Correspondence

Psychodermatology in Ukraine and Belarus: an Eastern European perspective

Dear Editor,

Psychodermatology addresses the connection between skin and mind.[1,2] Patients with skin diseases often have psychological components that require appropriate assessment and treatment, but these symptoms are frequently overlooked and undertreated.[1–3] The prevalence of psychiatric comorbidity in outpatient dermatological settings is estimated to be 35–40%.[1] In routine practice, the patients with dermatologic conditions often resist psychiatry referral,[4] and dermatologists become solely responsible for assessing psychological percussions.[5] According to many studies, most dermatologists had no training on psychocutaneous disorders, and they are not sufficiently trained for the management of these patients.[1,4,6,7] Dermatologists' awareness about the psychological component of skin disease is a key to successful treatment.[5] Recent studies in different parts of the world have revealed that dermatologists are not well prepared to address psychocutaneous disorders. Jafferany *et al.*[1] noted that only 18% of dermatologists acknowledged having a clear understanding of psychodermatology, and only 42% could clearly identify and treat psychocutaneous disorders.[1] Gee *et al.*[4] showed that in more than 50% of dermatologists who were able to diagnose a psychodermatological disorder in 8 of 10 patients, and among those dermatologists 72% never prescribed antidepressant medication. In a study conducted in Turkey, Ocek *et al.*[6] identified that every third dermatological patient had comorbidity with a psychiatric disorder.

A survey study was conducted from February to June 2018 in seven cities of western, eastern, and central parts of Ukraine including the Ukrainian capital, Kyiv, and two Belarusian cities, Vitebsk and the capital of Belarus, Minsk. The survey questionnaire consisted of nine multiple-choice questions and two open-ended questions. The participants were asked about their demographic variables; level of training, skills, and degree of comfort in managing psychodermatologic disorders; referral patterns, knowledge of patient, and family resources on psychodermatology; and interest in continuing medical education (CME) on psychocutaneous disorders. The survey questionnaire was distributed to dermatologists in the national conferences and local regional meetings of dermatologists in Kyiv, Kharkov (Ukraine), and Vitebsk (Belarus). In addition, the survey questionnaire was also emailed to dermatologists in other cities of Ukraine and Belarus. A total of 460 questionnaires were distributed, and 396 were returned for analysis. SPSS (Statistical Package for the Social Sciences) was used for statistical analysis. The frequency of data was calculated, and categorical data were analyzed using the χ^2 test.

The demographic and practice characteristics of participants are presented in Table 1. Only 16.2% of dermatologists reported a clear understanding of the term psychodermatology in an open-ended question. Regarding the practice patterns, 316 (79.8%) respondents had frequent or some experience with psychodermatology and 137 (34.6%) identified psychiatric components in 10–25% of their patients, but only 20 (5.2%) felt very comfortable when diagnosing and treating patients with psychodermatologic conditions. Seventy-nine (19.9%) respondents referred patients with psychocutaneous disorders to a psychiatrist one time per month, and 70 (17.6%) of them never referred these patients to a psychiatrist. The most common diagnoses referred by dermatologists to psychiatrists are listed in Table 2.

Table 1 Demographic and practice characteristics of participants (n = 396)

Characteristics	Respondents, *n* (%)
Age, years	
<30	90 (22.7%)
31–40	111 (28.1%)
41–50	109 (27.5%)
51–60	50 (12.6%)
>60	36 (9.1%)
Gender	
Male	106 (26.8%)
Female	290 (73.2%)
Title	
Professor	18 (4.5%)
Associate professor	60 (15.2%)
Practicing dermatologists	271 (68.4%)
Trainees	47 (11.9%)
Location of practice	
Rural	5 (1.3%)
Urban	367 (92.7%)
Suburban	24 (6.0%)
Type of practice	
Private solo	40 (10.1%)
Private group	63 (15.9%)
Outpatient clinic	209 (52.8%)
Hospital based	91 (22.9%)
University based	30 (7.8%)
Length of practice, years	
0–5	115 (29.0%)
6–10	61 (15.4%)
>10	220 (55.6%)

Table 2 The most common diagnoses referred by dermatologists to psychiatrists

Psychocutaneous disorder	*n* (%)
Self-injurious skin lesions	136 (34.3%)
Trichotillomania	48 (12.1%)
Delusion of parasitosis	36 (9.1%)
Depression associated with skin disease	36 (9.1%)
Psoriasis	35 (8.7%)
Atopic dermatitis	33 (8.4%)
Anxiety associated with skin disease	15 (3.8%)

The top four dermatologic diseases associated with a psychiatric component seen by dermatologists include psoriasis, acne, alopecia areata, and atopic dermatitis. About 180 (47.5%) respondents had no training and never attended any educational events on psychocutaneous disorders in their professional life. Three hundred and thirty-five (84.6%) participants were unaware of any patient and family resources on psychodermatology. Only 15.4% of respondents reported about following internet resources known to them: European Society for Dermatology and Psychiatry (ESDaP) and Psychodermatology UK. Two hundred and forty-five (61.9%) respondents expressed an interest in attending any educational events on psychodermatology, and 16 (4%) showed no interest.

The topics of most interest to patients looking for additional education were as follows: self-injurious skin lesions (64.1%), depression and anxiety associated with skin disease (62.4 and 53%, respectively), trichotillomania (48.5%), and body dysmorphic disorders (45.2%). Miscellaneous topics (12.4%) included how to approach patients with chronic skin disease and use of psychotropic medications in dermatology.

This survey study is the first to assess the knowledge and awareness of dermatologists concerning psychocutaneous medicine in Eastern Europe. Our results are consistent with previous studies from the United States of America, Turkey, and the Middle East.[1,6,7] Only 16–18% of dermatologists had a clear understanding of psychodermatology. In our study, dermatologists wanted to learn about self-injurious skin lesions, depression, and anxiety associated with skin disease, trichotillomania, and body dysmorphic disorders, as compared to other similar studies where the participants were interested in anxiety and depression associated with skin disease and self-injurious skin lesions.[6] Similar to previous studies, most of the patients were unaware of additional resources available to them or their family on psychodermatology.[1,6,7] Self-injurious skin lesions, trichotillomania, delusion of parasitosis, anxiety and depression associated with skin disease, psoriasis, and atopic dermatitis were identified diagnoses for psychiatric referral or treatment. In a Polish study from Gdansk region, Wojewoda *et al*[8] described a series of Slavic patients with dermatitis artefacta and emphasized the need for collaboration between dermatologists and psychiatrists in diagnosing and treating such patients. This study has several limitations including the self-report design that might have led to some bias, and the survey respondents may have become aware of their knowledge gap in the process of completing the survey. A very low number of respondents were from rural areas as compared to urban and suburban population. This could be related to the distribution of dermatological services in the two countries.

In summary, our results showed that dermatologists are not sufficiently aware of psychodermatology. Significant information gaps were identified in the knowledge of patient and family resources as well. Survey results also showed a need for training and educational activities on psychocutaneous disorders in Ukraine and Belarus. Obtaining specific training will increase dermatologists' comfort level in treating patients with psychocutaneous disorders. We recommend the incorporation of formal training and didactics on psychodermatology in dermatology residency programs and hold regular educational events. Dermatology–Psychiatry liaison services may prove helpful in the management of these patients in clinical settings.

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