Congress Interviews

EMJ is delighted to present exclusive interviews with two leading figures from the European Academy of Dermatology and Venereology (EADV) 2026 Congress: Anthony Bewley, who explores the growing importance of psychodermatology and the relationship between skin health and psychological wellbeing; and Alexander Katoulis, who discusses advances in hair disease research, the challenges of scarring alopecias, and improving the diagnosis and management of hair disorders across Europe.

Featuring: Anthony Bewley and Alexander Katoulis



Anthony Bewley

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Q1 Could you tell us about your role as a Board Representative to the European Academy of Dermatology and Venereology (EADV) Executive Committee (EC) and the priorities you are particularly keen to advance?

I've been one of two UK EADV representatives for the past 3 years, and was also voted (by colleagues from across Europe) onto the EC of the EADV. My agenda is to progress the work of the EADV, in terms of education of trainees, but also the delivery and advancement of the EADV agendas. One of which is the annual Congress, which is a focus for clinical and academic excellence. The last conference in Vienna, Austria, welcomed more attendees than many other global meetings, and the quality of the presentations shows that the EADV is now leading global dermatology.

Psychodermatology, which has emerged over the previous 10–20 years as a newer subspecialty, particularly interests me. It's quite clear from our patients that living with a dermatological condition is much more than the skin itself. For example, from the All-Party Parliamentary Group on Skin (APPGS) report in the UK in 2020, it was clear that a staggering 98% of patients living with a skin condition have psychosocial comorbidities.[1] Furthermore, an enormous 5% of patients feel so disabled by their skin condition that they would consider suicide. These are very alarming statistics. On top of that, we know that about 82% of dermatology HCPs don't always engage in the psychological holistic management of patients.

Q2 From your perspective, what are the most pressing challenges facing dermatology across Europe today?

Mental health is very much a priority across Europe. In the EADV and the European Society for Dermatology and Psychiatry

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(ESDaP), we've made it very clear that we advocate for at least regional psychodermatology clinics across Europe.[2] But to date, there are some European countries which do not have any psychodermatology specialist provision at all. Even in those that do have it, the distribution of psychodermatology services varies considerably. In the UK, the Getting It Right First Time (GIRFT) report, from 2021, made it clear that there should be at least regional clinics. This isn't happening yet, although some progress has been made, both in the UK and across Europe.

At the same time, we must be mindful of what our patients consider priorities in the management of their disease. Priority Setting Partnerships from advocacy groups, such as Psoriasis UK, using the James Lind model, show that our patients advocate for psychodermatology provision as a routine part of their assessment and management. It is now time for us to show HCPs and patient advocates that we hear that message.

Q3 Skin disease can have a significant impact on patients' psychological and social wellbeing, while psychological factors can also influence the experience and management of skin conditions. How important is it for dermatologists to recognise and address this two-way relationship?

Psychodermatology is often thought of as being two sides of the same coin.[3] It is either primary psychiatric disease presenting to dermatology HCPs, for example body dysmorphic disorder or obsessive compulsive disease disorders, such as trichotillomania (pulling out your hair) or chronic skin picking. These patients identify as being primarily dermatological patients, and although the primary pathology may actually be psychiatric, they do not want to see psychiatrists.

> **A staggering 98% of patients living with a skin condition have psychosocial comorbidities**

The other side of the coin is patients with skin disease who have psychosocial comorbidities. In the EADV, ESDaP, and national organisations such as Psychodermatology UK, we recognise that the patient's voice needs to be heard. Living with chronic skin conditions quite commonly leads to anxiety and/or depression. Dermatology HCPs often feel as though we're not trained, but I would argue that every single dermatologist and venereologist in Europe has had some basic training. We are all psychodermatologists; we can all assess the psychosocial wellbeing of our patients. If it seems outside of your competencies, then we can signpost patients to other specialties like psychological services, psychiatric services, primary care, or even to online help, such as mindfulness support. If you want to have further training in psychodermatology, there is an EADV masterclass, the ESDaP diploma, and a training school



run by Psychodermatology UK and the British Association of Dermatologists (BAD).[4-6]

