

Screening for depression and suicidality in psoriasis patients: A survey of US dermatologists



To the Editor: Significantly increased risks for depression and suicidality have been found in psoriasis patients,¹ and psoriasis has been independently associated with major depression.² Therefore, it is important to be able to identify depression and suicidal ideation and behavior (SIB) among psoriasis patients. Standardized screening tools, such as the Patient Health Questionnaire-2 (PHQ-2), enable rapid identification of depression and SIB within minutes, making screening feasible, efficient, and effective in the outpatient setting.^{3,4}

Among psoriasis patients, almost 50% with psychologic distress are not recognized or identified.⁵ There are likely several reasons for this, including dermatologists not asking all psoriasis patients about their mood, not feeling comfortable doing so, or a combination of both. We evaluated dermatologists' practices and comfort screening for and discussing depression and SIB in psoriasis patients.

The New York University Langone Health institutional review board approved this cross-sectional, anonymous survey study; 74 of 101 US dermatologists (73% participation rate, 27 declined) completed surveys online or in-person at dermatologic meetings, including the 2018 American Academy of Dermatology annual meeting, New York University Advances in Dermatology Symposium, and Dermatologic Society of Greater New York monthly meetings. Statistical analyses were performed by using SPSS (IBM, Armonk, NY); the *t* or Mann-Whitney U tests were used to determine differences and the Fisher's exact and Somers delta tests were used to determine associations (significance threshold $P < .05$).

Table I displays participant characteristics. Nearly 57% of participants agreed or strongly agreed that psoriasis patients require regular monitoring for depression and SIB; however, only 27% said they ask about mood in the majority of their encounters with these patients. Only 7% reported using a depression screening tool, and <30% were familiar with the PHQ-2. On a scale of 1 (not at all comfortable) to 10 (very comfortable), mean \pm standard deviation (SD) comfort scores were >7 for asking about mood (7.8 ± 2.5), discussing depression (7.4 ± 2.5), and referring patients to mental health services (8.2 ± 2.3), but the mean \pm SD score for asking about SIB was only 6.3 ± 2.8 . Use of a screening tool and belief that patients require regular monitoring were associated with significantly

Table I. Participant demographics and characteristics (N = 74)

Characteristic	Value*
Age, y, mean \pm SD (range)	48.1 \pm 14.4 (31-86)
Sex	
Men	35 (47.3)
Women	39 (52.7)
Time practicing since residency, y, mean \pm SD (range)	16.5 \pm 14.0 (1-47)
Completed a fellowship	14 (18.9)
Board-certified in additional specialty	8 (10.8)
Practice type	
Solo private practice	15 (20.3)
Group private practice	32 (43.2)
University-affiliated or academic practice	20 (27.0)
Other	7 (9.5)
Practice location	
Urban	39 (52.7)
Suburban	29 (39.2)
Rural	2 (2.7)
Other	4 (5.4)
Hours a week seeing patients	
≤ 35	41 (55.4)
>35	33 (44.6)
No. of patients with psoriasis	
<50	25 (33.8)
50-99	29 (39.2)
100-150	4 (5.4)
>150	16 (21.6)
Percentage of psoriasis patients on systemic medications	
<25	36 (48.6)
25-49	30 (40.5)
50-75	7 (9.5)
>75	1 (1.4)
Use biologic therapies	65 (87.8)
Percentage of psoriasis patients on biologic therapies	
<25	43 (58.1)
25-49	26 (35.1)
50-75	4 (5.4)
>75	1 (1.4)
Use depression screening tool(s)	5 (6.8)
Familiar with PHQ-2	20 (27.0)
Screening beliefs, "Psoriasis patients require regular monitoring for depression and suicide."	
Strongly agree	9 (12.2)
Agree	33 (44.6)
Neutral	22 (29.7)
Disagree	8 (10.8)
Strongly disagree	2 (2.7)
Screening practices and frequency, "How often do you ask psoriasis patients about their mood?"	

Continued

Table I. Cont'd

Characteristic	Value*
Almost every patient encounter	11 (14.9)
≥50% of patient encounters	9 (12.2)
<50% of patient encounters	26 (35.1)
Rarely	28 (37.8)
Comfort asking patients about depression, [†] mean ± SD (range)	7.8 ± 2.5 (1-10)
Comfort talking with patients about depression, [†] mean ± SD (range)	7.4 ± 2.5 (1-10)
Comfort asking patients about SIB, [†] mean ± SD (range)	6.3 ± 2.8 (1-10)
Comfort referring patients for mental health services, [†] mean ± SD (range)	8.2 ± 2.3 (1-10)

PHQ-2, Patient Health Questionnaire-2; SD, standard deviation; SIB, suicidal ideation and behavior.

