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Perspective

Identifying and addressing stress, anxiety, and depression in the allergist's office

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Evidence of the relationship between allergic diseases and mental health concerns has been steadily accumulating during the past 30 years. This body of research has established robust connections between allergic diseases and a variety of psychiatric symptoms, including stress, anxiety, and depression.¹ Moreover, the relationship between particular allergic diseases, such as asthma, and psychiatric symptoms of stress, anxiety, and depression is particularly well documented.^{1,2} This relationship warrants attention, given its implications for patient health and functioning within and outside the allergist's office. Indeed, studies have found that the presence of psychiatric symptoms among individuals with an allergic disease is associated with increased risk of worse disease control, poor treatment outcome, and reduced quality of life.^{1,2} Despite this evidence, however, a lack of recognition of psychiatric symptoms and their effect on a patient's allergic disease remains among allergists/immunologists. This lack of attention to psychiatric symptoms among patients with allergic diseases may be in part attributable to limited knowledge on how to best assess and address these symptoms. Assessing and addressing psychiatric symptoms in patients with allergic diseases are critical to ensuring quality of care and increasing positive outcomes for patients. We propose that the assessment of stress, anxiety, and depression should be standard care for all patients with an allergic disease. In addition, there is an opportunity for the delivery of brief, targeted psychological interventions within the context of allergists' offices for patients presenting with these symptoms.

Patients and their health care providers would benefit from the evaluation of psychiatric symptoms at the start of every appointment. This procedure would require a limited time commitment because several brief, reliable, and valid questionnaires are freely available for

assessing the severity of current psychiatric symptoms. For example, the 21-item Depression, Anxiety, and Stress Scale³ assesses the severity of anxiety, depression, and stress symptoms within the past 2 weeks. The measure has strong psychometric properties, takes just a few minutes to complete, and is at a third-grade reading level, making it accessible for most patients.³ The measure also provides clinical cutoffs, allowing health care providers to quickly classify patients' symptoms as normal, mild, moderate, severe, or extremely severe. Severe or extremely severe scores suggest the presence of a possible mood or anxiety disorder.

The information provided by the 21-item Depression, Anxiety, and Stress Scale, or other available questionnaires, can be particularly useful for health care providers. First, given the stigma often associated with the experience of psychiatric symptoms, patients may be more willing to disclose their symptoms on a questionnaire than directly to a health care provider. Second, the items on the questionnaire offer health care providers with a starting point to discuss psychiatric symptoms. Health care providers can ask patients to elaborate on certain items and discuss how particular psychiatric symptoms may affect their allergic disease or treatment. Understanding psychiatric symptom severity will also allow for proactive planning of treatment regimens because patients with more severe psychiatric symptoms may benefit from additional support. For example, if a patient has extremely severe depression, there is a greater likelihood that the patient may not adhere to treatment or may be more likely to miss appointments. In these cases, health care providers can initiate steps to improve treatment outcomes, such as problem solving with the patient to identify ways to improve treatment adherence, increasing the frequency of appointment reminders, using telehealth to facilitate contact with the patient, and/or initiating a referral to a psychologist or psychiatrist for further evaluation and treatment.

Although referral to a psychologist or psychiatrist is an excellent option, allergists/immunologists need to recognize that a referral may not be sufficient to address the patient's needs. Patients who experience severe stress, anxiety, and depression may be less likely

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to pursue a referral because of feeling overwhelmed or a lack of motivation. Many patients also face multiple treatment barriers, including financial constraints, limited time, transportation difficulties, and/or reduced availability of mental health care providers in their area. Thus, although we recommend that a referral to a mental health care provider still be offered, we also argue that there is a need for brief psychological interventions that can be effectively delivered by non-mental health care professionals (eg, nurses) in allergists' offices.

One such intervention is brief behavioral activation treatment.⁴ Brief behavioral activation treatment assists patients in identifying and engaging in meaningful activities while also decreasing ineffective behaviors that maintain symptoms of depression and anxiety (eg, isolation and avoidance). Studies have found that brief behavioral activation treatment is efficacious in reducing symptoms of depression and anxiety across various populations and settings.⁴ Brief behavioral activation treatment is also a time-efficient and straightforward, simple treatment to deliver, making it amenable to being learned and delivered by non-mental health care professionals. Moreover, brief behavioral activation treatment does not require a preset number of sessions, allowing the treatment to be flexibly applied across settings.⁴ Thus, brief behavioral activation treatment may be particularly well suited for delivery in allergists' offices, where opportunities for direct intervention can be limited because of time constraints.

Speaking to the potential utility of brief behavioral activation treatment for patients with allergic disease and psychiatric symptoms, a recent uncontrolled trial reported that a 1-session brief behavioral activation treatment for patients with chronic spontaneous urticaria could be successfully delivered by medical professionals with a limited

background in psychological intervention delivery.⁵ Patients with poor disease control and elevated depression symptoms were offered brief behavioral activation treatment in addition to their standard care. One month after the treatment, patients exhibited considerable reductions in depression symptoms and functional impairment. Brief behavioral activation treatment was also associated with improvements in urticaria control. Despite the preliminary nature of this study, it provides a model for other allergists seeking to address psychiatric symptoms to improve patient outcomes.

Patients may not view allergists' offices as a place to discuss mental health concerns; however, such discussions should be commonplace given the intimate connection between physical and mental health.² As such, allergists/immunologists have a responsibility to adequately assess and address psychiatric symptoms in their patients. Although such an approach may require a slight increase in time with each patient, doing so will translate into much improved treatment outcomes.

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