Identification and Management of Psychiatric Co-Morbidities in Dermatological Disorders

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Abstract

Background: Comprehensive management of most of the dermatological disorders should include inputs for better mental health. Clinical practice of Psychodermatology, established at a tertiary hospital helps in effectively managing depression and anxiety associated with these conditions. We describe our experience and resultant insights of our Psychodermatology practice. Methods: Common educational program for both the departments set stage for initiation of this activity. Objective clinical findings of 70 patients were recorded by both on as per a common protocol by Psychiatrist and Dermatologist. Summary of Dermatological and Psychiatric findings of cases seen over a period of 6 months, as well as the professional insights are elucidated in this paper. Results and Conclusion: Patients with varied dermatological conditions were referred including various psychocutaneous disorders, fungal infections, melasma, vitiligo etc. Patients suffering from psoriasis had maximal psychiatric morbidity and Depressive disorders were the commonest psychiatric diagnosis among these referred patients (42.8%). Acceptance of psychiatric intervention by patients was very good to excellent due to liaison between dermatologist and psychiatrist for joint understanding as well as management of these cases. Senior clinicians referred more of these patients than the junior consultants.

Keywords: Psychodermatology, Psychocutaneous Disorders, Liaison Psychiatry

Introduction

Many of the dermatological disorders bring double suffering to mankind. The suffering is firstly distress due to the skin lesions and secondly due to psychological disturbances due to unacceptable changes in the appearance. Psychiatric illnesses commonly co-occur in various Dermatological disorders. About 30% of Dermatology outpatients suffer psychiatric problems, which is higher than in general population. Psychocutaneous disorders are those in which skin lesions are triggered or
exacerbated by psychological ill health or syndromal psychiatric disorders\textsuperscript{4, 5}.

High prevalence of depression, anxiety and suicidal ideation in conditions like psoriasis, vitiligo, acne etc has been researched and need for psychiatric intervention has been reported\textsuperscript{4, 6, 7, 8}. Managing these disorders is seldom simple unless Dermatologist is well versed with psychiatric aspects of these disorders and vice versa. Past literature on managing psychocutaneous disorders reports effectiveness of psychotropic medication in managing associated pruritis\textsuperscript{9}. Basavraj et al 2010 have emphasized the importance of application of bio-psycho-social model in management of these patients\textsuperscript{7}.

In Indian setting, where stigma exists for either of these disorders systematic effort to encourage help seeking by patients is necessary. Research about management of psychocutaneous disorders stresses on liaison between dermatologist and psychiatrist\textsuperscript{5, 7, 8}. In absence of overt anxiety or depressive features and classical dermatological signs and symptoms, a significant proportion of these patients’ symptoms appear to belong to no-man’s land, which clinicians are not formally trained in managing.

Psychodermatology clinics though ideal in managing these cases are rarity in present times in India. Integrated management of such disorders needs practical application of knowledge about treatment of these disorders. There are practical, financial and professional difficulties which often limit implementation of this knowledge, especially in private practice setting. The authors have been working jointly with such patients for their effective management over past few years. Some important observations when managing these patients that emerged from this practice are summarized here.

**Methods**

Joint interdepartmental academic activity was planned initially for staff of Psychiatry and Dermatology departments to sensitize the staff in referring these patients for psychiatric intervention. Interpersonal communication between psychiatrists and dermatologists was emphatically increased for discussing each patient referred for joint intervention by dermatologist and psychiatrist. Information of each patient was documented in a combined pre-determined format that included socio-demographic information and clinical assessment by Dermatologist and Psychiatrist.

After routine dermatological assessment, dermatologist referred the patient for psychiatric intervention. Both clinicians discussed the case before and after psychiatric assessment and advice.

**Results**

Over a period of six months, we assessed a total of 70 patients with various dermatological problems who were jointly seen by dermatologist and psychiatrist. Group consisted of 35 males and 35 females of various age groups from adolescence to old age.

