ORIGINAL ARTICLE

Psychological comorbidities associated with skin diseases

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ABSTRACT

Background: Psychiatric disorders are common among patients with a skin disease.

Objective: To identify the prevalence of psychiatric disorders in dermatological patients.

Patients & Methods: Four hundred and sixty eight randomly-selected patients of 12-65 years from the out-patient clinics, dermatology department of Al-Hussain Hospital, Al-Azhar University, Egypt, were included in the study. The study was done in two stages. In the 1st stage, General Health Questionnairre 12 (GHQ-12) was conducted. In the 2nd stage, Psychological Symptoms Questionnaire (PSQ) was administered to those who were found to be positive for psychiatric morbidity in stage 1.

Results: According to GHQ-12 screening, 107 out of 468 patients (22.86%) were positive for psychiatric morbidity. The pattern of psychiatric ailments detected by PSQ was as follows: major depressive illness in 30.84% (33/107) patients, generalized anxiety disorder in 22.43% (24), mixed anxiety and depression state in 32.71% (35) and dysthymia in 14.02% (15) of the patients.

Conclusion: In conclusion, psychiatric co-morbidity is very common among dermatological patients as compared to the general population. If a dermatologist is well alert, the recognition and management of these co-morbid conditions will be minimized, and better quality of life can be further assured.

KEYWORDS: psychiatric disorders, dermatological, skin diseases, Al-Husain Hospital.

INTRODUCTION

The presentation of psychological and emotional problems is very common in general population, but this sickness may remain undetected. In a survey of medical wards in an English hospital, it was found that physicians or nurses had not recognized half the psychiatric morbidity.[1]

It has been observed by dermatologists, and it is now widely documented, that psychiatric disorders are frequent among patients with skin problems, more than in the general population.[2] Wessely and Lewis[2] in 1989 found that the prevalence of psychiatric morbidity among new attendees presenting with skin problems in the dermatology clinic was 40%.

Purpose of this study is to detect the intensity of the psychiatric disorders which may be present in patients attending dermatological out-patient department in Al-Husain Hospital, Cairo, Egypt.

PATIENTS AND METHODS

This study was conducted at the outpatient dermatology clinics, Al-Husain Hospital, Cairo. Four hundred and sixty eight, randomly selected, patients of both genders, between 12-65 years of age, were included in the study. All the personal

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and clinical details, including the degree of education, marital status, general illness and dermatological diagnosis (Table 1), were recorded.

Table 1 List of skin disorders

Disease	Patients
contact dermatitis	7
Lichen simplex chronicus	22
Seborrheic dermatitis	45
Atopic dermatitis	36
Others eczemas	10
Psoriasis	49
Lichen planus	13
Alopecia areata	29
Vitiligo	33
Acne	89
Melasma	14
Urticaria	13
Bacterial infections	11
Fungal infections	17
Viral infections	9
Pemphigus vulgaris	18
Discoid lupus erythematosus	7
Systemic lupus erythematosus	4
Dermatitis artefacta	1
Trichotillomania	3
Other dermatoses	38

This was a two-stage study. In the 1st stage General Health Questionnaire 12 (GHQ-12) was completed. The GHQ-12 is a self-administered instrument designed to detect minor, non-psychotic psychiatric disorders.[3,4] It consists of self-rated questionnaire of 12 items. Each question has four possible responses; less than usual, no more than usual, rather more than usual or much more than usual, with answers given on a four-point scale. GHQ-12 scores were computed by collapsing adjacent responses to obtain a dichotomous scoring (0-0-1-1), ranging from 0 to 12. It has recently been shown that the cut-off threshold ≥ 4 for psychiatric case identification maximizes sensitivity and specificity of GHQ-12 in a dermatological setting.[5] Thus, for the purpose of this study, patients scoring 4 or more have been enrolled in the 2nd stage. In the 2nd stage, Psychological Symptoms Questionnaire (PSQ): questionnaire for the recording of intensity and change in general psychosomatic symptoms, as well as in emotional state (discontent, negative mood, activity, temperament, compulsiveness), was administrated to every patient found to be high scorer in General Health Questionnaire.

RESULTS

Out of 468 patients, 252 were male and 216 were female (1.7:1). According to General Health Questionnaire screening, 22.86% (107) of the patients were positive for psychiatric evaluation. Out of 216 females, 20.83% (45) were positive for psychiatric illness and out of 252 males, 24.60% (62) were found to be suffering from psychiatric illness (Table 2).

