Descrivere caratteristiche, ruolo e attività attribuite ad un Istituto di Ricovero e Cura a Carattere Scientifico (IRCCS).

Descrivere quali sono i criteri con i quali si misura la validità di un test psicometrico o di un questionario.

Descrivere le diverse tipologie progettuali previste dall'ultimo Bando della Ricerca Finalizzata 2021 del Ministero della Salute.

Delineare il disegno di uno studio sperimentale di efficacia di un trattamento psicoterapeutico o riabilitativo.

Delineare le differenze tra Ricerca Corrente e Ricerca Finalizzata in un Istituto di Ricovero e Cura a Carattere Scientifico (IRCCS).

Definizione e metodi di misurazione dell'attendibilità di un test psicometrico.

Concorso pubblico n. 1 risorse nel profilo di ricercatore sanitario, categoria DS per laureati in Psicologia da assegnare alla Direzione Scientifica ISG

Domande prova orale

1. Misurare il distress nel paziente oncologico.
2. Il concetto di crescita post-traumatica (post-traumatic growth) in oncologia.
3. Il disturbo di adattamento.
4. I disturbi reattivi nel paziente oncologico.
5. Aree della ricerca psicologica nei tumori cerebrali.
6. Descrivere il fenomeno del chemo-brain.
7. L'approccio neuropsicologico al paziente oncologico.
8. I PROs o Patient Report Oucomes: caratteristiche e utilità.
9. La distorsione (o bias) in uno studio scientifico. Cos'è e come gestirla.
10. Alexitimia e malattia dermatologica: cos'è e come misurarla.

Domande Informatica

1. Cos'è il Provider
2. Cosa significa Login
3. Cos'è word
4. Cos'è la posta elettronica
5. Cos'è il backup
6. Definizione di account
7. Definizione di motore di ricerca
8. Definizione di browser
9. Definizione di software
10. Definizione di scanner
11. Definizione di hardware
12. Che cos'è Excel
13. Cosa significa zippare un documento
14. Che cos'è una USB
15. Definizione di file
16. La firma digitale
17. La PEC
18. Cos'è un data-base?
19. Che cosa comprende il pacchetto office?
20. A cosa serve il programma Power Point?
21. Per cosa vengono utilizzate le formule in Excel
22. Cosa indica l'estensione .xls?
23. Cosa indica l'estensione .doc?

ORIGINAL ARTICLE
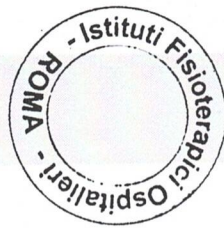
The Psychological Burden of Skin Diseases: A Cross-Sectional Multicenter Study among Dermatological Out-Patients in 13 European Countries

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The contribution of psychological disorders to the burden of skin disease has been poorly explored, and this is a large-scale study to ascertain the association between depression, anxiety, and suicidal ideation with various dermatological diagnoses. This international multicenter observational cross-sectional study was conducted in 13 European countries. In each dermatology clinic, 250 consecutive adult out-patients were recruited to complete a questionnaire, reporting socio-demographic information, negative life events, and suicidal ideation; depression and anxiety were assessed with the Hospital Anxiety and Depression Scale. A clinical examination was performed. A control group was recruited among hospital employees. There were 4,994 participants—3,635 patients and 1,359 controls. Clinical depression was present in 10.1% patients (controls 4.3%, odds ratio (OR) 2.40 (1.67–3.47)). Clinical anxiety was present in 17.2% (controls 11.1%, OR 2.18 (1.68–2.82)). Suicidal ideation was reported by 12.7% of all patients (controls 8.3%, OR 1.94 (1.33–2.82)). For individual diagnoses, only patients with psoriasis had significant association with suicidal ideation. The association with depression and anxiety was highest for patients with psoriasis, atopic dermatitis, hand eczema, and leg ulcers. These results identify a major additional burden of skin disease and have important clinical implications.

INTRODUCTION

Despite the high prevalence of skin conditions (Rea et al., 1976; Dalgard et al., 2004) and the strong association of psychiatric disorders with skin disease (Hughes et al., 1983, Picardi et al., 2000), the true extent of psychological co-morbidity across Europe is not known. This is important because the care of patients with skin disease may be inadequate if their psychological problems are not also recognized and treated.

