Journal of Population Therapeutics & Clinical Pharmacology

RESEARCH ARTICLE
DOI: 10.53555/h8rpya19

A CROSS-SECTIONAL STUDY ON EVALUATION OF PSYCHIATRIC MORBIDITY IN DERMATOLOGY PATIENTS IN A TERTIARY CARE CENTER AT TELANGANA

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ABSTRACT

Introduction: Due to its receptivity to emotional cues and capacity to communicate emotions like wrath, fear, embarrassment, and frustration, skin has a specific place in psychiatry. Disfiguring skin conditions may turn out to be psychological catastrophes because they not only harm the patient's self-esteem but also induce stigmatization. The aim of present study is to assess the psychiatric morbidity in dermatology patients.

Material & methods: The present observational study was conducted among 70 patients of dermatology diagnosed with psychiatric morbidity fulfilling the inclusion & exclusion criteria who visited to dermatologist during the study duration of one year. The recorded data was analyzed using SPPS version 25.0

Results: Out of 70 patients 35.7% were females and 64.3% were males. The mean age of males were 34.9±12.3 years and of females were 36.8±11.2 years. Among psychiatric diagnosis the most common problem was depression (30%) followed by adjustment disorder (15.7%). Dermatological diagnosis of patients with psychiatric morbidity showed that most common diagnosis was chronic utricaria (21.4%) followed by psoriasis (14.2%), alopecia (12.8%). Psychopathologies of the patients with urticaria, psoriasis, alopecia shows that maximum patients suffered from depression.

Conclusion: Dermatological illnesses have an impact on how they progress due to psychiatric morbidity. When necessary, dermatological clinics should seek out psychiatric evaluation, and patients should be monitored with the help of dermatologists and psychiatrists.

Keywords: Dermatology, Psychiatric Morbidity, Skin

INTRODUCTION

The body's main organ, the skin, greatly influences how it appears. A person's physical, mental, and sense of self- confidence depend on having healthy, normal skin.[1] Due to its receptivity to emotional cues and capacity to communicate emotions like wrath, fear, embarrassment, and frustration, skin has a specific place in psychiatry.[2] Numerous dermatological disorders, such as atopic dermatitis, psoriasis, alopecia areata, urticaria, angioedema, and acne vulgaris, are influenced by psychological factors. Body dysmorphic disorder (BDD) and somatic delusional disorder, such as delusions of parasitosis or a bad body odor, are two basic psychiatric diseases that commonly present to dermatologists with physical symptoms. Dermatologists also treat individuals who exhibit compulsive behaviors that could be a result of trichotillomania, obsessive-compulsive

disorder (OCD), or psychogenic excoriation. The variety of dermatologic adverse effects to psychiatric medications is a significant component of the interaction between psychiatry and dermatology. [3,4] The brain serves as the center of psychological functions, and since both the skin and the brain share an ectodermal origin and are influenced by the same hormones and neurotransmitters, there is a connection between them.

The neuro-immuno-cutaneous system, often known as the NICS, is a complex interplay between the immunological and neuroendocrine systems that unites the two fields of study.[5] The release of mediators from the neuro-immuno cutaneous system has been used to explain the relationship between the neurological system, skin, and immunity.[6] Patients who seek dermatological care frequently have psychopathological issues.[7,8] The following can be used to establish a link between psychiatric illness and dermatological conditions: Skin lesions' emergence and the disease's chronic course may commonly impede patients' ability to lead fulfilling social and professional lives; as a result, psychiatric morbidity may develop as an adverse effect, less frequently, these skin diseases may be caused by fundamental psychological conditions such as obsessive compulsive and delusional disorders, and systemic lupus erythematosus may be the cause of both skin symptoms and the psychiatric complaints. Lithium and some antipsychotic medications can cause dermatological illnesses, whereas some medications used to treat dermatological conditions, such as corticosteroids, can produce psychiatric symptoms. [9-11] The prevalence of psychological morbidity in dermatological illnesses is considerable, according to prior studies. A prevalence of 20.6% was found in a research by Picardi et al on 1389 patients of dermatology outpatient clinics.[7] In a study conducted by Hughes et al and later published in the Indian Journal of Psychiatry, it was shown that outside patients who visited dermatology clinics had a high prevalence rate of 30% psychological illness.[12] A study done by Kessler et al similarly reveals a 30% prevalence.[13] Hence the aim of present study is to assess the psychiatric morbidity in dermatology patients.

