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Editorial

Psychodermatology: the missing piece of the puzzle

Skin diseases have important effects on the emotional well-being and quality of life (QoL) of the affected individuals. Chronic inflammatory skin diseases, such as psoriasis, not only lead to physical discomfort but the altered appearance also results in psychosocial difficulties and increased risk of anxiety and depression. Psychiatric comorbidity is estimated to occur in up to one-third of dermatological patients. Significant psychological stress can lead to impaired social functioning, anxiety and depression. For instance, health-related Qol (HRQL) of patients with psoriasis measured by SF-36 in a study was significantly affected with impairment in physical and mental functioning comparable to patients with that seen in cancer, arthritis, heart disease, diabetes, and depression.[1]

It is well known in many skin diseases, such as atopic dermatitis and psoriasis, there are emotional factors influencing the disease course. Psychological stress is considered a significant trigger for T-helper 1 cell-medicated inflammation in psoriasis and hence exacerbation of psoriasis. Up to 80% of psoriasis patients report that psychological distress results in flares of their disease.[2] Moreover, feeling stigmatised and despair can lead to reduced treatment compliance and hence worsening of psoriasis. On the other hand, the disease process itself may provoke skin changes that can affect the cosmetic and functional level to such an extent that it becomes a source of stress. The negative psychosocial impact can in turn exacerbate the skin conditions, leading to a vicious cycle for the patients.

A tragic case of homicide and suicide of a sufferer of chronic eczema early this year has aroused public attention of the significant psychological impact of skin diseases. The cosmetic concern, low self-esteem, social rejection, embarrassment, impairment of working ability and disturbing symptoms, such as pruritus and pain, of skin diseases can have a profound impact on the mental state of the patients and their families.

In this issue of the Journal, the Altınöz et al studied the distress tolerance and the anxiety state of patients with psoriasis, supporting the relationship between mental states and skin diseases. The psychological stress can lead to anxiety as well as depression and higher prevalence of suicidal ideation has been reported in psoriatic patients than in general population.[3] The relationship is supported by a local study of QoL and the risk of depression and anxiety in 80 psoriasis patients followed up in a public skin clinic in 2010 of which 34% reported Dermatology Life Quality Index (DLQI) of over 10, indicating a very large effect on their QoL. Thirty-six percent indicated at least an anxiety state and 11% indicated a depression disorder according to the validated Hospital Anxiety and Depression Scale.

With the time constraint during consultation, clinicians tend to underplay the psychological reaction to the skin diseases of the patients. It would affect the treatment compliance and hence the outcome. Patients with psoriasis may benefit from a holistic approach that addresses both the skin disease and the psychological

status. Screening of stress and timely referral for treatment of stress and psychiatric morbidities can result in improved QoL in patients with skin diseases. It is only after properly recognising the emotional impact of the disease on the patients that we can improve the treatment compliance and optimise the disease outcome in both the physical condition as well as psychological well-being of our dermatological patients.

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