

Anxiety, Depression, COVID-19 Anxiety, and the Effects of Hospital Environment on Patients Presenting to Dermatology Outpatient Clinic During the Pandemic

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Abstract

Background: The World Health Organization has defined the COVID-19 infection as a pandemic. Anxiety and depression are emphasized to increase with the pandemic. **Aims:** The current study aimed to identify anxiety, depression, and COVID-19 anxiety of patients who presented to the dermatology outpatient clinic and the effects of hospital environment on them during the pandemic. **Materials and Methods:** A questionnaire was applied, including questions about the sociodemographic characteristics, the state of being hesitant about transmission of COVID-19 infection in hospital, pandemic-associated attitudes in hospital, persons and hospital sites thought to be risky for transmission of the infection, opinion about tele-dermatology, State-Trait Anxiety Inventory (STAI1, STAI2), Hospital Anxiety and Depression Scale (HADS), and the COVID-19 Anxiety Scales (CAS). The diagnoses of skin disorders were recorded after examinations. **Results:** The study included 458 patients (60.7% females, the mean age was 31.8 years) who presented to the dermatology outpatient clinic in March 2021. Of patients, 64.7% rated their hesitancy as moderate and higher about the transmission of the COVID-19 infection in hospital. With the STAI1 scale, the rate of moderate and severe anxiety was 47.6%; with the HADS, the rate of anxiety was 26.6%; with the HADS, the rate of depression was 37.3%; and with the CAS, the rate of anxiety due to COVID-19 was 3.9%. **Conclusion:** Dermatology patients should be evaluated to be adversely affected at least as much as the other members of the society. Patients found the hospital environment risky in terms of the transmission of COVID-19 infection, creating an additional stress factor.

Keywords: Anxiety, COVID-19, depression, dermatology, hospital environment

INTRODUCTION

The virus, which appeared in Wuhan, China in December 2019, has shortly affected the whole world, leading to deaths of millions of people, with sequelae of the infection in many organs, especially in the lungs.^[1] The COVID-19 infection, which the World Health Organization announced as a pandemic, has not only adversely affected bodily health, but mental health and social life as well.^[1,2] Psychological problems, including anxiety, depression, and stress, were reported to increase with the pandemic.^[2]

Many diseases of dermatology affect the mental health and/or mental health changes the course of the

dermatological disease, which makes up a joint working area for dermatology and psychiatry and is defined as psychodermatological diseases.^[3] The pandemic may not only affect the entire society psychologically and adversely but it may also affect dermatology patients whether they have a psychodermatological disease or not. There are a limited number of studies on the psychiatric effects of the pandemic on dermatology patients.^[4]

The COVID-19 infection is known to be transmitted in crowded environments where social distance cannot be

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maintained (1.5 m) and after contact with the infected surface.^[5] In hospital environments, in areas such as waiting rooms, examination rooms, and elevators, social distance cannot be maintained and there are common contact areas such as chairs, door handles, and wheeled beds. Although both physicians, patients, and hospital management take precautions, patients who present to the dermatology outpatient clinic may have concern about contracting COVID-19 in hospitals. This study was planned to identify the anxiety, depression, COVID-19 anxiety, and the effects and anxiety caused by being in the hospital environment in patients who presented to the dermatology outpatient clinic during the pandemic.

