated with skin conditions.

CBT Techniques

Whilst some CBT informed 'techniques', such as habit reversal and relaxation can (and should) be incorporated into routine dermatology practice, CBT psychotherapy and the use of in-depth CBT protocols requires delivery by highly specialist accredited practitioners (usually CBT therapists accredited by an internationally recognised professional body or clinical psychologists who have completed an accredited training course). However, in order to be able to refer patients for CBT interventions, it is essential that healthcare clinicians working with dermatology patients are able to assess for the presence of forms of psychological distress that are likely to be amenable to treatment with this approach. Consequently, this chapter will have as a theme running through the 'practice points' tips as to how to identify psychological distress quickly during routine consultations with

dermatology patients. Further information on the assessment of psychological distress associated with dermatological conditions can be viewed for free by UK healthcare practitioners on the Health Education England e-learning portal (https://portal.e-lfh.org.uk/) and can be purchased by practitioners from other countries via integrity (https://www.eintegrity.org/).

The Impact that Skin Conditions Can Have on Psychosocial Functioning

Prevalence of Distress in Skin Conditions

Many people with skin conditions manage extremely well without psychological support: in the UK, around half of the population experience, a skin condition each year and the majority of these people cope well. Nevertheless, around 10–15% of patients with skin conditions experience clinically significant distress. However, objective skin condition severity is not a good predictor of psychological distress: clinician severity ratings tend to be only weakly associated with psychological distress, while patient severity ratings are more strongly associated with distress. It is not uncommon for there to be a poor agreement between clinician and patient assessments of disease severity. These discrepancies suggest that psychological factors are particularly important in the development and maintenance of distress associated with skin conditions.

Practice Point

It is worthwhile establishing the patient's view on the severity of their condition as an initial gauge of their distress: 'How severe do you rate [name of skin condition] on a 1–10 scale?'. If the patient's rating is significantly higher than the clinician's rating, then there be a need to assess further about the impact of the condition.

Impact

The impact of skin conditions can be considerable, for example, psoriasis has been found to have a similar impact on health-related quality of life as diseases such as cancer, arthritis and heart disease. Skin conditions can affect many areas of life, including work/school, leisure, personal relationships and socialising. Some skin conditions cause physical symptoms that are difficult to live with, such as pain, itch or skin flaking. These symptoms can, in turn, cause difficulty in sleeping and tiredness, which is known to be a risk factor for the development of illnesses such as depression and anxiety. Furthermore, some patients may engage in unhelpful coping strategies such as avoidance of exercise or excessive use of alcohol. Indeed, there is some evidence that some skin condition populations have higher levels of

substance use and clearly this has the propensity to adversely affect both the skin condition itself, general physical, and mental health. Treatment of the skin condition can also be problematic, as the treatments may be time-consuming and/or unpleasant. The skin condition can affect the individual's view of themselves and trigger thoughts of being 'unattractive' or worries of being 'rejected' by other people. Regrettably, negative reactions from others, such as staring and negative comments, are not uncommonly experienced by people with skin conditions. As such, stigmatisation poses an additional burden that may require learning and rehearsal of strategies to manage other peoples' reactions and such strategies can be built into CBT treatment protocols.

Practice Point
A significant minority of individuals find that their skin condition negatively affects their wellbeing and psychosocial functioning. Therefore, it is essential to acknowledge and validate this by routinely asking all patients directly about potential psychosocial impacts of their disease e.g. 'It isn't unusual for [name of skin condition] to have an impact on how people feel; how is it affecting you?'

Overlapping Categories of Psychological Distress

The relationship between skin conditions and psychological distress can be classified into three overlapping categories: primary psychological; 'psychophysiologic'; and secondary psychological. CBT can play a role in supporting adjustment in conditions found within all three of these categories. CBT can be the main form of treatment for presentations within the primary psychological category of conditions. In primary psychological conditions, the aetiology of the presenting problem is psychological, for example, as in trichotillomania. There are established CBT protocols that have been developed for treating trichotillomania and typically involve behavioural techniques associated with habit reversal.

In secondary psychological conditions, the aetiology of the complaint is a known skin disease (e.g. vitiligo, nodular prurigo, etc.) yet the presence of the condition can understandably be associated with significant psychological distress. CBT treatment protocols are not well established for the treatment of secondary distress related to skin disease. However, the protocols developed and tested for treating anxiety and depression are highly modifiable and there is emerging evidence that they are effective with dermatology patients.