Psychodermatology depends on local competencies and regional availabilities. Some clinics, like our own in London, UK, have a dermatologist and a psychiatrist sitting in the room at the same time, with psychologists running in parallel. But there are a whole range of different models, and, in 2014, myself and some colleagues wrote about how to set up a psychodermatology clinic.[7]

Q4 Which patient groups or dermatological conditions are particularly likely to benefit from a psychodermatological approach?

Although all dermatological conditions have psychosocial comorbidities (many of us now working in psychodermatology do not refer to the psychological disease as 'co-morbidities, but rather as a domain of the holistic disease), there are various areas within dermatology which attract special interest. One emerging example is paediatric psychodermatology, particularly in the context of genetic dermatoses such as epidermolysis bullosa. In some centres across Europe, psychologists are routinely part of the service for patients with genodermatoses. Some clinics also have specific psychological support for more common dermatological conditions like psoriasis and atopic dermatitis. Another emerging specialty is psychodermato-oncology, which involves the psychosocial comorbidities of patients living with a diagnosis of skin cancer, but also living with the management of their skin cancer. This is particularly relevant for patients who have received immunotherapy for advanced melanoma.



"The brain itself is subject to the consequences of neuroinflammation, which may then lead to some of the psychosocial comorbidities"

We're increasingly aware of the concept of neuroinflammation. We used to think that if you have skin disease, then of course you would feel unhappy about your body image and how your skin is affected by living with an, often, very visible difference, which not only has its own symptoms such as skin pain or itch, but also enormously impacts your quality of life. However, we're recently discovering that the brain itself is probably involved in inflammation as a part of the whole-body inflammatory burden.[8] Our patients can now understand that it's not their fault that they feel the way they do when they have a skin condition, and that the disease itself is eliciting psychological and psychiatric disease as part of the neuro-cutaneous inflammation. There is increasing evidence, particularly with the advent of biologics and monoclonal antibodies to interleukins, that the brain itself is subject to the consequences of neuroinflammation, which may then lead to some of the psychosocial comorbidities of living with various skin conditions. There is also research that has shown that the brain changes in response to long-standing skin disease. For example, a study from 2026[9] looked at functional MRI scan results, which showed that patients with psoriasis had changes in the brain. What we don't know yet is whether management of the skin disease reverses the changes. We're also interested in something called psycholag, which is the difference between physical resolution of skin disease and psychosocial resolution of skin disease.[10] It's a bit like jetlag: when you fly to a distant country, you may arrive there bodily, but your brain may take some time to catch up. With psycholag, when your physical skin gets better, your psychosocial comorbidities may take a little longer to improve.

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Q5 How can clinicians distinguish between the psychological burden of living with a visible skin condition and situations in which psychological factors may also influence the presentation or management of the disease?

I would argue that all dermatologists are psychodermatologists to some extent. When you have a patient with a skin disease, it is really important to ask basic, open, Socratic questions, such as: 'How does this make you feel?' This, firstly, engages the patient, and, secondly, allows the patient a platform to relate their psychological wellbeing and, perhaps, a little about their quality of life.

Dermatology HCPs have two fears about this. The first one is that they are not sufficiently trained to assess patients, and this is not the case. All of us have basic training and communication skills in managing the basic psychosocial comorbidities of our patients. The second fear is that if you ask this question, it will lead to a very prolonged consultation. We know from research that this is not the case: asking these questions engages the patient, makes for a patient-centred consultation, and improves the adherence to any agreed treatment modality. Investing the time to find out about the psychosocial comorbidities is hugely beneficial.