MATERIALS AND METHODS

A questionnaire was administered to all patients involving the following: sociodemographic characteristics, medical history, and any history of postponement of presentation for dermatological and non-dermatological complaints or regular dermatologic visits, or treatment during the pandemic; a personal history of COVID-19, or of losing any relatives due to COVID-19; hesitancy about being infected with COVID-19 in the hospital environment; in hospital pandemic-directed behaviors (use of double masks, face shield, frequent use of cologne and disinfectant, avoiding hand contact and sitting in waiting rooms, or lying or sitting on wheeled bed and/or chair in examination rooms); spending time in other risky areas such as emergency room, stairs, elevators, physicians' rooms, nurses' rooms, intervention rooms or getting in contact with healthcare personnel (physicians, nurses, others, patients, and patients' relatives); patients' opinions about tele-dermatology; as well as the State-Trait Anxiety Inventory (STAI1, STAI2), the Hospital Anxiety and Depression Scale (HADS), and COVID-19 Anxiety Scale (CAS) were administered. The diagnoses of dermatological disease were recorded after dermatological examination. The study was approved by İzmir Katip Çelebi University Ethics Committee with the decision number 0050 on February 18, 2021. All patients gave written informed consent, and the study was conducted in accordance with the Helsinki's Declaration.

STAI1 and STAI2, which was developed by Spielberger *et al.*,^[6] to measure state-trait anxiety levels of individuals older than 14 years of age (1970) were adapted to the Turkish society by Öner and Le Compte in 1995.^[7] The STAI1 is a 4-point Likert-type scale consisting of 20 items that aim to determine how an individual feels at a certain time and under certain conditions.^[7]

The HADS was developed by Zigmond and Snaith^[8] to determine the risk of anxiety and depression of the patient and to measure the change in its level and severity. The validity and reliability in Turkey were conducted by Aydemir *et al.*^[9] The HADS is a self-assessment scale

with 14 items, with two 7-item subscales measuring depression (HADS-D) and anxiety (HADS-A). Patients' dermatologic diseases can be evaluated by using HADS.^[10] The COVID-19 Anxiety Scale (CAS) measures the anxiety caused by the COVID-19 pandemic, over the last 2 weeks using a 5-point Likert scale,^[11] the Turkish validity and reliability of which were performed by Evren *et al.* in 2020.^[12] A limitation of our study is that no patients underwent a psychiatric evaluation clinically. The data were analyzed with the SPSS 15.0 package program using one-sample Kolmogorov–Smirnov, the Mann–Whitney *U*, χ^2 , *T*-tests in independent groups and Spearman's correlation tests.

RESULTS

A questionnaire was given to patients who voluntarily participated in the study, and the patients were presented to the dermatology outpatient clinic in March 2021, of whom 458 were included in the study (60.7% were females; mean age 31.8 years; range 15–81 years). Table 1 shows the sociodemographic characteristics of the participants. Table 2 shows the data on the diagnoses after dermatological examination, the presence of comorbidity and postponing presentation for a diagnosis, follow-up and treatment interruption during the pandemic, complaints about skin disorder, and/or other complaints. Of patients, 10.9% had COVID-19 infection, 43.8% of whom received no medication at home, and 52.1% received medication at home, and 4.2% were hospitalized with no need for intensive care. In terms of re-infection, 54.2% contracting COVID-19 had no idea about their illness, 37.5% considered not being re-infected, and 8.3% considered likely to be re-infected. The mortality rate due to COVID-19 infection was 11.4% among the relations/

Table 1: The sociodemographic characteristics

The sociodemographic characteristics of the patients	% (n)
Sex	
Female	60.7 (278)
Male	39.3 (180)
Education status	
Primary-secondary	11.4 (52)
High school	38.9 (178)
College	49.8 (228)
Vocation	
Student	32.3 (148)
Housewife	15.3 (70)
Worker	10.5 (48)
Self-employment	10.3 (47)
Healthcare worker	8.1 (37)
Retired	7.9 (36)
Teacher	5.7 (26)
Officer	5.5 (25)
Unemployed	4.6 (21)

Table 2: Diagnoses after dermatological examination, presence of comorbidity, postponing presentation for a diagnosis, follow-up and treatment interruption during the pandemic, complaints about skin disorder, and/or other complaints