*Value is n (%) unless otherwise indicated.

[†]On a scale of 1 (not at all comfortable) to 10 (very comfortable).

increased comfort asking and talking about depression (Table II). Use of a screening tool and familiarity with the PHQ-2 were associated with significantly increased comfort asking about SIB. Frequency of screening and comfort asking and talking about depression and SIB were positively correlated. In addition, there was a significant positive correlation between the number of systemic medications used/prescribed by providers and screening frequency.

The psychologic impact of psoriasis is substantial, and most participating dermatologists believed that it is important to regularly monitor psoriasis patients for psychiatric comorbidity. Overall, most felt relatively comfortable asking about depression, although expressed less comfort asking about SIB.

Factors associated with increased comfort included use of a screening tool, PHQ-2 familiarity, increased screening frequency, and belief that patients should be regularly monitored. Characteristics associated with screening for depression in practice included use of and familiarity with screening tools. Limitations of our study include a relatively small sample size, reliance on self-reported assessments, and potential for selection and nonresponse bias, as responders might have had a particular interest in psoriasis or mental health or might have felt more comfortable assessing for psychiatric comorbidity than nonresponders.

In this study, >70% of participants screen for depression in less than half of encounters, which highlights an important knowledge and practice gap. Further medical education on the available depression screening tools, such as the PHQ-2, and how to implement them into practice might help improve care and more completely address the needs of psoriasis patients.

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Table II. Dermatologist characteristics associated with increased or decreased levels of comfort

Characteristic	Comfort asking about depression, mean score ± SD		Comfort talking about depression, mean score ± SD		Comfort asking about SIB, mean score ± SD	
	Present	Absent	Present	Absent	Present	Absent
Use depression screening tool(s)	9.8 ± 0.4*	7.7 ± 2.5	9.8 ± 0.4*	7.2 ± 2.5	8.8 ± 2.2*	6.1 ± 2.7
Familiar with PHQ-2	NS		NS		7.4 ± 2.4*	5.9 ± 2.8
Screening beliefs, any agree vs do not agree	8.5 ± 1.8*	6.9 ± 2.9	7.9 ± 2.3*	6.6 ± 2.6	NS	
Screening practices and frequency						
≥50% of patient encounters	9.2 ± 1.7*	7.3 ± 2.5	8.7 ± 2.2*	6.9 ± 2.5	NS	
Screen in general, yes vs no	8.5 ± 1.8*	6.7 ± 3.0	8.0 ± 2.2*	6.2 ± 2.6	NS	

Depending on the distribution of the data and presence of outliers, either the t test or Mann-Whitney U test was performed to determine differences between groups.

Factors not associated with a significant difference: sex, years practicing (≥10 vs <10), completing a fellowship, board certification in an additional specialty, practice type, practice location, hours per week seeing patients (>35 vs ≤35), number of patients with psoriasis (≥100 vs <100), number of systemic medications used/prescribed (≥6 vs <6), percentage of psoriasis patients on systemic medications (≥50% vs <50%), use of biologic therapies, and percentage of psoriasis patients on biologic therapies (≥50% vs <50%).

PHQ-2, Patient Health Questionnaire-2; NS, nonsignificant difference; SD, standard deviation; SIB, suicidal ideation and behavior.

*Significant difference, P < .05.

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REFERENCES

1. Kurd SK, Troxel AB, Crits-Christoph P, Gelfand JM. The risk of depression, anxiety, and suicidality in patients with psoriasis: a population-based cohort study. *Arch Dermatol*. 2010;146(8):891-895.
2. Cohen BE, Martires KJ, Ho RS. Psoriasis and the risk of depression in the US population: National Health and Nutrition Examination Survey 2009-2012. *JAMA Dermatol*. 2016;152(1):73-79.
3. Lowe B, Kroenke K, Grafe K. Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *J Psychosom Res*. 2005;58(2):163-171.
4. McDonald K, Shelley A, Jafferany M. The PHQ-2 in dermatology-standardized screening for depression and suicidal ideation. *JAMA Dermatol*. 2018;154(2):139-141.
5. Richards HL, Fortune DG, Weidmann A, Sweeney SK, Griffiths CE. Detection of psychological distress in patients with psoriasis: low consensus between dermatologist and patient. *Br J Dermatol*. 2004;151(6):1227-1233.

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