MATERIAL & METHODS

Thepresentobservationalstudywasconductedamong70patientsofdermatologydiagnosedwithpsychiatric morbidity who visited to dermatologist during the study duration of one year.The ethical permission was taken from the institution before the commencement of study. Patients were asked to sign the consent form before participation. The patients were enrolled in the study on the basis of following inclusion and exclusion criteria:

Inclusion criteria-

a) Patientsofagegroup18-65yrs.
b) Both male and female population.
c) Diagnosedcaseofdermatologicaldisorderasdiagnosedbytheconsultantdermatologist.

Exclusion criteria-

a) Psychiatric illness prior to onset of dermatological disorder.
b) Patients suffering from chronic medical debilitating illnesses.
c) Mental sub-normality.
d) Adults receiving orthose who received steroids in last 6 months.

Patients age, gender, marital status, habits, dermatological & systemic diseases, previous drug use, the treatment modality applied after diagnosis, psychiatric diagnosis and recommended psychiatric therapy were recorded. The duration of dermatological diseases was also determined. The patients who had personal and/or family history of psychiatric disorders and/or previous suicide attempt were also recorded.

The recorded data was analyzed using SPPS version 25.0. The results were expressed in the form of frequency, percentage and mean (standard deviation). The chi square test will be used to express the categorical data. The level of significance was kept at $p<0.05$.

RESULTS

Out of 70 patients 35.7% were females and 64.3% were males. The mean age of males were 34.9±12.3 years and of females were 36.8±11.2 years. Total 65.7% patients were married, 30% were unmarried and 4.2% were divorce/widow. Mostly 57.1% of patients were housewife and 12.8% were students. 67.1% patients had dermatological disease from less than one year and 32.8% had disease from more than one year. Only 8.5% patients had deleterious habit of alcohol consuming and 17.1% were smoker as show in table 1.

Table: 1 shows demographic data of patients

Variable		N (percentage)
Gender	Male	25 (35.7)
	Female	45 (64.3)
Age	Meanage male	34.9±12.3
	Meanage female	36.8±11.2
Marital status	Married	46 (65.7)
	Unmarried	21 (30)
	Divorce/widow	3 (4.2)
Occupation	Housewife	40 (57.1)
	Student	9 (12.8)
	Unemployed	7 (10)
	Retired	4 (5.7)
	Officials	5 (7.1)
	Worker	3 (4.2)
	Others	2 (2.8)
Duration of disease	Less than one year	47 (67.1)
	More than one year	23 (32.8)
Alcohol consumer		6 (8.5)
Smoker		12 (17.1)

Among psychiatric diagnosis the most common problem was depression (30%) followed by adjustment disorder (15.7%), anxiety (11.4%), psychosomatic disorders (10%), obsessive compulsive disorder (7.1%), conversion (4.2%), dysthymic disorder (4.2%) and attention deficit & hyperactivity (2.8%) as shown in table 2.

Table: 2 shows psychiatric diagnosis for patients

Psychiatric morbidity	N (percentage)
Depression	21 (30)
Adjustment disorder	11 (15.7)
Anxiety	8 (11.4)
Psychosomatic disorders	7(10)
Obsessive compulsive disorder	5 (7.1)
Conversion	3 (4.2)
Dysthymic disorder	3 (4.2)
Attention deficit& hyper activity	2 (2.8)
Others	10 (14.2)

Dermatological diagnosis of patients with psychiatric morbidity showed that most common diagnosis was chronic utricaria (21.4%) followed by psoriasis (14.2%), alopecia (12.8%), acute utricaria(10%), neurodermatitis(10%), behcets disease (8.5%), atopic dermatitis(7.1%), drug eruptions (7.1%), pemphigus (5.7%), generalized pruritis(1.4%) and angiooedema (1.4%) as shown in table 3.

Table: 3 shows Dermatological diagnosis of patients with psychiatric morbidity

Dermatological diagnosis	N (percentage)
Chronic utricaria	15 (21.4)
Psoriasis	10 (14.2)
Alopecia	9 (12.8)
Acute utricaria	7 (10)
Neuro dermatitis	7 (10)
Behcets disease	6 (8.5)
Atopic dermatitis	5 (7.1)
Drug eruptions	5 (7.1)
Pemphigus	4 (5.7)
Generalized pruritis	1 (1.4)
Angiooe dema	1 (1.4)

Psychopathologies of the patients with urticaria, psoriasis, alopecia shows that maximum patients suffered from depression and least suffered from OCD, conversion and hyperactivity as shown in table 4.

