

# Mental Health Services: The Missing Piece or Missing Peace for Patients With Atopic Dermatitis



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## PRACTICE POINTS

- The mind-body connection plays a role in many conditions, including atopic dermatitis.
- Atopic dermatitis can make patients feel anxious, stressed, and depressed; at the same time, those feelings can lead to worsening of the condition.
- There are many barriers to getting mental health care in the United States, from financial constraints to stigmatization.
- Mental health is part of overall health and should be more highly prioritized by all physicians.

There is a well-established connection between the mind and the skin, and it is clear that this relationship is bidirectional—not only does skin disease increase the risk for depression, anxiety, sleep disturbance, and suicidality, but psychologic stress actually can worsen skin disease through multiple mechanisms, including direct damage to the skin barrier.<sup>1,2</sup> Psychologic stress also impacts the microbiome, another critical driver of skin disease.<sup>3,4</sup> The concept of the itch-scratch cycle vividly illustrates the vicious interplay between the mind and body in atopic dermatitis (AD).

However, patients with AD are not the only ones impacted—caregivers also experience psychologic stress. Remarkably, one study of patients with AD and their caregivers found that the caregivers actually reported significantly worse mental health and anxiety ( $P=.01$  and  $P=.03$ , respectively) than patients themselves, even when controlling for the severity of disease.<sup>5</sup>

Thus, it would seem obvious for mental health to be a central component of AD care—to improve patient and caregiver quality of life while also improving symptoms. Research has actually borne this out, with one systematic review and meta-analysis concluding that psychological intervention has a beneficial effect on AD,<sup>6</sup> and another that the addition of psychological and educational interventions to conventional treatment provided better therapeutic results in alleviating eczema severity and psychological symptoms.<sup>7</sup> One study demonstrated that patients with AD who received cognitive behavioral therapy via the internet displayed a statistically significant improvement in their disease ( $P<.001$ ) as measured by the Patient-Oriented Eczema Measure compared with those in the control group who received standard care alone. They also reported improvements in perceived stress, sleep problems, and depression in the intervention group that were sustained at 1-year follow-up.<sup>8</sup> These findings are particularly impactful because clinical results were achieved while leveraging an internet-based approach to therapy.

Regrettably, despite the preponderance of evidence supporting the connection between mental health and AD, there remain considerable unmet needs. A recent cross-sectional survey of 954 adults with AD and caregivers of children with AD ( $N=954$ ) conducted by the National Eczema Association found that half of patients were never asked about mental health during any of their visits, and of those referred for mental health resources, only 57% utilized the recommended services.<sup>9</sup> Importantly, patients aged 18 to 34 years reported wanting to be asked about mental health.

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Of those who did receive referrals, most were for counseling services (23%), followed by alternative mental health therapy such as music or art therapy (15%), cognitive behavioral therapy (13%), or peer/social support groups (12%). Approximately 10% reported receiving a pamphlet or a brochure only.<sup>9</sup>

Physicians who treat patients with AD can and must do better, but first we must explore why these referral rates are so low. As with many complex problems, there is unlikely to be one simple unifying reason. As expected, the answer is nuanced and multifaceted, and—most importantly—staggeringly incomplete.

For starters, mental health interventions rarely are as easy as applying a cream or taking a pill. Hedman-Lagerlöf et al<sup>8</sup> specifically pointed out that although their approach—using internet-based cognitive behavioral therapy—was explicitly designed to be more accessible with fewer resources, it required approximately 35 hours of treatment over 12 weeks, requiring both substantial time and commitment from patients who often are already burned out and exhausted due to AD. They even underscored that the most commonly reported adverse effect of therapy was increased stress or worry, making it a difficult sell.<sup>8</sup>

Even before most patients have a chance to consider the time required and the potential adverse effects of mental health interventions for AD, greater hurdles exist. Finances, medical insurance, and wait times were highlighted as barriers to care in a systematic review.<sup>10</sup> These are deep-seated problems in the United States; while they may be surmountable in certain geographic areas, the frequency with which these concerns arise means that it does not take too many failed attempts at referring patients for mental health services before clinicians just give up—similar to any form of operant conditioning.

A more elusive concept is stigmatization. Although it may not be quantifiable, the idea is that patients may encounter additional challenges when seeking mental health care, either because the interactions themselves may worsen their symptoms (eg, increased anxiety) or they may be more likely to have a negative perception of the experience.<sup>11</sup> A 2020 systematic review of barriers to addressing common mental health problems found that stigma was the most prominent barrier in adolescents, with the second most prominent being negative attitudes and beliefs about mental health services and professionals.<sup>12</sup> As a clinician, I can attest that I have sometimes detected skepticism when I have suggested mental health services to patients and have even been asked outright if I thought the problem was all in their head. My patients with AD generally have been much more open to the idea of mental health support, especially after I explain the powerful mind-body connection, than patients with other conditions—most notably delusions of parasitosis—who have been much more dismissive

of such overtures. An oft-cited paper from 1976 frames the problem perfectly, describing what can happen after a referral for mental health services.<sup>13</sup> The authors stated that the suggestion of mental health makes patients feel that the dermatologist does not believe them in the first place. Beyond this, the authors pointed out that referring the patient elsewhere reduces their hopes for dermatologic treatment.<sup>13</sup>

Knowing now—perhaps more than ever before—that the mind and skin are intimately connected compels us to solve these problems and find ways around these obstacles. Selecting the optimal forms of mental health services for each patient, having the structural support of the health care system, and winning the trust of patients and caregivers while combating stigma are undoubtedly tall orders; however, understanding the stakes for patients with AD, their caregivers, and society as a whole should inspire us to keep pushing forward.

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