Psychiatric Comorbidity in Dermatology Patients in a Tertiary Care Centre in Western U.P

Shilpa[1], Prakash Chandra[2], Akhil Dhanda[3], Anubhav Bhushan Dua[4]

[1]Post Graduate, [2]Prof. and Head, [3]Senior Resident, [4]Assistant Professor, Department of Psychiatry, Saraswathi Institute of Medical Sciences

Abstract

Skin is an organ that has a primary function in tactile receptivity and reacts directly upon emotional stimuli. Dermatological practice involves a psychosomatic dimension. A relationship between psychological factors and skin diseases has long been hypothesized. Psychodermatology addresses the interaction between mind and skin. It is divided into three categories according to the relationship between skin diseases and mental disorders. This article reviews different dermatological conditions under each of the three categories namely psychosomatic disorders, dermatological conditions due to primary and secondary psychiatric disorders. Dermatological conditions resulting from psychiatric conditions like stress/depression and those caused by psychiatric disorders are discussed. This review intends to present the relationship between the 'skin' and the 'mind' specifically from the dermatology point of view. The effects on the quality of life as a result of psychodermatological conditions are highlighted. A multidisciplinary approach for treatment from both dermatologic and psychiatric viewpoints are suggested.

Keywords: *Liaison therapy, mind, psychodermatology, quality of life, stress*

Introduction

Skin has a special place in psychiatry with its responsiveness to emotional stimuli and ability to express emotions such as anger, fear, shame and frustration, and by providing self-esteem, the skin plays an important role in the socialization process, which continues from childhood to adulthood.[1] The relationship between skin and the brain exists due to more than a fact, that the brain, as the center of psychological functions, and the skin, have the same ectodermal origin and are affected by the same hormones and neurotransmitters.[2] Psychodermatology describes an interaction between dermatology and psychiatry and psychology. The incidence of psychiatric disorders among dermatological patients is estimated at about 30 to 60%.[3] Psychiatry is more focused on the 'internal' non-visible disease, and dermatology is focused on the 'external' visible disease. Connecting the two disciplines is a complex interplay between neuroendocrine and immune systems that has been described as the NICS, or the neuro-immuno-cutaneous system. The interaction between nervous system, skin and immunity has been explained by release of mediators from NICS.[4] It has been reported that

Corresponding Author:
Dr. Shilpa
Post Graduate, Department of Psychiatry
Saraswathi Institute of Medical Sciences
Shilpa.bishnoi108@gmail.com
8867815598

psychologic stress perturbs epidermal permeability barrier homeostasis, and it may act as precipitant for some inflammatory disorders like atopic dermatitis and psoriasis.[5] Dermatologists have stressed the need for psychiatric consultation in general, and psychological factors may be of particular concern in chronic intractable dermatologic conditions, such as eczema, prurigo and psoriasis.[6,7] Patients with psychocutaneous disorders frequently resist psychiatric referral, and the liaison among primary care physicians, psychiatrists and dermatologists can prove very useful in the management of these conditions. Thus consideration of psychiatric and psychosocial factors is important both for the management of psychodermatologic disorders and for some aspects of secondary and tertiary prevention of a wide range of dermatologic disorders.[8] Regardless of psychiatric morbidity, skin diseases can greatly affect patients' quality of life.[9] The drugs used in the treatment of dermatological diseases such as steroid and retinoid may lead to psychiatric symptoms.[10] Not surprisingly, a relationship between psychological factors and skin diseases has long been hypothesized. There is a common opinion that many cases of skin disease are caused by psychological stress, or are related to certain personality traits, or represent a complication of a psychiatric disorder. Although the dermatologists awareness of the problem is increasing.[11] co-occurring mental disorders go often unrecognized and are believed to be less frequent than they actually are in many skin conditions. There is a need for a biopsychosocial approach to patients with skin disease.[12,13] Liaison therapy enables multidisciplinary approach with the cooperation of psychiatric and dermatologic terms and simultaneous diagnostic procedures and treatment of patients with psychodermatologic disorders.[14]

Classification

Although there is no single universally accepted classification system of psychocutaneous disorders and many of the conditions are overlapped into different categories, the most widely accepted system is that devised by Koo and Lee.

Psychodermatology is divided into three categories according to the relationship between skin diseases and mental disorders : 1) Psychophysiologic (psychosomatic) disorders caused by skin diseases triggering different emotional states (stress), but not directly combined with mental disorders (psoriasis, eczema); 2) primary psychiatric disorders responsible for self-induced skin disorders (trichotillomania) and 3) secondary psychiatric disorders caused by disfiguring skin (of ichthyosis, acne conglobata, vitiligo), which can lead to states of fear, depression or suicidal thoughts.

Psychophysiologic (Psychosomatic) disorders

Here psychiatric factors are instrumental in the etiology and course of skin conditions. The skin disease is not caused by stress but appears to be precipitated or exacerbated by stress.

