Research Paper Medical Science

Psychiatric Aspects of Psoriasis : a Clinical Review

Sagar Karia Senior Resident Doctor Department of Psychiatry, Lokmanya Tilak Municipal Medical College Mumbai.

Avinash De Sousa Research Associate Department of Psychiatry, Lokmanya Tilak Municipal Medical College Mumbai.

ABSTRACT

Psoriasis is a debilitating skin condition that often occurs on visible areas of the body and is lifelong. Patients with psoriasis have been known to suffer from psychological problems and psychiatric comorbidity but there is a dearth of scientific literature and systematic studies on the same. Few studies exist in India and there are few studies done worldwide. The present paper reviews these studies and also looks at quality of life and how it is affected in patients with psoriasis. The review is purely clinical and not a systematic one yet tries to elucidate the psychiatric aspects of psoriasis.

KEYWORDS psoriasis, psychological aspects, psychiatric aspects, quality of life.

INTRODUCTION

Psychodermatology, or psychocutaneous medicine, focuses on the boundary between psychiatry and dermatology that deals with the study of the influence of psychosocial stress in the exacerbation or chronicity of skin illness. Understanding the psychosocial and occupational context of skin diseases is important for the optimal management of psychodermatologic disorders. It also analyses existing psychiatric comorbidities in many dermatologic conditions and the role of adjuvant treatment which can be psychopharmacological, psychotherapeutic or social [1].

Psychopathological disorders are highly prevalent among dermatology patients. The prevalence of psychiatric morbidity in dermatological out-patients ranges from 25%-43%. It has been found that 33% of skin patients suffer from some psychiatric morbidity [2], Wesseley and Lewis reported it to be 40% [3]. Hughes and others have reported 30% of outpatients and 60% of inpatient with dermatologic disorders had high score of GHQ-28 suggesting psychological distress [4]. A study of 132 patients of dermatology department by Attah Johnson and Mostaghimi found that the psychiatric diagnoses for the women patients were: normal variation 17/65, anxiety neurosis 11/65, and neurotic depression 37/65 while for the men patients, the psychiatric diagnoses were: normal variation 21/67, anxiety neurosis 15/67, and neurotic depression 30/67. One man with psoriasis had features of schizophrenic psychosis [5]. Filakovic and others have reported that the prevalence of depression in dermatological patients was around 30% which was more in comparison to patients in general practice where prevalence of depression was 22% [6].

The relation between psychiatry and skin diseases can be evaluated from two aspects:

1. On one hand, psychiatric comorbidity influences the development and course of dermatologic diseases via the effects of stress, depression, and anxiety.
2. On the other hand, cosmetically disfiguring dermatologic diseases may cause significant psychosocial distress for patients [7].

Prevalence of psychiatric comorbidity in psoriasis

Psoriasis is a chronic inflammatory skin disease that is characterized by thick, red, scaly lesions that may appear on any part of the body affecting 1-2% of general population. Multiple factors like genetic predisposition, hyperproliferation of keratinocytes, vascular alterations in the skin, upregulation of cytokines, and immunological as well as auto-immunological disturbances are responsible for the development of lesions. Also, observations of stress-induced onset or exacerbations of psoriasis, as well as a symmetrical distribution of psoriatic plaques indicate an additional, important role of the nervous system in the development of this entity. Many studies illustrate that the majority of patients believe stress or psychological distress as one of the factors in the manifestation of their condition. Depression and anxiety are the most common disorders that are associated with psoriasis and symptoms of psoriasis, especially pruritus, are related to depression. The psychological morbidity associated with pruritus in psoriasis may be secondary to poor sleep quality. There is evidence that patients with high levels of stress experience pruritus more frequently than patients with lower stress levels [8-12].

Patients with high stress levels report an increased frequency of psoriasis when compared with people with lower stress levels [13]. Chronic alcohol abuse results in the impairment of health-related, social and occupational functioning [14].