	% (n)
Diagnosis	
Acne vulgaris	40.9 (187)
Pruritus	13.8 (63)
Seborrheic dermatitis	35 (7.6)
Contact dermatitis	5.5 (25)
Verruca vulgaris, anogenital warts	4.6 (21)
Scabies	3.5 (18)
Fungal diseases	3.5 (18)
Psoriasis vulgaris	3.5 (18)
Urticaria	3.1 (14)
Xeroderma	3.1 (14)
Telegen effluvium, non-cicatricial alopecia	2.4 (11)
Melanocytic nevus	2.2 (10)
Pyoderma	1.7 (8)
Others (pityriasis rosea, alopecia areata, bullous diseases, shingles zoster, lichen planus, vitiligo, diseases of oral mucosa, skin cancers)	4.5 (40)
Comorbidities	
Yes	11.1 (51)
No	89.9 (407)
Followed-up at the dermatology clinic	
Yes	27.5 (126)
Interruption of follow-ups, yes	36.5 (46)
Interruption of treatment, yes	26.1 (33)
No	72.5 (332)
Postponing hospital presentation for skin disorders	
Yes	38.9 (178)
No	61.1 (280)
Postponing hospital presentation for non-skin disorders	
Yes	31.2 (143)
No	52.6 (241)
No complaint other than skin disorders	16.2 (74)

relatives of our patients, 32.7% of whom were the first- and second-degree relatives. Questioning hesitancy about the transmission of COVID-19 infection in the hospital with a 5-point Likert scale, 7.6% responded “not hesitated at all,” 27.7% “slightly hesitated,” 28.2% “moderately hesitated,” 17% “quite hesitated,” and 19.2% “very hesitated.” The question “Do you think that the hospital is more risky than other crowded and closed facilities and further precautions should be taken concerning transmission of COVID-19 infection?” was pointed “yes” by 76.0% of the participants. At presentation to the dermatology outpatient clinic, 64.8% were found to wear double masks, 62.9% to take care not to touch anywhere with their hands, 52.8% to have the frequent use of cologne and/or disinfectant, 18.6% to choose not to sit in the waiting rooms, 15.7% to choose not to use wheeled beds and/or chairs in physicians’ room, 7.4% to

wear gloves, and 4.9% to wear face shield. The question “Indicate the areas you find risky in terms of COVID-19 infection transmission in the hospital” was asked and 3.5% of the responders answered that they did not find the hospital environment risky. Of the responders, 65.9% found emergency department risky, 65.7% elevators, 64.8% waiting rooms, 28.4% stairways, 27.0% intervention rooms, 15.9% physicians’ room, and 12.9% nurses’ room. As to the question “people you find bearing a risk to transmit COVID-19 infection in the hospital,” patients and their relatives were marked at a rate of 89.7%, other hospital staff 40%, nurses 29.5%, and physicians 27.9%. For the suggestion “I prefer to have a video examination by a physician instead of presenting to the hospital, and if necessary, I would prefer to present to the hospital,” 24.5% of the participants marked “absolutely agree,” 34.5% “can be,” 24.2% “I am undecided,” 5.0% “ok, if not possible,” and 11.8% “absolutely disagree.”

The mean scores of the participants’ CAS, HADS-D, HADS-A, STAI1, and STAI2 are presented in Table 3. With the cut-off values of the scales, the rate of moderate and severe anxiety with the STAI1 scale was 47.6% and that of persistent moderate and severe anxiety was 65.4%; with the STAI2 scale, the rate of anxiety was 26.6% and that of depression was 37.3% with the HADS; the rate of anxiety due to COVID-19 was 3.9% with CAS. Statistical analysis of scores by gender is presented in Table 3.

A positive correlation was found between the STAI1, the STAI2, the HADS-D score, the HADS-A score, and the CAS score (between the STAI1 and STAI2 scores $P < 0.00$, $r = 0.63$; the STAI1 score and the HADS-D score $P < 0.00$, $r = 0.39$; the STAI1 score and the HADS-A score $P < 0.00$, $r = 0.56$; the CAS score and the STAI1 score $P = 0.001$, $r = 0.16$; the HADS-D score and the STAI2 score $P < 0.00$, $r = 0.50$; the STAI2 score and the HADS-A score $P < 0.00$, $r = 0.71$; the STAI2 score and the CAS score $P > 0.00$, $r = 0.18$; the HADS-D score and the HADS-A score $P < 0.00$, $r = 0.57$; the HAD-D score and CAS score $P < 0.00$, $r = 0.16$; HADS-A score and CAS score $P < 0.00$, $r = 0.23$). No correlation was found between age and any scale score with Spearman’s rho correlation test ($P > 0.05$).

