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Original Article

Psychiatric morbidity in dermatological out-patients: an issue to be recognized

Robina Aslam, Altaf Qadir*, Faria Asad**

Psychiatry Department, Allama Iqbal Medical College, Lahore.
*Psychiatry Department, Post Graduate Medical Institute, Lahore.
** Dermatology Department Unit-II, King Edward Medical University/Mayo Hospital, Lahore.

Abstract ***Objective*** The aim of our study was to assess the prevalence of anxiety and depression in the patients suffering from skin disorders.

Patients and methods Two hundred consecutive patients attending out-patient Department of Dermatology, Jinnah Hospital, Lahore, were studied. Hospital Anxiety and Depression Scale, Urdu version was administered to each patient after taking informed consent, as this scale was designed specifically for use in non-psychiatric hospital departments. A personal information sheet was also completed for the total sample of 200 patients.

Results Among them 36.5% were males and 63.5% were females, with a majority in the age range of 16-30 years. 20% cases of depression and 28% cases of anxiety were found in the total sample, using cut off point as 11 or more on HAD Scale. High scores were associated with conditions like acne, psoriasis, eczema, all tending to be extensive, chronic and disfiguring and easily visible. The association between sex, marital status, employment status and caseness is discussed.

Conclusion There is a high rate of psychological problems in dermatological out-patients suffering from chronic and disfiguring skin conditions.

Key words
Hospital Anxiety and Depression Scale, anxiety, depression.

Introduction

Skin is the largest organ of the body and determines to a great extent its appearance and plays a major role in social and sexual communication. A healthy normal skin is essential for a person's physical and mental well being and sense of self confidence.[1]

Perception of surface alteration as a handicap and its evaluation in terms of quality and quantity of damage varies from individual to individual and from dermatosis to dermatosis. Psychiatric disturbance and psycho-social impairment is reported in at least thirty percent of the dermatological patients. Among all psychiatric disorders anxiety and depression are observed more commonly and their recognition is important in the management of the disease.[2]

In the present study the aim was to find out the magnitude of anxiety and depression in our common dermatological patients and its correlation with age, sex, marital and

Address for correspondence
Dr. Robina Aslam
Psychiatry Department,
Allama Iqbal Medical College,
Lahore

employment status as well as with dermatological diagnosis. For this purpose, we used Hospital Anxiety and Depression Scale (HAD). The psychometric validity of HAD has been established by validating the questionnaire against the structured psychiatric interviews.[3] The use of HAD also facilitated rates of psychiatric caseness to be calculated for the current sample. Psychiatric caseness refers to an individual whose scores indicate that they are in need of more detailed psychiatric assessment, as such scores indicate the presence of clinically significant levels of anxiety and/or depression. Scores of less than 8 on the HAD scale tend to be reported by individuals with no clinically significant problems with anxiety or depression. Scores between 8 and 10 are likely to be obtained by mildly disturbed individuals, whereas scores between 11 and 21 are likely to indicate clinically significant anxiety and depression.[4]

Subjects and methods

This study was carried out at the out-patient dermatology clinic of Jinnah Hospital, Lahore which is a tertiary care hospital. All patients aged 16 years and above were given a research questionnaire i.e. Hospital and Anxiety Depression Scale (HADS) including an information letter and informed consent form. A research assistant was there to provide further information and assistance in answering the questionnaire.

All the relevant details regarding history, examination and treatment were recorded on a pre-designed proforma.

Statistical analysis was performed on variables of specific interest of the study including sex, age, marital and employment status, as well as dermatological diagnosis. The relationship between disease variables and psychiatric caseness was observed.

Table 1 Distribution of study population by socio-demographic characteristics (%)

No. of cases	*Males (n=78)*	*Females (n=122)*
Age (years)		
16-30	20	40
31-45	11	14
46-60	08	07
Marital status		
Single	15	34
Married	20	21
Others	04	06
Occupation		
Employed	26	12
Unemployed	13	49
Education status		
Educated	29	45
Uneducated	10	16

Results

A total of 200 patients were studied and majority of the study population was between 16 to 30 years of age and number of females predominated. Among the males 51.28 % were married and rest were single and amongst females only 34% were married. Majority of males were employed as compared to the females. 74.35% of the males were literate as compared to females in which literacy rate was 73.77%. The distribution of study population by socio-demographic characteristics is shown in **Table 1**. 20% cases of depression and 28% cases of anxiety were found in the total sample by applying the recommended cut off values. Details of HADS findings are shown in **Table 2**.

Females were found more anxious and

Table 2 Distribution of cases according to case status

	Depression			*Anxiety*		
Case status of patient	*Male (%)*	*Female (%)*	*Total (%)*	*Male (%)*	*Female (%)*	*Total (%)*
Definite cases	9	11	20	07	21.	28.
Doubtful cases	9	17	26	12	22.	34
Non-cases	19	35	54	11	18	37

Table 3 Association between sex, marital status. employment and caseness status

	Depression Cases	*Anxiety cases*
Males	17	14
Female	23	43
Males		
Married	08	04
Unmarried	09	10
Female		
Married	08	17
Unmarried	15	26
Males		
Employed	08	06
Unemployed	09	08
Females		
Employed	06	09
Unemployed	17	34

depressed than males. Unmarried females with dermatological problems were also found to be more anxious and depressed. The association between sex, marital status, employment status and anxiety and depression is shown in **Table 3**.