Psychiatric comorbidity was detected in 67% psoriasis patients by Gaikwad and others [15]. The prevalence of psychiatric morbidity as assessed in patients of psoriasis was found to be 53.3%; prevalence of depression was 23.3% and of anxiety was 3.3% [16]. Around 25% of patients having psoriasis developed psychiatric morbidity in a study conducted in India. It included adjustment disorder (62%), depressive episode (29%) and dysthymia (4%) [17]. In another study 37% patients with psoriasis had psychiatric comorbidities- adjustment disorder (13.3%), depressive episode (10.0%), alcohol dependence (6.6%), paranoid schizophrenia (3.3%), and delusional disorder plus severe depressive episode with psychotic symptoms (3.3%) [18]. A large study compared psychiatric morbidity in the three skin conditions i.e. psoriasis, alopecia areata and vitiligo. In that study, psychiatric morbidity was found in 34% of vitiligo patients, 38% of psoriasis patients and 36% of AA patients. Anxiety was detected in 12% of vitiligo patients, 10% of psoriasis patients and 24% of AA patients while depression was found in 22% of vitiligo patients, 28% of psoriasis patients and 14% of AA patients. Four percent of each group of patients had both anxiety and depression [19]. Jowett and Ryan found that 24% of psoriasis patients had depression and 58% suffered from anxiety [20]. The profile of psychiatric diagnosis was 65% adjustment disorder depressed type, 30% depressive episodes and 4% dysthymia in another research. However, no anxiety disorders were detected in the study [21]. There are studies showing that prevalence of alcohol consumption and smoking is high among psoriasis patients [22-24].

Quality of Life in Psoriasis

The skin, the most visible organ, determines to a great extent our appearance and plays a major function in social and sexual communication. Appearance is important in our society and it influences the way we are perceived by others. Skin diseases causing an altered or impaired appearance may profoundly affect those afflicted. Aside from causing physical discomfort and inconvenience, it has been demonstrated that they influence the patient's personal and social life, daily functioning and psychologic status. Skin disease may provoke negative emotions such as shame or embarrassment, anxiety, lack of confidence and even psychiatric diseases like depression. The patients' self-image may be profoundly depressed and his self-esteem threatened. Aside from discomfort in social relationships, patients may experience inferiority, feel discriminated against and stigmatized. Thus, regardless of psychiatric morbidity, skin diseases can greatly affect patient's quality of life (QOL) [25].

Studies have shown that QOL is affected severely in psoriasis patients [26-27]. A study that compared QOL in AA, psoriasis and vitiligo patients and found poorest QOL in psoriasis and best in AA group [19]. Many factors contributing to lower QOL in psoriasis include the chronic nature of the disease and the lack of control over unexpected outbreaks of the symptoms [28]. Patients may feel humiliated when they need to expose their bodies during swimming, intimate relationships, using public showers, or living in conditions that do not provide adequate privacy [29]. Psoriasis affects patients' social life, daily activities, occupational, and sexual functioning [30].

CONCLUSIONS

Psychiatric comorbidities are very much prevalent in dermatology patients particularly those suffering from psoriasis. Psoriasis is a chronic condition and it has bearing on the quality of life of patients too. Due to chronic nature and long standing treatment to be taken, literature has showed prevalence of psychiatric disorders particularly depression and anxiety very common in them. Also rate of substance use are high in them. Disfiguring lesions and shame or guilt associated with it leads to impaired socio-occupational functioning of these patients. All these lead to poor quality of life in them

