Hong Kong J. Dermatol. Venereol. (2009) **17**, 67-68

Editorial

Dermatology and psychiatry

Dermatological diseases can affect patient's psychosocial well-being.[1] Misunderstanding of noninfectious skin conditions may make patients suffering from dermatological diseases feel embarrassed and rejected. The psychological impact can lead to loss of confidence and social withdrawal. Mental health and skin conditions are closely related and skin problems may be precipitated or exacerbated by psychological stress or vice versa.

Koo and Lebwohl classified the relationship between dermatological diseases and psychiatric disorders into three categories: (1) dermatological diseases (psoriasis, eczema) that are not directly connected to the mind but react to emotional states, such as stress and negative emotions; (2) primary psychiatric disorders (trichotillomania, delusion of parasitosis) responsible for self-induced skin problems; and (3) secondary psychiatric disorders (depression, social phobia) caused by disfiguring dermatological diseases.[2]

Psychiatric disorders, especially depression and anxiety disorders, are common among people with dermatological diseases.[3-6] Depression is characterized as two weeks or more of depressed mood or loss of interest or pleasure in activities that the patient previously found pleasurable or interesting.[7] There may be other associated symptoms including psychomotor agitation or retardation, change in sleep pattern, change in appetite, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, indecisiveness, decreased concentrating ability, and recurrent thoughts of death with or without suicidal ideation. The person cannot maintain previous social or occupational functioning. Social phobia is also common in people with disfiguring dermatologic diseases,[5] such as psoriasis and acne,[3,8] especially among those who have been teased about their skin condition.

Suicidal ideation has been reported in a wide range of dermatological diseases, including psoriasis and acne.[4,9] Fifty percent of patients who attempt suicide have a physical illness, especially chronic disease and chronic pain. Severe pruritus and disfiguring skin conditions have also been associated with a higher frequency of suicidal thoughts.[4,9,10] In some patient groups, such as the adolescence, even clinically mild skin disease has been associated with suicide.[6]

During clinical assessment, enquiry about the impact of skin problem on emotional, social and occupational functioning can be useful to assess the associated psychosocial burden. The itchiness, pain and disfiguring appearance may hinder a person from doing different activities ranging from sleep to work. The role of psychosocial stressors in the onset or exacerbation of the skin condition is important.[6] There may be worries that if a dermatologist enquires about psychosocial factors, the patient may think that "the problem is not real" or "they are crazy".[6] It would be helpful if patients know the association between skin problem and psychological stress, for example stress can lead

to heart attack or peptic ulcer. Recognition of mental illness in dermatology is crucial for psychiatric treatment.

Screening questionnaires including General Health Questionnaire, Beck Depression Inventory, Hospital Anxiety and Depression Scale are commonly used to screen psychiatric co-morbidity.[11,12] Although the questionnaires cannot replace clinical assessment in diagnosing psychiatric disorders, they may be useful in case finding especially when the mean consultation duration is short as in the local situation.

In Hong Kong, Chan et al reported the prevalence of psychiatric disorders in their study of people with psoriasis.[13] As depression is so common, its associated factors are indicators which may be useful in our clinical practice. Interestingly, the impact of depression on health-related quality of life (HRQoL) found in their study may partially explain the weak correlation between impairment in HRQoL and clinical severity of psoriasis reported by Tse and Ho.[14] Those patients who have great impairment in HRQoL, severe psoriasis and history of depression should be enquired about their psychosocial well-being.

Knowledge of mind-body interactions and interventions may help to improve patients' skin conditions and quality of life. Psychological treatment and psychotropic medications can benefit patients with depression or anxiety related to their skin problems. Reviews have indicated that selective serotonin reuptake inhibitors antidepressants are beneficial in the management of depression or anxiety disorders that are encountered in dermatological diseases and they also have a good side-effect profile.[15] Other pharmacological properties of antidepressants such as histamine H1 blocking effect of tricyclic antidepressants like amitriptyline and trimipramine, can help in skin conditions such as urticaria and pruritus. Referral to psychiatric assessment can be beneficial especially in patients who have persistent psychological distress or suicidal idea.

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