Some skin conditions can also be considered to have a 'psychophysiologic' element, in which the physical symptoms are exacerbated by inflammation associated with stress, which can, for example, be the case in psoriasis or atopic dermatitis. Indeed, there is evidence that inflammation can play an important role in mental health. There are several well established CBT protocols used for stress reduction that are likely to be beneficial to patients living with skin disease, and relaxation/stress reduction strategies can be easily added into most CBT treatment protocols.

The Different Types of CBT

Background

CBT is a collection of therapeutic approaches that has at its heart an understanding that people do not simply respond to a situation, but rather respond on the basis of both the situation and their interpretation and physical reactions to that situation. Figure 7.2 shows a diagram of the simple 'five areas model' used as a starting point

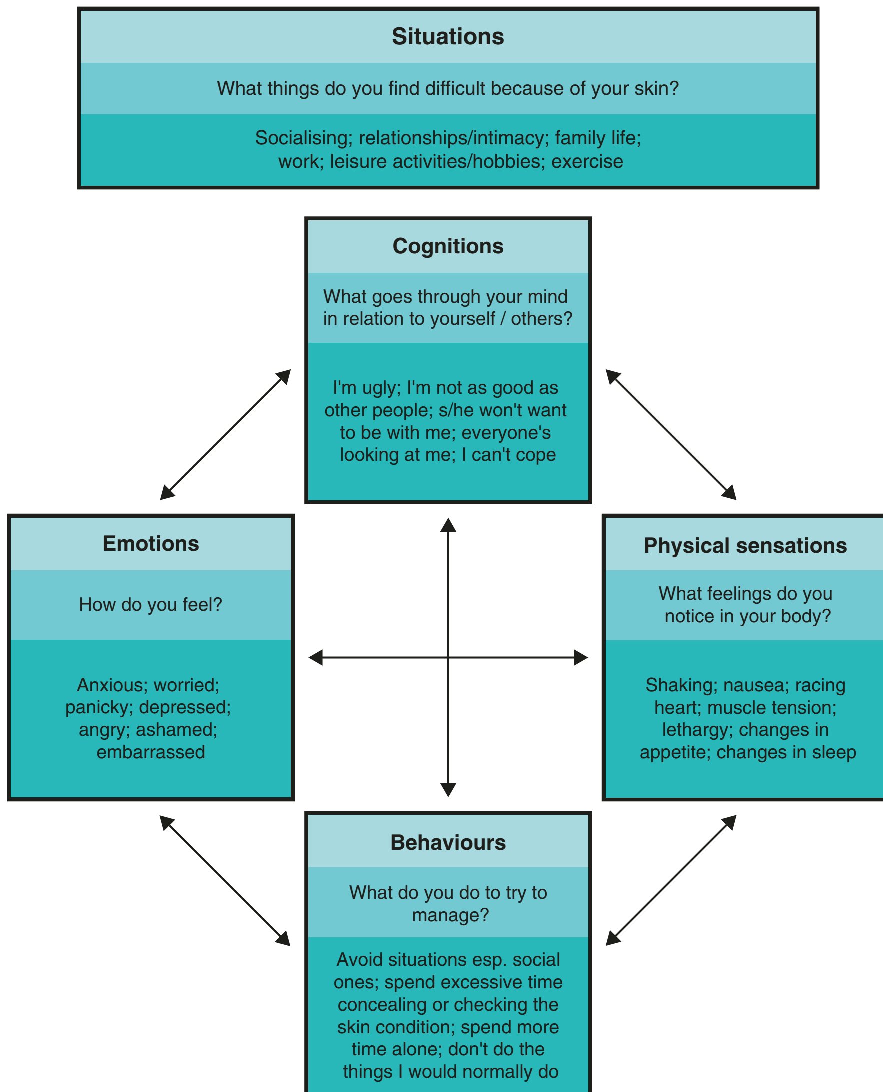

Fig. 7.2 Diagram of CBT five areas model, with example information gathering questions and responses that indicate the potential benefit of a CBT approach

in many CBT protocols. Figure 7.2 includes examples of questions that can be used to reveal information relating to each specific 'area'.

