

Appendix

Scales

Patient Health Questionnaire PHQ-2²⁷

Over the last 2 weeks, how often have you been bothered by any of the following problems ?

Not at all Several days More that half the days Nearly every day
0 1 2 3

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless

General Anxiety Disorder Assessment GAD-2²⁷

Over the last 2 weeks, how often have you been bothered by any of the following problems ?

Not at all Several days More that half the days Nearly every day
0 1 2 3

1. Feeling nervous, anxious or on edge
2. Not being able to stop/control worrying

The scales are validated and translated to many languages (<http://www.phqscreeners.com>). For both short versions with a range from 0 to 6 there is a cut-off value ≥ 3 with sensitivity and specificity values for both scales about .85 and Cronbach alpha about .83.

EQ5D-VAS: a standardized generic instrument assessing general health state⁹ with a visual analogue scale, from “0” – “100” (worst to best imaginable health state).

Perceived Stigmatisation Questionnaire PSQ²⁹

Answer : *never, almost never, sometimes, often, always*

1. People avoid looking at me
2. People I don't know act surprised or startled when they see me
3. People don't know what to say to me
4. People feel sorry for me
5. People don't know how to act around me
6. People do “double takes” or turn around to look at me
7. People I don't know stare at me
8. People seem embarrassed by my looks

9. People are relaxed around me*
10. Strangers are polite to me*
11. People I don't know say "Hi" to me*
12. People are friendly with me
13. People I don't know smile at me in a friendly way*
14. People are kind to me*
15. People are nice to me*
16. People treat me with respect*
17. People call me names
18. People make fun of me
19. People bully me
20. People laugh at me
21. People pick on me

Perceived Stress Scale -10^{30 31}

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

In the last month, how often have you...

1. ...been upset because of something that happened unexpectedly?
2. ... felt that you were unable to control the important things in your life?
3. ... felt nervous and "stressed"?
4. ...felt confident about your ability to handle your personal problems?
5. ...felt that things were going your way?
6.found that you could not cope with all the things that you had to do?
7. ... been able to control irritations in your life
8.felt that you were on top of things?
9. ...been angered because of things that were outside of your control?
10. ...felt difficulties were piling up so high that you could not overcome them?

Dysmorphic Concern Questionnaire³²

Have you ever...

Not at all	Same as most people	More than most people	Much more than most people
0	1	2	3

1. Been concerned about some aspects of your physical appearance
2. Considered yourself malformed or misshaped in some way (nose/hair/skin/sexual organs/overall body build)
3. Considered your body to be malfunctioning in some way (excessive body odour, flatulence, sweating)
4. Consulted or felt you needed to consult for plastic surgeon/dermatologist/physician about these concerns
5. Been told by others/that you are normal in spite of you strongly believing that something is wrong with your appearance or bodily functioning
6. Spent much time worrying about a defect in your appearance/ bodily functioning
7. Spent much time covering up defects in your appearance/bodily functioning

Background information Questionnaire

(On all questions tick next to the right answer, you may skip questions you do not wish to answer)

Age: _____ years

Gender: Male Female

What is your country of birth? _____

What is your country of origin? _____

How long have you lived in (country) _____ years

What is your highest level of education? _____

What is your marital status?

Single

Married/ with a partner Do you live with your partner? Yes No

What is your employment status?

Employed

At school/ university

On sick leave

Retired

Unemployed

How is your household income?

Low

Middle

High

Did you experience serious economic difficulties in the last 5 years? Yes No

Have you had any stressful life events during the last 6 months (serious illness, death of close friend or family member, accident, divorce or other events)?

Yes No

Approximatively, what is your weight? _____
your height? _____

How old were you (approximatively) when the skin disease started? _____ years

Within the last year, how severe has your skin disease been?

Mild
Moderately
Severe

Right now, how severe is your skin disease?

Mild
Moderate
Severe

Did you ever have suicidal ideation? Yes No

If yes: how often does it happen?

Every day
Every week
Every month
Sometimes during the year

Did you ever have suicidal ideation because of your skin? Yes No

If yes: how often does it happen?

Every day
Every week
Every month
Sometimes during the year

How often did your skin disease flare during the last year?

Every day
Every week
Every month
Sometimes during the year

Right now, where do you have flare? (you can tick several boxes)

- Face/neck
- Scalp
- Hands/arms
- Torso
- Legs/feet
- Genital area
- Other places

Overall, how satisfied are you with your appearance?

- Very satisfied
- Quite satisfied
- Indifferent
- Quite unsatisfied
- Very unsatisfied

Do you itch now (within the last 24 hours)? Yes No

If yes, please answer the following questions:

How long has your itch lasted?

- Less than 6 weeks
- 6 weeks or more

How bad is your itch? (*Mark an X in a box*)

0	1	2	3	4	5	6	7	8	9	10
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No itch

worst imaginable itch

Please select what sensations you feel along with itch

- Itch only** Yes No
- Burning** Yes No
- Stinging** Yes No
- Pain** Yes No
- other** Yes No

This questionnaire concerns the last 7 days. Please select only one answer per question

How often have you experienced an itching, burning, stinging, tingling sensation or pain on your skin?	0 never	1 rarely	2 sometimes	3 often	4 always
To what extent has the itching negatively affected you in your everyday life (e.g. if you must wear specific clothing), in your leisure time and/or at work?	0 not at all	1 a little bit	2 somewhat	3 rather	4 very
To what extent does the itching make you feel impaired when dealing with other people (e. g. embarrassed, insecure)?	0 not at all	1 a little bit	2 somewhat	3 rather	4 very
To what extent does the itching have a negative impact on your sleep?	0 not at all	1 a little bit	2 somewhat	3 rather	4 very
To what extent has the itching influenced your enjoyment of life and your mood?	0 not at all	1 a little bit	2 somewhat	3 rather	4 very