Table: 4 shows psycho pathologies of the patients with urticaria, psoriasis, alopecia

Psychopathologies	Utricaria N (%)	Psoriasis N (%)	Alopecia N (%)
Depression	10 (45.4)	5 (50)	4 (44.4)
Adjustment disorder	4 (18.1)	1 (10)	2 (22.2)
Anxiety	3 (13.6)	1 (10)	1 (11.1)
Psychosomatic disorders	2 (9)	2 (20)	1 (11.1)
Obsessive compulsive disorder	1 (4.5)	-	-
Conversion	1 (4.5)	-	-
Dysthymic disorder	-	1 (10)	1 (11.1)
Attention deficit &hyper activity	1 (4.5)	-	-
Others	-	-	-

DISCUSSION

Dermatological abnormalities and psychiatric problems have long been linked.[8,14] Dermatological conditions can impair daily life, self-esteem, and respect. In fact, they could raise issues with self-image, leading to an identity crisis. Dermatology patients may suffer from disorders including anxiety, depression, and other psychological issues as a result of their patients' considerably greater concern and worry about diseases that are related to their physical appearance[15].The present study was conducted for a period of one year among 70 patients dermatology diagnosed with psychiatric morbidity. The present study aim to assess the the psychiatric morbidity, consultation rate and results in patients. The mean age of the patients in Woodruff et al's study[16] were 44.88 years for all patients and 46.8 years for female patients.

The average age of the participants in our study was 36.8 years for females and 34.9 years for males. Female patients and widows are more likely to have psychiatric morbidity, especially if they have widespread lesions from alopecia, eczema, psoriasis, pruritis, urticaria, or acne. Higher rates of

psychiatric illness have been discovered in females, widows, and widowers. However, there were no changes according to the patients' age or level of education.[9] In our study, there were considerably more female patients, and married patients were more likely to have psychiatric illness. House wives, students, the retired, the unemployed, and teachers all had greater rates of psychiatric illness.

In the current study, individuals who had dermatological issues for more than a year had a morbidity rate of 32.8%, compared to 67.1% for patients who had issues for less than a year. Patients' eventual psychological acclimatization to the condition may be the cause of the decreased rate of psychiatric morbidity in long-term disease patients. The most frequent finding in Puli mood et al.'s study was depression (34%).[17] The diseases that contributed most to psychiatric disorders were chronic urticaria, exfoliative dermatitis, and STDs. Depression and adjustment disorder were the two most common psychological issues found in Aslan et al.'s study [18] of people with physical diseases. Mild to moderate depression, mild anxiety, and severe depression have all been documented by Wood rufft et al[16]. Individuals with a history of psychiatric illnesses (40%), individuals with a familial history (29%) and patients with an extra systemic condition (29%) have all been recorded in their patient group.

Our findings were similar to these studies: depression (30%) followed by adjustment disorder (15.7%), anxiety (11.4%), psychosomatic disorders (10%), obsessive compulsive disorder (7.1%), conversion (4.2%), dysthymic disorder (4.2%) and attention deficit & hyperactivity (2.8%). Depression and suicide attempts are more common in both sexes when dismorphic disorders like psoriasis and acne cause sores, especially on the face. In the Turkish study by Akay et al [19], patients with psoriasis had a depression rate of 58%, those with lichen planus had a rate of 53%, and those in the control group had a rate of 20%. Comparing the rate in the psoriasis group to the control group, it was clearly greater. As a result, the PASI and depression scores were comparable. The three most common dermatological conditions that were also associated by psychopathologies were chronic urticaria, psoriasis, and alopecia areata. Dermatological conditions like psoriasis that are chronic and disabling might result in depression-related suicide. These results were similar to findings of our study.

Steroid and retinoid medications, which are used to treat dermatological conditions, might cause mental problems.[11]. Therefore, it is important to keep a close eye on individuals who need steroid treatment for psychopathologies. As a result, there must be a solid patient-doctor interaction and education for patients with dermatological illnesses and their families. Patients should be given individual or group therapy, and websites and associations should be created for them.[17]We believe that structured communication amongst patient groups in our nation should be offered. It is advised to inform the parents of young patients and offer psychiatric consultations. This advice is equally applicable to the partners of patients who are married. The only limitation to this study was small sample size and lack of control group.

CONCLUSION

Dermatologists' detection of psychiatric illnesses is insufficient by itself. In order to improve the patients' quality of life, collaboration between a dermatologist and a psychiatrist is crucial. The diagnosis of a psychiatric problem may be delayed and treatment may be hampered by a dermatologist's ignorance of the prevalence of psychiatric morbidity in dermatological conditions. Dermatologists need to be more aware of and attentive to their patients' potential psychiatric illness. We believe that after dermatologist shaved efinitively recognized a patient's issues, they can be adequately informed, sent to psychiatrists, and monitored with the help of both dermatologists and psychiatrists.

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