How CBT Works

CBT draws heavily on cognitive neuroscience and learning theory, which has identified how patterns of responding can be learnt and maintained. It seeks to use a guided approach to support patients to recognise for themselves the role played by the different 'areas'. This involves the patient developing an ability to stand back from the presenting problem and to try out new ways of responding. In traditional CBT this typically involves engaging in exposure and carrying out 'behavioural experiments' to experientially test unhelpful thoughts or assumptions and to learn via experience that anticipated adverse consequences do not occur at all or with a much lesser frequency than expected. The patient is also guided to challenge or 'restructure' unhelpful thought content (e.g. 'I'm ugly') and recognise unhelpful cognitive processing associated with specific thought content (for example, labelling oneself as ugly is an example of 'self-criticism' and 'over generalisation').

Practice Point

For some individuals, cognitive (e.g. thoughts and thinking styles) and behavioural (e.g. actions) factors exacerbate the distress associated with the skin condition. Therefore, it can be useful to directly ask patients about the content of their thoughts and investigate how their thoughts might influence their behaviour and mood as shown in Fig. 7.2.

Development of CBT Over Time

CBT has sometimes been described as developing in 'waves', with the first wave occurring in the 1950s and 1960s being focused primarily on techniques drawn from behaviour therapy and learning theory, and the second wave which arose in the 1970s and 1980s being focused on developing protocols that sought to identify and modify cognitive processes and thought content. The most recent 'wave' of CBT has placed emphasis on assisting people to reconnect with the present moment and to learn how to reconnect with values and aspects of their lives that typically become lost in the maelstrom of psychological distress. These so-called 'third wave approaches' include adapted forms of CBT to include mindfulness and Acceptance and Commitment Therapy (ACT). Both these approaches differ from earlier forms of CBT in placing more emphasis on decoupling from cognitive processes and tolerating affect and thought content as opposed to seeking to directly restructure them. They also place a large amount of emphasis on fostering a non-judgemental stance towards oneself and others. ACT also places emphasis on context and behaviour.

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy (MBCT) has been trialled with a limited number of skin conditions, that thus far show promising results: reliable and/or clinical changes in social anxiety for treatment completers, and participants rating MBCT as satisfactory and beneficial. However, methodological limitations mean that further research on third-wave CBT interventions for skin conditions is required before they can be included in clinical guidelines. As yet there has only been limited investigation of ACT for treating skin related distress.

CBT Approaches Within Stepped Care

Stepped Care

In some countries, guidelines for the treatment of depression and anxiety disorders follow a stepped care model, in which the least restrictive treatment that is likely to improve mental health is first recommended, and then more intensive treatment is provided as necessary if the patient remains significantly distressed. Figure 7.3 shows how CBT approaches can be used with patients at all steps of the stepped care model.

As mental and physical health problems can adversely affect each other, we recommend that CBT interventions for people with skin conditions acknowledge the presence and impact of the skin condition. At steps one and two, CBT-based interventions would benefit from the inclusion of skin-specific self-help materials. Normalising information, such as reading about examples of other people with skin conditions, can be valuable for reducing shame and promoting engagement in interventions.

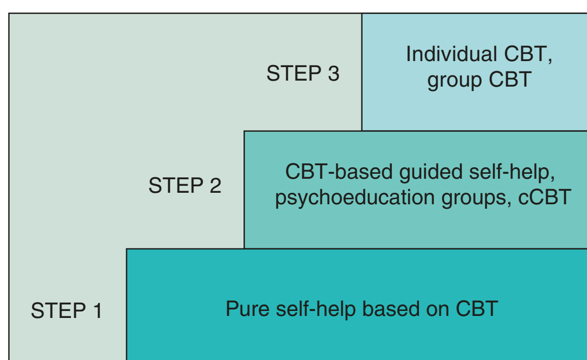

Fig. 7.3 CBT approaches within the stepped care model

Practice Point
CBT-based interventions can be delivered in a variety of formats, depending on the patient's needs and preferences. Some patients may be put off by the idea of receiving 'therapy' or attending 'a group', so it is useful to alert patients to the fact that CBT-based interventions do not solely consist of face-to-face psychotherapy, but can involve having access to self-help materials and e-support resources.