Psoriasis

Psoriasis is a relatively common, chronic and inflammatory and hyperproliferative skin disease that occasionally requires systemic therapy. Stress has long been reported to trigger psoriasis.Psoriasis is associated with a variety of psychological difficulties, including poor self-esteem, sexual dysfunction, anxiety, depression and suicidal ideation. Psoriasis is associated with substantial impairment of health-related quality of life (HRQOL), negatively impacting psychological, vocational, social and physical functioning. The most common psychiatric symptoms attributed to psoriasis include disturbances in body image and impairment in social and occupational functioning.Quality of life may be severely affected by the chronicity and visibility of psoriasis as well as by the need for lifelong treatment. Five dimensions

of the stigma associated with psoriasis have been identified: (1) Anticipation of rejection, (2) feelings of being flawed, (3) sensitivity to the attitudes of society, (4) guilt and shame and (5) secretiveness. Depressive symptoms and suicidal ideation was frequently associated in psoriasis. In general, psychological factors, including perceived health, perceptions of stigmatization and depression are stronger determinants of disability in patients with psoriasis than are disease severity, location and duration. In a recent prospective study of patients with psoriasis, the frequency of psychiatric disturbance decreased with improvement in the clinical severity and symptoms of psoriasis. The emotional effects and functional impact of the disease are not necessarily proportionate to the clinical severity of psoriasis.

Atopic dermatitis

The onset or exacerbation of atopic dermatitis often follows stressful life events. Symptom severity has been attributed to interpersonal and family stress, and problems in psychosocial adjustment and low self-esteem have been frequently noted. Adults with atopic dermatitis are more anxious and depressed compared with clinical and healthy control groups. Children with atopic dermatitis have higher levels of emotional distress and more behavioral problems than healthy children or children with minor skin problems.

Psychosocial morbidity in atopic dermatitis

Psychological stress may be an acquired factor affecting the expression of atopic dermatitis.[35] Atopic individuals with emotional problems may develop a vicious cycle between anxiety/depression and dermatologic symptoms. In one direction, anxiety and depression are frequent consequences of the skin disorder. The misery of living with atopic dermatitis may have a profoundly negative effect on health-related quality of life (HRQOL) of children and their families. Teasing and bullying by children and embarrassment by adults and children can cause social isolation and school avoidance. The social stigma of a visible skin disease, frequent visits to doctors and the need to constantly apply messy topical remedies all add to the burden of disease. Lifestyle restrictions in more severe cases can be significant, including limitations on clothing, staying with friends, owning pets, swimming or playing sports. The impairment of quality of life caused by childhood atopic dermatitis has been shown to be greater than or equal to that of asthma or diabetes.

Conclusions

Psychodermatologic disorders are conditions involving interaction between the mind and the skin. They fall into three categories; psychosomatic, primary psychiatric disorders and secondary psychiatric disorders. Atopic dermatitis, eczema, urticaria, psoriasis, herpes simplex, alopecia areata, rosacea, etc are regarded among dermatological psychosomatic disorders with psychogenic manifestation/exacerbation. It is suggested to use a biopsychological model, which takes into account the psychological (e.g. psychiatry comorbidity such as major depression and the impact of skin disorder on the psychological aspects of quality of life) and social (e.g. impact upon social and occupational functioning) factors, in addition to the primary dermatologic factors, in the management of the disease. The treatment of psychodermatological disorders should be carried out through the liaison therapy, which enables multidisciplinary approach, including family physician, dermatologist, psychiatrist and psychologist. It is very important to educate dermatologists in the diagnostic procedures and therapy of psychiatric disorders, which sometimes coexist with the skin disease. Majority of psychodermatological disorders can be treated with cognitive-behavioral psychotherapy, psychotherapeutic stress-and-anxiety-management techniques and psychotropic

drugs. Psychopharmacologic treatment includes anxiolytics, antidepressants, anti-psychotics and mood stabilizer. The cooperation of the dermatologist and a psychiatrist in order to increase the life quality of the patients is of utmost importance. A dermatologist's lack of knowledge on the psychiatric morbidity rates in dermatological diseases may delay the diagnosis of psychiatric condition and hinder the treatment, and hence establishment of separate psychodermatology units and multicenter research about the relationship of skin and psyche is necessary in the form of prospective case-controlled studies, and multisite therapeutic trials can provide more insight into this interesting and exciting field of medicine. The management of psychodermatologic disorders requires evaluation of the skin manifestation and the social, familial and occupational issues underlying the problem. Once the disorder has been diagnosed, management requires a dual approach, addressing both dermatologic and psychologic aspects. A mutual, respectful collaboration between dermatologists and mental health professionals might be of help for many psychiatric patients. Therefore, understanding of biopsychosocial approaches and liaison approach involving general practice, psychiatrist, dermatologist and psychologist treatment in this field is essential.

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