DISCUSSION

To our best knowledge, the present study is the first to identify anxiety, depression, COVID-19 anxiety, and hospital state anxiety and fear and concern about the COVID-19 infection transmission in patients presenting to the dermatology outpatient clinic. In early March, when the study was conducted, the number of daily cases was between 9,000 and 10,000, with the number of daily deaths between 70 and 80; however, toward the end of March, the number of daily cases increased approximately to 39,000, with the number of daily deaths exceeding 150

Table 3: Mean, standard deviation, min–max scores of CAS, HADS-D, HADS-A, STAI1, STAI2 scales (statistical analysis of scores by gender)

	N	Mean (Sd)	Min–max	P-value
CAS score				
Male	180	0.5 (Sd 1.4)	0–15	
Female	275	1.8 (Sd 3.0)	0–20	<i>P</i> < 0.00*
Total	455	1.2 (Sd 2.5)	0–20	
HADS-D score				
Male	173	5.6 (Sd 3.3)	0–17	
Female	267	6.5 (Sd 3.7)	0–19	<i>P</i> = 0.01*
Total	440	6.2 (Sd 3.6)	0–19	
HADS-A score				
Male	173	6.4 (Sd 3.8)	0–19	
Female	267	7.8 (Sd 4.5)	0–20	<i>P</i> = 0.02*
Total	440	7.3 (Sd 4.3)	0–19	
STAI1 score				
Male	170	38.5 (Sd 10.3)	20–66	
Female	263	39.9 (Sd 9.8)	20–66	<i>P</i> = 0.14#
Total	433	39.3 (Sd 10.0)	20–66	
STAI2 score				
Male	171	40.9 (Sd 8.8)	23–62	
Female	265	44.27 (Sd 9.6)	13–74	<i>P</i> < 0.00*
Total	437	42.9 (Sd 9.4)	13–74	

N = number, Sd = standard deviation, CAS = COVID-19 Anxiety Scales, HADS-D = Hospital Anxiety and Depression Scale-Depression, HADS-A = Hospital Anxiety and Depression Scale-Anxiety, STAI1, STAI2 = State-Trait Anxiety Inventory 1, State-Trait Anxiety Inventory 2

One-sample Kolmogorov–Smirnov test was used for the analysis of normal distribution

*Statistically analyzed with Mann–Whitney *U*-test

#Statistically analyzed with independent samples *T*-test

according to the data of Republic of Turkey, Ministry of Health just as in the whole World.^[13] Özdin and Bayrak Özdin,^[14] in their study on anxiety and depression in the Turkish society during the pandemic in April 2020, detected depression at a rate of 23.6% and anxiety at a rate of 45.1% with the HADS, with significantly elevated levels of anxiety and depression in women when compared with men. The present study, conducted about 1 year later, found the rate of anxiety by 26.6% and depression by 37.3% with the HADS, with depression scores of women being higher than those of men, with significantly elevated levels of anxiety and depression in women when compared with men.