The Global Burden of Diseases Study recently demonstrated that skin diseases were the fourth leading cause of nonfatal disease burden (Hay et al., 2014). Assessing the burden of skin disease is crucial for evidence-based allocation of resources and to position Dermatology in a global health perspective

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Work done in Giessen, Germany and Oslo, Norway. Patient recruitment in dermatological out-patient clinics from 13 European countries

Abbreviations: CI, confidence interval; HADS, Hospital Anxiety and Depression Scale; OR, odds ratio

(Freeman, 2014), but the choice of appropriate method remains a challenge. A wider perspective of the burden of physical conditions is demonstrated by the significant occurrence of depression in diabetes, asthma, heart disease, and arthritis (Scott *et al.*, 2007). It is predicted that depressive disorder will be the second cause of disease burden worldwide by 2030 (Mathers and Loncar, 2006), and the contribution of mental health to the burden of physical conditions is stressed in the context of the World Health Organization strategies by their slogan "there is no health without mental health" (Prince *et al.*, 2007). The co-occurrence of mood disorders and physical conditions has been emphasized by the World Mental Health Survey (Scott *et al.*, 2007, 2010). Measurement of the mental health of patients with physical diseases may therefore appropriately contribute to the overall measurement of the burden of disease.

European studies have shown that patients with atopic eczema, hand eczema, acne, and hidradenitis suppurativa have an increased risk of depression (Cvetkovski *et al.*, 2006; Dalgard *et al.*, 2008; Onderdijk *et al.*, 2013; Sanna *et al.*, 2014a), and 10% of patients with psoriasis are clinically depressed (Dowlatshahi *et al.*, 2013). Although anxiety is a separate entity, it is less studied and mostly described as accompanying depression in dermatological patients with psoriasis and occupational eczema (Boehm *et al.*, 2012; Kurd *et al.*, 2010). Population-based studies have shown significant associations of acne, eczema, and psoriasis with suicidal thoughts (Kurd *et al.*, 2010; Halvorsen *et al.*, 2011, 2014). In a study from Germany, 16% of patients with atopic dermatitis had suicidal ideation compared with 1% of the controls (Dieris-Hirche *et al.*, 2009).

Little is known about psychological co-morbidity of common skin diseases from a global perspective. The aim of this study was to investigate the co-occurrence of depression, anxiety, and suicidal thoughts in patients with common skin diseases across several European countries.

RESULTS

In total, 5,067 individuals agreed to take part—3,651 patients and 1,416 controls. The participation rate was 79.9%. Of the initial 3,651 patients, 16 were excluded, 9 because they were too young and 6 because of missing data, leaving 3,635. Of the initial 1,416 controls, 57 were excluded because they had a skin disease, leaving 1,359 (see flow chart).

The subject characteristics are given in Table 1: there were more females in both the patient and control populations. The mean patient age was 47 years versus 41 years for the controls, P<0.001. Overall 92% participants originated from the country where the study took place (data not shown). The socio-economic level distribution was similar in the two groups. Overall 35.6% of the patients reported stress compared with 30.6% of the controls, P<0.001. Overall patients had more physical co-morbidities compared with the controls, 28.8% versus 16.0%, P<0.001.

The overall distribution of the skin conditions is given in Table 2. The most common skin conditions were as follows: psoriasis (17.4%), non-melanoma skin cancer (10.9%),

infections of the skin (6.8%), eczema (6.4%), acne (5.9%), nevi (4.9%), atopic eczema (4.5%), skin tumors (4.2%), hand eczema (4.0%), and leg ulcers (3.4%).

Data on depression among dermatological patients are given in Table 3. Overall 10.1% dermatological patients were clinically depressed compared with 4.3% controls (P<0.001, adjusted OR 2.40, 95% confidence interval (CI) 1.67–3.47). The highest adjusted OR for depression were found among patients with leg ulcers (OR 10.17, 95% CI 4.07–25.41), hand eczema (OR 4.00, 95% CI 2.01–7.97), atopic dermatitis (OR 3.27, 95% CI 1.61–6.62), psoriasis (OR 3.02, 95% CI 1.86–4.90), and infections of the skin (OR 2.65, 95% CI 1.39–5.06).