While evaluating these patients on Psychiatric evaluation list, 33/107 patients (30.84%) were suffering from major depressive episode (depressive illness), 15 patients (14.02%) had chronic long-lasting form of low grade depression sharing many characteristic symptoms of major depressive disorder (dysthymia), 24 patients (22.43%) had generalized anxiety disorder and 35 patients (32.71%) were suffering from mixed anxiety and depression state.

Out of 216 females, 7.41% (16) were suffering from major depressive episode, 3.24% (7) were recognized as patients of dysthymia, 4.17% (9)

Table 2 Results of GHQ-12

Patients	Total number	High scorers	%
Female	216	45	20.83%
Male	252	62	24.60%
Total	468	107	22.86%

had generalized anxiety disorder and 6.02% (13) were suffering from mixed anxiety and depression state.

Out of 252 males, 6.75% (17) were suffering from major depressive episode, 3.17% (8) had dysthymia, 5.95% (15) had generalized anxiety disorder and 8.73% (22) suffered from mixed anxiety and depression state (Table 3).

Table 3 Pattern of psychiatric disorders

Disorders	Female (n=216)	Male (n=252)	Total (n=468)
Major depressive episode	16 (7.41%)	17 (6.75%)	33 (7.05%)
Dysthymia	7 (3.24%)	8 (3.17%)	15 (3.21%)
Generalized anxiety disorder	9 (4.17%)	15 (5.95%)	24 (5.13%)
Mixed anxiety and depression state	13 (6.02%)	22 (8.73%)	35 (7.48%)

DISCUSSION

Psychiatric morbidity is one of the major public health problems. In Northern Ireland, major depressive episode was seen in 2.4 % in males and 6.0% in females and rates of generalized anxiety disorder were 3.5% in males and 3.7% in females, respectively.[6] In France, high rates of psychotropic drug consumption drew attention of concerned authorities and 46% of the studied population was found to have mental disorders.[7] The knowledge of mind-body interactions and interventions can help to improve patients' skin conditions and ultimately their quality of life.[8] The field of psychodermatology has developed as a result of increased interest and understanding of the relationship between skin disease and various psychological factors.[9]

Skin diseases should be measured not only by symptoms, but also by physical, psychological, and social parameters. "Patients' needs arise from the disease itself, from the effects of the disease on the patient's life and from the process of care."[10]

Psychiatric disorders are not uncommon among people with established skin disease. In a study, psychiatric illness was 40% amongst new attendees at a dermatology clinic.[2] Physical or apparent disfigurement of integument can itself become a source of emotional distress which may predispose to psychiatric illness resulting in maladjustment in psychological and social well being of a person. This fact may be overlooked or underestimated by medical community including dermatologists.

In the present study, 39.1% patients attending dermatological clinic exhibited considerable psychiatric pathology. This figure is comparable with other studies.[2] Female patients are as affected as males i.e. 40.8% vs. 37.5%. Major depressive episode, generalized anxiety disorder, mixed anxiety and depression state and dysthymia are main diagnostic categories found in dermatological patients, i.e. 17.3%, 7.6%, 11.2% and 1.7% respectively. This figure is also comparable with that of Pakistan study.[8] Results of our study and the previous studies[2,11] point to the extent and magnitude of psychiatric problems in dermatological patients.

Psychiatric disorder, if undetected, may become a source of poor compliance with dermatological treatment or it may become a source of excessive or inappropriate use of dermatological services.

Patients with body dysmorphic disorder, acne, psoriasis, and particularly men and women with facial conditions are more likely to have reactive depression and be at risk of suicide.[12,13] Suicide risk

can influence decisions regarding management of these disorders. A study comparing the prevalence of depressive symptoms among patients with mild to moderate noncystic facial acne vulgaris, moderate to severe psoriasis, atopic dermatitis, and alopecia areata found a 5.6% prevalence of suicidal thoughts among acne patients compared with a 5.5% prevalence of suicidal thoughts among more severely affected psoriasis patients.[14]

Psychotropic drugs are sometimes an important component of dermatologist's therapeutic armamentarium.[15] When taking into account the use of psychotropic drugs in dermatology, accurate diagnosis and existence of appropriate indication for use of a drug is very important. This can only be achieved if we know the degree of the problem-relating psychiatric co-morbidity.

CONCLUSION

This study shows that psychiatric co-morbidity is very common in dermatological clinics as compared to general population and clinics of primary care physicians. Major depressive episode, generalized anxiety disorder, mixed anxiety and depression state and dysthymia are main psychiatric entities. Consideration of psychiatric and psychosocial factors is important both for the management, and for some aspects of prevention of a wide range of dermatologic disorders. Some dermatology patients are likely to benefit from psychotherapeutic interventions and psychotropic agents for the management of the psychosocial co-morbidity, in addition to the standard dermatologic therapies for their skin disorder.

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