The number of studies is limited on the psychological effects of the pandemic on dermatology patients.^[4] In pre-pandemic studies, the role of psychological factors was mentioned in approximately one-third of such patients.^[10,15,16] Studies conducted in the field of psychodermatology have pointed to the presence of psychiatric comorbidities and emphasized the importance of psychiatric evaluation.^[10] A multi-center study found that dermatology patients had significantly higher levels

of depression, anxiety, and suicidal thoughts than did the control group, with anxiety at a rate of 17.2% and depression at a rate of 10.1%.^[17] Kutlu *et al.*^[18] drew attention to an increase in the number of patients diagnosed with alopecia areata 2 months after the onset of the pandemic, which revealed its association with events such as unemployment and death occurring during the COVID-19. Kuang *et al.*^[19] reported during the pandemic an increase in exacerbation, anxiety, and depression-related complaints in psoriasis patients, whereas Shen *et al.*^[19,20] showed an increase in disease activity in chronic urticaria patients in their studies. Lada *et al.*^[21] emphasized that the COVID-19 pandemic might adversely affect the mental health of the whole society as well as psychodermatology patients along with general dermatology patients. It is recommended that dermatology patients should be directed to physical activity, hobbies, diet, and alternative methods that they know to relax themselves in order to maintain mental health and quality of life, regardless of whether or not they have diseases affected by psychological factors.

Patients and controls who presented to the cosmetology clinic in January 2020 were applied the CAS, which showed a mean CAS score of 3.5, increasing, in all participants after 3 months.^[22] The current study conducted in March 2021 found lower CAS scores than those of the aforementioned study, which was associated with the fact that 1 year passed after the announcement of the pandemic and increased compliance with the recommendation for protection against the pandemic. The study by Temiz *et al.*^[22] reported that 51.3% of the cosmetology patients had moderate and severe symptoms of depression with the use of the Hamilton Depression (HAM-D) and Hamilton Anxiety (HAM-A) scales, with anxiety scores being significantly higher than the controls.^[22] The current study found the rates of anxiety and depression being 26.6% and 37.3%, respectively, with the HAD scale. STAI1 is a scale that measures momentary anxiety in any situation. Previously, the STAI1 scale was used to measure anxiety in dermatology patients before the punch biopsy procedure, and an average score of 37.7 was found,^[23] with a mean STAI1 score of 39.3 in our patients waiting to be examined in the outpatient clinic. In another study in which the anxiety of patients was measured with STAI1 before septoplasty surgery, a mean STAI1 score was similar to the STAI1 mean score of our study group.^[24] The similarity between anxiety levels of patients waiting to be examined in the dermatology outpatient clinic during the pandemic and that before surgery or minor surgical interventions before the pandemic suggests that being in the hospital during the pandemic may cause anxiety. Of our patients, 64.7% had moderate and above hesitancy about transmission of COVID-19 infection in hospital, with 76.0% of those who thought that hospital was more risky in terms of COVID-19 infection transmission and that more precautions should be taken in hospital than in other crowded environments. At presentation to the hospital,

more than half of all participants were wearing double masks, taking care not to touch their hands anywhere, and frequently applying disinfectants and/or cologne on their hands. In terms of COVID-19 transmission, the emergency room, elevators, and patient waiting room were specified as risky areas in more than half of the participants, with 89.9% participants defining patients and their relatives as persons who had a risk of transmitting infection.

These data showed the negative effects of the hospital environment on patient psychology in terms of COVID-19 infection. Studies on tele-dermatology are under way in our country, but there is no tele-dermatology practice in most hospitals. A study in France examined the opinions of physicians who performed tele-dermatology and those of patients and found some negative aspects of the practice with respect to both the physicians and the patients and emphasized that tele-dermatology would find a ground on quarantine days in the future.^[25] The current study determined that 57.0% of the patients thought positively about tele-dermatology, 24.2% undecided, and 16.8% thought negatively.

In conclusion, this study exhibited that patients presenting to the dermatology outpatient clinic had increased anxiety in the hospital environment during the pandemic, with approximately one-third of the patients having anxiety and depression. The acceleration and implementation of tele-dermatology in order to reduce additional stress that may occur in the hospital environment will contribute to the prevention of the already existing psychological disorders as well as hospital-environment associated stress.

It should be kept in mind that the pandemic may adversely affect the mental health of the whole society, as well as dermatology patients.

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Conflicts of interest

There are no conflicts of interest.

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