Table 1. Characteristics of study population, N = 4,994

	Patients N = 3,635 N (%)	Controls N = 1,359 N (%)	P-value
Countries			
Belgium	248 (6.8)	131 (9.6)	—
Denmark	256 (7.0)	122 (9.0)	—
France	114 (3.1)	20 (1.5)	—
Germany	278 (7.6)	133 (9.8)	—
Hungary	250 (6.9)	134 (9.9)	—
Italy (two centers)	499 (13.7)	46 (3.4)	—
Netherlands	213 (5.9)	—	—
Norway (two centers)	527 (14.5)	218 (16.0)	—
Poland	250 (6.9)	125 (9.2)	—
Russia	248 (6.8)	120 (8.8)	—
Spain	249 (6.9)	116 (8.5)	—
Turkey	250 (6.9)	109 (8.0)	—
UK	253 (7.0)	85 (6.3)	—
Gender (MD = 17)			
Females	2,045 (56.5)	903 (66.6)	<0.001
Age years Mean SD (MD = 91)	47.2 (SD = 17.9)	41.1 (SD = 13.6)	<0.001
Females	46.0 (SD = 17.6)	41.1 (SD = 13.3)	<0.001
Males	48.6 (SD = 18.2)	41.1 (SD = 14.2)	<0.001
Marital status (MD = 322)			
Single	863 (26.0)	362 (26.7)	<0.001
Married/partner	1,978 (59.6)	840 (62.0)	—
Separated/divorced	273 (8.2)	119 (8.8)	—
Widowed	203 (6.1)	34 (2.5)	—
Self-reported socioeconomic level (MD = 106)			
Low	644 (18.2)	215 (15.9)	0.183
Middle	2,589 (73.1)	1,012 (75.1)	—
High	307 (8.7)	121 (9)	—
Stressful life events during last 6 months (MD = 97)			
Yes	1,262 (35.6)	412 (30.6)	<0.001
Physical co-morbidities[1] (MD = 479)			
Yes	993 (28.8)	170 (16.0)	<0.001

Abbreviation: MD, missing data.
[1]Physical co-morbidities: any treated cardio-vascular, chronic respiratory, diabetes, or rheumatologic disease.

Table 2. Distribution of common skin diseases among dermatological out-patients (N = 3,635) in 13 European countries

Diagnosis	Overall N (%)	BE N=248 MD=7	DK N=256 MD=1	FR N=114 MD=0	DE N=278 MD=4	HU N=250 MD=4	IT N=499 MD=0	NL N=213 MD=13	NO N=527 MD=4	PL N=250 MD=0	RU N=248 MD=2	ES N=249 MD=0	TR N=250 MD=0	UK N=253 MD=1
Psoriasis	626 (17.4)	42 (17.4)	41 (16.1)	15 (13.2)	27 (9.9)	24 (9.8)	82 (16.4)	23 (11.5)	128 (24.5)	56 (22.4)	67 (27.2)	50 (20.1)	25 (10.0)	46 (18.3)
Non-melanoma skin cancer	394 (10.9)	34 (14.1)	61 (23.9)	7 (6.1)	44 (161)	2 (0.8)	31 (6.2)	48 (24.0)	102 (19.5)	4 (1.6)	—	24 (9.6)	1 (0.4)	36 (14.3)
Infections skin	243 (6.8)	17 (7.1)	9 (3.5)	6 (5.3)	31 (11.3)	16 (6.5)	55 (11.0)	10 (5.0)	13 (2.5)	18 (7.2)	4 (1.6)	18 (7.2)	40 (16.0)	6 (2.4)
Eczema	229 (6.4)	12 (5.0)	16 (6.3)	3 (2.6)	23 (8.4)	11 (4.5)	23 (4.6)	14 (7.0)	18 (3.4)	32 (12.8)	20 (8.1)	12 (4.8)	—	45 (17.9)
Acne	213 (5.9)	11 (4.6)	3 (1.2)	2 (1.8)	4 (1.5)	3 (1.2)	31 (6.2)	3 (1.5)	23 (4.4)	6 (2.4)	13 (5.3)	9 (3.6)	75 (30.0)	30 (11.9)
Nevi	177 (4.9)	20 (8.3)	2 (0.8)	8 (7.0)	10 (3.6)	11 (4.5)	34 (6.8)	12 (6.0)	16 (3.1)	2 (0.8)	—	42 (16.9)	—	20 (7.9)
Atopic eczema	162 (4.5)	3 (1.2)	6 (2.4)	3 (2.6)	11 (4.0)	22 (8.9)	17 (3.4)	3 (1.5)	30 (5.7)	30 (12.0)	28 (11.4)	2 (0.8)	6 (2.4)	1 (0.4)
Benign skin tumors	152 (4.2)	18 (7.5)	4 (1.6)	5 (4.4)	10 (3.6)	6 (2.4)	35 (7.0)	7 (3.5)	12 (2.3)	1 (0.4)	—	37 (14.9)	4 (1.6)	13 (5.2)
Hand eczema	143 (4.0)	2 (0.8)	16 (6.3)	5 (4.4)	16 (5.8)	5 (2.0)	17 (3.4)	8 (4.0)	20 (3.8)	8 (3.2)	16 (6.5)	—	24 (9.6)	6 (2.4)
Leg ulcers	121 (3.4)	1 (0.4)	1 (0.4)	4 (3.5)	4 (1.5)	79 (32.1)	5 (1.0)	8 (4.0)	6 (1.1)	7 (2.8)	4 (1.6)	1 (0.4)	—	1 (0.4)