REFERENCES

1. Picardi A, Abeni D, Renzi C, Braga M, Melchi CF, Pasquini P. Treatment outcome and incidence of psychiatric disorders in dermatological out-patients. J Eur Acad Dermatol Venereol. 2003;17(2):155-9. | 2. Golpour M, Hosseini SH, Khademloo M, Mokhmi H. Mental Health and Suicidal Ideation in Patients with Dermatologic Disorders. World Applied Sciences Journal 2010;11(5):573-7. | 3. Wessely SC, Lewis GH. The classification of psychiatric morbidity in attenders at a dermatology clinic. Br J Psychiatry. 1989;155:686-91. | 4. Hughes JE, Barraclough BM, Hamblin LG, White JE. Psychiatric symptoms in dermatology patients. Br J Psychiatry. 1983;143:51-4. | 5. Attah Johnson FY, Mostaghimi H. Co-morbidity between dermatologic diseases and psychiatric disorders in Papua New Guinea. Int J Dermatol. 1995;34(4):244-8. | 6. Filaković P, Biljan D, Petek A. Depression in dermatology: an integrative perspective. Psychiatr Danub.2008;20(3):419-25. | 7. Schultz HY. Society for Investigative Dermatology skin disease comorbidities project launch conference proceedings. J Invest Dermatol. 2009;129(3):525-8. | 8. Reich A, Szepietowski JC. Vasoactive peptides in the pathogenesis of psoriasis. G Ital Dermatol Venereol. 2008;143(5):289-98. | 9. Mousa EL, Abd F,Zaher EM, Abd H, Ezzat MA, Mostafa KA, Heba F. Comorbid psychiatric symptoms in patients with psoriasis. Middle East Current Psychiatry April 2011 - Volume 18 - Issue 2 - p 78–85. | 10. Reich A, Szepietowski JC, Wiśnicka B, Pacan P. Does stress influence itching in psoriatic patients? Dermatol Psychosom. 2003;4:151–5. | 11. Reich A, Hrehorów E, Szepietowski JC. Pruritus is an important factor negatively influencing the well-being of psoriatic patients. Acta Derm Venereol. 2010;90(3):257-63. | 12. Zachariae R, Zachariae CO, Lei U, Pedersen AF. Affective and sensory dimensions of pruritus severity: associations with psychological symptoms | and quality of life in psoriasis patients. Acta Derm Venereol. 2008;88(2):121-7. | 13. Devrimci-Ozguven H, Kundakci TN, Kumbasar H, Boyvat A. The depression, anxiety, life satisfaction and affective expression levels in psoriasis patients. J Eur Acad Dermatol Venereol 2000:14(4):267–71. | 14. Dediol I, Buljan M, Buljan D, Bulat V, Zivković MV, Situm M. Association of psoriasis and alcoholism: psychodermatological issue.PsychiatrDanub. 2009;21(1):9-13. | 15. Gaikwad R, Deshpande S, Raje S, Dhamdhere DV, Ghate MR. Evaluation of functional impairment in psoriasis. Indian J Dermatol Venereol Leprol. 2006;72(1):37-40. | 16. Sharma N, Koranne RV, Singh RK. Psychiatric morbidity in psoriasis and vitiligo: a comparative study. J Dermatol. 2001;28(8):419-23. | 17. Mattoo SK, Handa S, Kaur I, Gupta N, Malhotra R. Psychiatric morbidity in vitiligo and psoriasis: a comparative study from India. J Dermatol. 2001;28(8):424-32. | 18. Kumar V, Mattoo SK, Handa S. Psychiatric morbidity in pemphigus and psoriasis: a comparative study from India. Asian J Psychiatr. 2013;6(2):151-6. | 19. Saleh HM, Salem SAM, El-Sheshetawy RS and El-Samei AMA. Comparative Study of Psychiatric Morbidity and Quality of Life in Psoriasis, Vitiligo and Alopecia Areata. Egyptian Dermatology Online Journal 4 (1): 2, 2008. | 20. Jowett S and Ryan T. Skin disease and handicap: an analysis of the impact of skin conditions. Soc Sci Med. 1985;20(4):425-9. | 21. Mattoo SK, Handa S, Kaur I, Gupta N and Malhotra R. Psychiatric Morbidity in Psoriasis: Prevalence and Correlates in India. German J Psychiatry 2005; 8:17-22 | 22. Braathen LR, Botten G, Bjerkedal T. Psoriatics in Norway.A questionnaire study on health status, contact with paramedical professions, and alcohol and tobacco consumption. Acta Dermato-Venereologica (Suppl) 1989; 142:9-12. | 23. Lindegard B. Disease associated with psoriasis in a general population of 159,200 middle-aged urban, native Swedes. Dermatologica 1986;172:298-304. | 24. Mills CM, Srivastava ED. Harvey IM Smoking habits in psoriasis: a case controlled study. Br J Dermatology 1992;127: 18-21. | 25. Ongenae K, Beelaert L,van Geel N, Naeyaert JM. Psychosocial effects of vitiligo. J Eur Acad Dermatol Venereol. 2006;20(1):1-8. | 26. Tejada Cdos S, Mendoza-Sassi RA, Almeida HL Jr, Figueiredo PN, Tejada VF. Impact on the quality of life of dermatological patients in southern Brazil. An Bras Dermatol. 2011;86(6):1113-21. | 27. Karelson M, Silm H, Kingo K. Quality of life and emotional state in vitiligo in an Estonian sample: comparison with psoriasis and healthy controls. Acta Derm Venereol. 2013;93(4):446-50. | 28. Gelfand JM, Feldman SR, Stern RS, Thomas J, Rolstad T, Margolis DJ. Determinants of quality of life in patients with psoriasis: a study from the US population. J Am Acad Dermatol. 2004;51(5):704-8. | 29. Fortune DG, Richards HL, Griffiths CE. Psychologic factors in psoriasis: consequences, mechanisms, and interventions. Dermatol Clin. 2005;23(4):681-94. | 30. Weiss SC, Kimball AB, Liewehr DJ, Blauvelt A, Turner ML, Emanuel EJ. Quantifying the harmful effect of psoriasis on health related quality of life. J Am Acad Dermatol. 2002;47(4):512-8. |