Psychosocial aspects of common skin diseases

Madhulika A. Gupta, MD, CCFP, FRCPC

Consideration of psychosocial factors is essential for managing an estimated 30% of dermatologic disorders effectively; many of these disorders, such as acne, psoriasis, and atopic dermatitis, are common in primary care.[1,2]

When assessing dermatology patients for presence of psychiatric and psychosocial comorbidity, it is useful to consider the two major classifications in psychodermatology[1,2]: cutaneous associations of psychiatric disorders and psychosocial and psychiatric aspects of dermatologic disorders.

In the first group (eg, delusions of parasitosis and trichotillomania) the cutaneous symptom is essentially the result of a primary psychiatric condition, and effective management of the skin problem involves managing the underlying psychiatric disorder. The larger second group consists of disorders that have a primary dermatopathologic basis that might be influenced by psychosocial and psychiatric factors. In this group the psychosocial effect of having a cosmetically disfiguring condition can contribute to serious morbidity. The latter group is most common in primary care.

Psychosocial factors affect the skin

Most dermatologic disorders influenced by psychosocial factors are associated with both psychosocial stress, which exacerbates the condition, and psychologic and psychiatric disease, such as depression, anxiety disorders, and body image problems.

In addition to stress from major life events, a psychosocial stressor in some disorders, such as psoriasis and atopic dermatitis, is how the disorder affects patients' lives. This disease-related stress can result in flare ups of the disorder. In contrast to other stress-reactive dermatoses, such as urticaria, acne, alopecia areata, and atopic eczema, psychosocial stressors more frequently[3] predate onset or exacerbation of psoriasis, suggesting that psoriasis is more sensitive to stress than some other stress-reactive dermatologic disorders.

For example, a recent position paper on psoriasis[4] proposes that assessing how psoriasis affects a patient's life is better than a body surface area measurement for delineating psoriasis severity. This suggests that psychosocial comorbidity in some instances is the most important feature of the disorder.

Disease-related stress and the effect of psoriasis on patients' lives should be assessed within a developmental context. In general, psoriasis patients who are between 18 and 45 years old experience more frequent problems related to appearance and socialization and to occupation and finances than older people do.[5] Adverse effects are reduced in those older than 45, with a further decline in those older than 65. This most likely reflects the fact that in earlier adulthood, people are establishing social relationships and starting careers; therefore social stigma associated with cosmetically disfiguring disorders has the greatest effect.

Contrary to studies in the 1970s, which reported that women were more affected than men by cosmetic disfigurement caused by psoriasis, recent studies show that both men *and* women are equally affected. This finding might indicate that it is more socially acceptable for men to express concerns about their appearance and that an attractive appearance has played an increasingly important role in socialization for men over the last 20 years.

Early-onset psoriasis

Another factor to consider is that younger patients with early-onset (younger than 40 years) psoriasis are more likely to have greater genetic susceptibility and tend to experience more severe and recurrent disease.[6] They are also likely to have certain personality traits, such as difficulties expressing anger.[6] Most psoriasis-related stress arises from social stigma and reactions of people in social situations, and difficulties with assertiveness might

render these patients more vulnerable to psoriasis-related stresses. These findings suggest that even clinically mild disease, when cosmetically disfiguring, should be treated aggressively.

Presence of depressive disease in pruritic conditions, such as psoriasis and atopic dermatitis, might have important clinical implications. Severity of depression has been shown to increase when pruritus increases. A decrease in pruritus after effective treatment correlated with a decrease in the severity of depression. A depressed clinical state might decrease the threshold for pruritus, which is one of the most distressing symptoms of psoriasis and atopic dermatitis.[7] These findings highlight the complex and possibly bidirectional relation between psoriasis severity, psychological factors, and quality of life and its importance in overall management of patients.

Findings different for acne

Severity of depressive symptoms increases when severity of psoriasis increases.[8] This, however, is not a consistent finding in acne. Even mild to moderate acne has been associated with depression scores similar to those of patients with severe psoriasis.[9] In contrast to psoriasis patients,[8] acne patients in cross-sectional studies do not consistently show a direct correlation between clinical severity of acne and severity of depressive symptoms. Prospective studies involving treatment of acne have shown, however, that psychological morbidity in both mild to moderate noncystic acne and more severe cystic acne improved with treatment. Acne has a peak incidence during adolescence, a time when people are normally highly concerned with their appearance and body image. In some vulnerable adolescents, even mild acne could add to their existing psychological burden and result in severe depression. This explains the lack of a consistent correlation between acne severity and severity of depression scores in cross-sectional studies.

Suicide risk

Depressive disease in dermatology patients can be associated with substantial risk of suicide. Suicide risk can influence decisions regarding management of these disorders. A study comparing the prevalence of depressive symptoms among patients with mild to moderate noncystic facial acne vulgaris, moderate to severe psoriasis, atopic dermatitis, and alopecia areata found a 5.6% prevalence of suicidal thoughts among acne patients compared with a 5.5% prevalence of suicidal thoughts among more severely affected psoriasis patients.[9] The acne patients in this study were mainly adolescents and young adults. This finding also suggests that adolescents are typically more vulnerable to development of depressive disease, regardless of whether they have acne. Clinical depression is often an underlying problem when acne patients have difficulty functioning in school or the workplace, or isolate themselves to the point that they miss school or work.[10]

Comorbidity

Clinical depression in acne can complicate use of certain treatments; for example, isotretinoin has been sporadically associated with depression and other psychiatric reactions. When depressive symptoms are present in acne patients who are also using isotretinoin, depression might not be related to the isotretinoin. Current literature suggests that the association between isotretinoin and depression is idiosyncratic and generally unpredictable. A careful history will reveal whether onset or exacerbation of depressive symptoms is temporally related to isotretinoin therapy; depressed acne patients should always be assessed for suicide risk.

Acne and other body image problems, such as eating disorders, might also coexist.[11] Patients with *acne excoriee* have psychological conflicts that are very similar to dynamics encountered in adolescents with eating disorders, eg, difficulties coping with emerging developmental tasks of young adulthood. Some patients present with concerns about minimal acne, and their concern is out of proportion to the clinical severity of acne. In these patients, the acne might become the focus of body image concerns and be a cutaneous manifestation of an underlying body image problem, such as an eating disorder and body dysmorphic disorder.

In this issue of *Canadian Family Physician*, Barankin and DeKoven (page 712) review some of the most salient aspects of the psychosocial effect of acne, atopic dermatitis, and psoriasis. They focus on how dermatologic disorders affect patients' lives, which is largely secondary to the cosmetic disfigurement caused by the disorders and the resultant psychologic comorbidity. The authors have further stressed the importance of the biopsychosocial approach to evaluating dermatologic patients and determining disease severity. Adopting a comprehensive biopsychosocial model right from initiation of therapy by primary physicians is likely to reduce the dermatologic and psychosocial morbidity associated with the disease. ✦

Dr Gupta *is a Professor (part-time) in the Department of Psychiatry at the University of Western Ontario in London.*

Correspondence to: *Dr M.A. Gupta, 490 Wonderland Rd S, Suite 6, London, ON N6K 1L6; telephone (519) 657-4222; fax (519) 657-4233; e-mail* magupta@uwo.ca.

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