Abbreviations: BE, Belgium; DE, Germany; DK, Denmark; ES, Spain; FR, France; HU, Hungary; IT, Italy (Rome and Padua); NL, the Netherlands; NO, Norway (Oslo and Stavanger); PL, Poland; RU, Russia; TR, Turkey; UK, United Kingdom.

Table 4 gives data on anxiety in patients with common skin diseases. Overall, anxiety affected 17.2% of the patients compared with 11.1% of the controls ($P < 0.001$, adjusted OR 2.18, 95% CI 1.68–2.82). The highest adjusted OR for anxiety disorders were found among patients with psoriasis (OR 2.91, 95% CI 2.01–4.21), leg ulcers (OR 2.80, 95% CI 1.18–6.64), hand eczema (OR 2.60, 95% CI 1.45–4.67), and acne (OR 2.53, 95% CI 1.40–4.58).

Suicidal ideation in common skin conditions is described in Table 5. Overall 12.7% of the dermatological patients reported suicidal ideation compared with 8.3% of the controls ($P < 0.001$, adjusted OR 1.24, 95% CI 0.95–1.62). Only patients with psoriasis had a significant association with suicidal thoughts (OR 1.94, 95% CI 1.33–2.82). Of the patients reporting overall suicidal ideation, 53.6% reported that the suicidal thoughts were because of their skin condition: specifically 67.6% of patients with psoriasis and 68.0% of patients with atopic dermatitis reported suicidal ideation because of their skin.

DISCUSSION

We found a significantly higher prevalence of clinical depression (10.1% vs. 4.3%), anxiety disorder (17.2% vs. 11.1%), and suicidal ideation (12.7% vs. 8.3%) among patients with common skin diseases compared with controls. These findings, from a wide geographical, cultural, and socio-economic base, have relevance for clinical services across Europe (Aguilar-Duran et al., 2014) because of the high prevalence of skin diseases.

The reference values in our control group are in accordance with estimations of the European prevalence of mental disorders (Wittchen et al., 2011). The co-occurrence of mental and dermatological problems has previously mostly been described in national single center studies. An Italian study of 2,579 dermatological patients showed an overall psychiatric morbidity of 25%, with a higher percentage of psychiatric cases in patients with skin infections, pruritic conditions, and alopecia (Picardi et al., 2000). However, the General Health Questionnaire used in both studies does not specifically measure depression and anxiety, as it does not measure symptoms of distress. Therefore, the Hospital Anxiety and Depression Scale (HADS) seems more appropriate to use: this instrument has shown solid psychometric properties regarding factor analysis and internal consistency. Although there is a shared variance of 30% of the subscales of depression and anxiety, the sensitivity and specificity for the anxiety and depression subscales are high, which allows separation of anxiety disorder from depression (Mykletun et al., 2001; Bjelland et al., 2002; Picardi et al., 2005; Breeman et al., 2014).

The interpretation of previous published work is often made difficult because of a lack of prospective control group data, with many studies relying on population reference values. Our results are, however, compatible with a Danish study using the Beck Depression Inventory that reported a depression prevalence of 13% in dermatological patients compared with 5% among controls (Zachariae et al., 2004).

Patients with leg ulcers had the highest rates of depression, and this association remained strong in the regression analysis.