There were 14 cases of anxiety among males and 43 cases of anxiety among females. Out of these males, there were 28.5 % cases of psoriasis and same number of cases of alopecia areata. Among the females, acne vulgaris outnumbered all other diagnoses i.e. 34.88%. Other diagnoses were 16.27% cases of melasma and 17.30% cases of chronic eczema. Other dermatoses encountered were vitiligo, psoriasis, alopecia, lichen planus, chronic urticaria, herpes zoster, warts and scabies with a varied proportion.

There were 17 cases of depression in males and 23 cases of depression in females. Out of these males, there were 58.8% cases of psoriasis. Other diagnoses encountered were chronic urticaria (22.7%), and acne, alopecia, eczema and herpes 5.8% each.

Among females, there were 21.7% cases of eczema and 17.37% cases of psoriasis, acne and vitiligo each. Other diagnoses encountered were chronic urticaria, melasma, herpes zoster and lichen planus. The distribution of definite cases of anxiety and depression with respect to their diagnostic category is shown in **Table 4**.

Discussion

Our results generally confirm the findings of previous studies that there are high rates of psychological problems in dermatological patients and a lot of reasons could account for this.

Firstly, psychiatric disorders may arise as a complication or a consequence of a primary skin disease, in reaction to disfigurement, perceived social stigma or undesirable changes in life-style resulting from skin disease. Secondly, the dermatologist may encounter disorders such as obsessive-compulsive disorder, trichotillomania, dysmorphophobia, delusion of parasitosis and factitious disorder, which are primarily

Table 4 Diagnosis in cases of HAD Score of 112 or more (n=200)

Diagnosis	*Anxiety*		*Depression*	
	Male	*Female*	*Male*	*Female*
Acne	21.42%	34.65%	5.82%	17.39%
Alopecia areata	28.5%	4.65%	2%	
Chronic urticaria	7.14	4.65	15.8%	8.69
Eczema		17.30%	5.8%	21.7%
Herpes zoster		2.32%	5.8%	4.34%
Lichen planus		3.65%	2%	4.34%
Melasma		16.27%		8.69%
Psoriasis	28.5%	4.65%	58.82%	17.39%
Scabies		1.32%	1.76%	
Vitiligo	7.14%	11.62%	3%	17.39%
Warts	7.14%	1.65%		

psychiatric in nature but present with dermatological manifestations. Thirdly, skin lesions and psychiatric symptoms may both be present in some systemic diseases, such as systemic lupus erythematosus or porphyria. Finally, some drugs used in dermatology, such as corticosteroids, may precipitate psychiatric symptoms and, conversely, certain drugs used in psychiatry such as lithium or some anti-psychotics may affect the skin.[5,6]

Skin diseases with high prevalence of psychiatric disorders in our study included acne, pruritus, urticaria, vitiligo and alopecia areata. The higher anxiety level in patients with acne was expected because of the widely recognized psychological impact of the disease. Many studies have reported elevated anxiety, marked impairment in emotional well being, death wishes and suicidal tendencies in patients with acne [7,8,9].

Depression was found to be fairly common in psoriatic patients in our study. Psoriasis is a chronic disease with onset usually in adult life. Not only it is unsightly and uncomfortable but also results in constant shedding of scales and requires treatment that is often messy, time consuming and expensive. Various international studies support the same fact.[10,11]

Patients with alopecia areata were also found anxious and depressed about their disease. Psychologically, the growth of hair parallels the course of physical development, increasing at puberty and waning in senility. The perception of excessive hair loss frequently is the focus of body dysmorphic concern. It may arouse feeling of “exposure“ and embarrassment and a feeling of no longer matching up with the current idea of feminity and masculinity.[12,13] Other chronic dermatosis like eczema and urticaria also showed significantly high anxiety and depression scores.

With regard to the variables associated with the presence of a psychiatric disorder in dermatologic patient it should be underlined that our study had a cross-sectional design that does not allow us to draw causal inferences. Therefore identification of a variable as a predictor does not imply that this variable plays an aetiological role in promoting psychiatric disturbance. In our study we observed higher levels of anxiety and depression in females, especially those who are unmarried, and unemployed.

Anxiety and depression are more relevant clinically in dermatology patients during critical psychosocial periods of development like infancy and adolescence. The touch of the caregiver, secure holding, hugging and consistent caressing during infancy is essential for mental health and social development. Similarly skin disease during adolescence and young adulthood can lead to greater emotional impact. Early recognition and treatment of depression associated with skin disorders can lead to improved therapeutic outcome and may avert disastrous outcomes, including suicide.[14]

As dermatologists act as primary care physician for patients with a wide range of skin diseases, they are in a unique position to recognize psychiatric morbidity and to take appropriate measure.

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