Most of the patients came from urban background 48 (68.5%), 12 (17.1%) from semi-urban areas and 10 (14.3%) from rural areas. Duration of illness varied from few days to several years with median duration being 3 (SD +/- 31.7) months.

Referrals to psychodermatology clinic were mainly initiated by senior staff of the department (assistant professors and Professor) who had more than 5 years experience in the subject. Out of 70 patients,
58 (82.9%) were referred by senior dermatologists.

Psychiatrists with more than 5 years experience in the subject assessed these patients clinically. Most of the referred patients (67 out of 70) were eventually clinically diagnosed to have some psychiatric illness and 64 (91.5%) were prescribed psychiatric drug treatment. Two of them preferred to wait for the distress to resolve spontaneously as it was stress related. Various psychiatric illnesses diagnosed in this population are summarized ahead (Table 1).

Major depressive disorder /Dysthymic disorder – 30 (42.8 %) was the commonest co-morbidity in these patients. Low mood and lack of interest in activities were readily reported when asked about these to the patients. Nineteen (27.1%) patients had Anxiety disorders (including Generalised anxiety disorder, Panic disorder, OCD, Social anxiety disorder). These were very common in patients suffering from pruritis as well as neurotic excoriation. Anxiety disorders were also common in urticaria and eczema as reported by others. Diagnosis of Adjustment disorder (15.7%) was seen across multiple dermatological conditions. Other Dermatological disorders included one case each of Lichen planus, Pellagra, Alopecia totalis, Gardner Diamond Syndrome, Plantar wart and Erectile dysfunction.

The other psychiatric diagnoses were Somatoform group of disorders (Pain disorder, hypochondriasis, Somatoform disorder NOS) – 3 (4.3%), Alcohol dependence syndrome – 1 (1.4 %), Paranoid schizophrenia - 1(1.4%), Delusional disorder (Delusional parasitosis) - 2 (2.8%) and Bipolar disorder – 1 (1.4%). Three patients (4.2%) had no psychiatric diagnosis.

More than one fifth of these dermatology patients (16 patients) had psoriasis. All of these had significant psychiatric morbidity. Ten of these patients (71.4%) were suffering from Major Depressive disorder.

Table 1. Psychiatric morbidity across various dermatological diagnoses

<table>
<thead>
<tr>
<th>Psychiatric Diagnosis</th>
<th>Mood Disorders</th>
<th>Anxiety Disorders</th>
<th>Adjustment Disorders</th>
<th>Schizophrenia and Psychotic Disorders</th>
<th>Somatoform disorders</th>
<th>ADS</th>
<th>None</th>
<th>Total (% of total patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic pruritus/Neurotic excoriation/urticaria</td>
<td>7 (includes 1 case – bipolar disorder)</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18 (25.7)</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16 (22.8)</td>
</tr>
<tr>
<td>Fungal infections</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8 (11.4)</td>
</tr>
<tr>
<td>Acne</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9 (12.8)</td>
</tr>
<tr>
<td>Vitiligo</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Mucositis/Folliculitis</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Melasma</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3 (4.3)</td>
</tr>
<tr>
<td>Herpes</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2 (2.8)</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>6 (8.6)</td>
</tr>
</tbody>
</table>
Concern about negative evaluation in the society and social distress was reported by 9 (12.8%) of these patients. Among these, 3 patients each of psoriasis, vitiligo and acne vulgaris were represented. However many of them (51 i.e. 72.8%) were undergoing one or more of other stresses in their personal lives and it was unrelated to the skin lesions. These mainly included interpersonal problems within family, financial constraints and other familial problems like serious medical illnesses or loss of close relative.

There was minimal stigma experienced during initial as well as subsequent consultation with psychiatrist, especially when they could see similar patients benefitting from treatment.