Pure Self-Help Based on CBT

'Step one' is the recognition, assessment and active monitoring of the mental health problem in primary care or an outpatient clinic. The CBT-based interventions at this step consist of 'pure' self-help, where distress has been recognised by a healthcare professional, and the patient has been given relevant self-help information to use independently. CBT-based self-help incorporates CBT formulations to help individuals understand how their thoughts and behaviours may be maintaining distress, and suggests the use of specific CBT techniques to facilitate change. Pure self-help is modestly clinically effective for anxiety and depression, with CBT-based self-help being more effective than educational self-help. There are a plethora of CBT-based self-help books and websites available, but clinicians need to be careful to direct patients to appropriate and reputable resources. Some examples have been provided at the end of this chapter. Several CBT-based self-help interventions for people with skin conditions have been trialled in recent years, although none are yet widely available. CBT-based interventions have been adapted for people with skin conditions with the inclusion of specific CBT techniques for the management of appearance related distress and common symptoms associated with skin disease such as itch. Studies have found some promising results, such as reductions in anxiety, depression, stress, shame, skin complaints and improvements in quality of life. However, further development work is needed before CBT-based self-help interventions for skin conditions are ready to be used in health services. In particular, studies of self-help interventions have reported high attrition rates and/or unexpected null findings on certain outcome measures. This suggests that further development work is needed to improve the acceptability of the interventions. Furthermore, caution must be exercised with self-help interventions as for some individuals, self-help increases awareness of psychological distress but does not provide enough support to make improvements. This is more likely to be the case for individuals whose psychological issues are more severe and/or longstanding.

CBT-Based Guided Self-Help, Psychoeducational Groups, cCBT

Patients who need additional support should be ‘stepped up’ with a referral (or self-referral) to mental health services. ‘Step two’ interventions, also known as ‘low-intensity’ interventions, involve limited contact time with a therapist or qualified mental health practitioner, typically over 6–8 sessions. Low-intensity CBT interventions can be delivered in a variety of formats, such as psycho-education groups, computerised CBT (cCBT), and individual or group ‘guided self-help’, in which patients receive advice on the use of self-help materials. Guided self-help has been shown to be more effective for depression than pure self-help. Low-intensity interventions are a cost-effective way of delivering treatment to a large number of patients and e-interventions can enable patients to access treatment despite geographic or time restrictions.

High-Intensity CBT

At step three, interventions are described as ‘high intensity’, as they involve more therapist contact time, typically up to 12–20 weekly sessions, with an accredited cognitive behavioural therapist or clinical psychologist. This form of CBT often involves individually tailoring treatment protocols and additional consideration of earlier experiences (including adverse childhood experiences that may have shaped patients underlying assumptions about the world, themselves, and other people).

Practice Point

Consider using brief screening tools such as the PHQ-2 and GAD-2. Where patients are exhibiting positive signs of distress consider using the full versions of these measures and where people score in the severe range consider referral for high-intensity CBT and consider other medications. For people in the mild range, consider referring to low-intensity CBT.

Signposting Patients to Places Where They Can Gain some Access to CBT and Mindfulness-Based Self-Help Information

Practice Point

Some CBT and mindfulness-based self-help techniques can be found on the following websites. Consider alerting patients to these sites.

- *Skin Support Website*
  Self-help website providing emotional support and information for people living with skin conditions—www.skinsupport.org.uk.
- *Patient Information Leaflets by St John's Institute of Dermatology*
  Leaflets about various skin conditions and dermatology treatments/procedures—https://www.guysandstthomas.nhs.uk/our-services/dermatology/patients/patient-leaflets.aspx.
- *Changing Faces*
  Charity supporting people who live with visible differences has lots of self-help information available—https://www.changingfaces.org.uk/.
- *Self-Help Access in Routine Primary Care (SHARP)*
  Short CBT-based self-help leaflets on a range of subjects including anxiety, depression, stress and physical health problems—https://www.primarycare-selfhelp.co.uk/.
- *Northumberland, Tyne and Weir NHS Foundation Trust Leaflets*
  CBT-based self-help booklets on a variety of mental health issues and difficult life events—https://web.ntw.nhs.uk/selfhelp/.
- *Mindfulness Resources*
  Free-to-download mindfulness meditation exercises—http://www.freemindfulness.org.