Motivational interviewing can also be helpful.[11] If you get the patient to decide their priority and their goals, make sure that they are achievable and that the patient focuses on how they are going to achieve those changes in their lifestyle. That empowers the patient and facilitates adherence and management of their skin condition, including their psychosocial comorbidities.

Q6 Despite growing recognition of the relationship between skin and mental health, what barriers prevent psychodermatology from being more widely integrated into routine care?

Psychodermatology is, I believe, going to become a routine part of at least regional centres, via a multidisciplinary team approach. Colleagues, such as nurses, pharmacists, psychologists, and other HCPs can, through a multidisciplinary team approach, manage patients more comprehensively and more cost-efficiently than in general dermatology clinics.[12] AI also is likely to have an influence on how psychodermatology is practiced. We know that there are various AI interfaces that patients can access, which some patients prefer, to talk about psychosocial comorbidities. Other patients prefer face-to-face, human-to-human contact. The availability of all modalities is likely to be the future.

Q7 What role can EADV play in raising awareness of psychodermatology and supporting dermatologists to incorporate psychological considerations into everyday clinical practice?

The EADV is actively championing psychodermatology. There are excellent training opportunities, as previously mentioned. The EU has actively commissioned better resources for improvements in mental health, and certainly the EADV is actively liaising with the EC to promote the importance of psychodermatology as pathway to facilitate holistic wellbeing.[13] The EADV also links very closely with the ESDaP and national psychodermatology organisations. Finally, the EADV encourages patient advocacy: patient organisations make it very clear that the psychosocial comorbidities are pre-eminent in their consciousness, and the EADV is very much encouraging psychodermatological support to be included in the guidelines.[14] They also encourage the creation of more patient materials, which support patients and signpost them towards better psychosocial support and wellbeing.

Q8 What research gaps need to be addressed to strengthen the evidence base for psychodermatological interventions and improve patient outcomes?

Research in psychodermatology is emerging and the quality of the research is getting better in my experience. The recent 2026 ESDaP Congress in Manchester, UK, showed how far European and global psychodermatological research has come.[15] I've alluded to neuroinflammation, psychological approaches such as motivational interviewing, the holistic management of patients, and the multidisciplinary team approach. We also need to train other specialties, for example, psychiatrists, paediatricians, and plastic surgeons. The good news is that the EADV has funded the latest ESDaP III study, and that

> **The EADV is very much encouraging psychodermatological support to be included in the guidelines**

various organisations across Europe are increasingly interested in the funding and the delivery of psychodermatology research. So, some of these demands are likely to be realised as time goes on.

Q9 What recent or emerging developments in psychodermatology are you most excited about, whether in research, clinical practice, or service provision?

There are so many that are very interesting. In our own centre, we have frequently been asked what is the best treatment for patients with delusional infestation, and we've recently demonstrated that it is a couple of antipsychotics, risperidone and amisilperide.[16] We've also shown that if we delay treatment of patients with conditions like delusion infestation, that the chances of anything actually working for those patients diminishes with time.

We also know from ESDaP studies I, II, and III that the burden of psychosocial comorbidities in patients who have long-standing skin disease is enormous.[17] We're particularly interested in how we encourage patients to become more resilient in living with their skin conditions. And then, finally, one of the most interesting emerging aspects of psychodermatology is the concept of neuroinflammation.

Q10 What is the most important change you would like to see in how dermatologists approach the psychological wellbeing of their patients over the next 5 years?

I'm going to go back to my original statement, which is about the facilitation of, at least, regional psychodermatology clinics across Europe and globally. There is a growing sense of importance about psychodermatology across the globe. The EADV and ESDaP have shifted from being solely European: 25–30% of attendees at the EADV Congress in Vienna, Austria, were from non-European countries. Furthermore, organisations such as the South Asian Association of Psychodermatology (SAAPD) have emerged, which indicates that the global voice of psychodermatology is growing louder. And that is surely great for our patients and for the development of dermatology's clinical and academic expertise.

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