**Discussion and Conclusion**

Many patients get referred for psychiatric consultation from various departments in a tertiary hospital. However many more need this help, especially those with dual diagnosis and complex clinical presentations. Studies in psychodermatology unanimously report that about 30% dermatology outpatients have psychiatric ailments. However in routine practice, not even 10% are referred to psychiatrist or prescribed any psychotropic medication. Stigmas, ignorance, invisible nature of psychological sufferings are some of the responsible factors. Only a few Dermatologists have expert knowledge and understanding of psychodermatology or willingness to attend educational programs in psychodermatology. Liaison clinics are useful in identifying and effectively managing these problems.

Dermatological illness, especially affecting exposed areas often causes distress due to social stigma. Psoriasis is often associated with stigma and rejection from others due to its external appearance and chronicity. Significant psychiatric morbidities have been reported in Psoriasis patients in literature.

Similar study reported from Manipal (India) by Shenoi S.D. et al in 2013 has many findings comparable to our report. Maximum patients were from second and third decade of life as in this study. Commonest dermatological diagnosis was Psoriasis seen in 23% cases in their study, we too had 20% patients with psoriasis. Most common psychiatric diagnosis was Dysthymia seen in 46% patients, in our sample 42.8% suffered from depressive disorders. Generalized pruritus, prurigo and chronic dermatitis were also seen commonly in our sample as with their report.

Stress is known to precipitate or exacerbate various dermatological conditions. In this study, 72.8% patients reported significant stress in their lives. This was assessed by asking open ended question about any significant stressful event ongoing at the time of interview. Though this was not objectively measured, was reported to be emotionally distressing by all these patients. Stress is known to induce derangements in epidermal function and can precipitate inflammatory dermatoses.

Dermatologist’s awareness of role of psychological factors in causation or exacerbation of dermatological conditions was important in referral of these patients to psychiatrist. Clinical expertise needed for managing these complex problems is definitely of higher level. Senior
dermatologists (82.9%) could identify and refer these patients, which was probably due to comfort in talking about these problems as well as greater expertise needed to identify these complex cases. Joint academic activities help in improving this awareness and expertise.

We discovered that significant functional impairment caused by dermatological disorders when accompanied by psychiatric disorders. This has been researched and reported in literature and was also confirmed in patients with psoriasis by authors in an earlier study. Apart from work functioning, social interactions and various relationships often suffer. Significant impairment in functioning often indicated psychiatric co-morbidity.

These patients often suffer double stigma, due to dermatological condition and added psychiatric problems. Thus these patients feel reluctant to consult psychiatrist and thus need to be assessed more sensitively by psychiatrist. This can be done by appropriate sequence of questioning i.e. asking about dermatological illness and alteration of sleep and appetite if any. Questions about its impact on functioning including family relationships, current life stresses and psychological distress if any may then follow. Patients often do recall repressed emotionally traumatic events during the interview. Any recent change in life, happenings around the onset of illness may be discussed as such triggers could be “apparently normal events.” Role of stress precipitating or exacerbating psychocutaneous disorders is well documented in literature.

Though psychiatric drug treatment needs not be started for most of these patients, we need not do so at the first visit. One of the differences between a patient primarily coming to psychiatrist and a liaison patient is that he takes time to understand and acknowledge the role of psychological factors in his illness and then be willing for treatment. Primary and co-morbid diagnoses need to be established clearly to ensure optimal dosages of drugs. In this study most of the patients (66 of them) could be prescribed medication during first visit itself.

Most of the patients referred by Dermatologist had significant psychiatric problems necessitating psychopharmacological treatment. Most of these patients were suffering from primary psychiatric conditions and not stress related disorders secondary to having dermatological ailment. Depressive disorder was the commonest psychiatric morbidity. Most of the patients improved after administration of Serotonin Specific Reuptake inhibitors. Doxepin was useful antidepressant for patients with pruritis. Psoriasis was the commonest dermatological condition referred for psychiatrist’s intervention.

Thorough understanding of such cases is valuable for either clinician in providing lasting relief and improved quality of life in these patients.

References


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