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Psychiatry's Relevance To Dermatology: Current Ideas

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ABSTRACT

The skin is an organ that primarily responds to tactile stimuli and directly responds to emotional impulses. The practise of dermatology has a psychosomatic component. There has long been speculation that psychological issues may be related to skin conditions. Psychodermatology examines how the mind and skin interact. According to the link between skin conditions and mental illnesses, it is categorised into three categories. In each of the three categories-psychosomatic illnesses, dermatological problems resulting from primary and secondary psychiatric disorders-different dermatological conditions are reviewed in this article. Psychiatric problems and its associated dermatological issues, such as stress and depression, are discussed. This review aims to precisely present the connection between the skin and the mind from a dermatology perspective. Psychodermatological problems' negative consequences on a person's quality of life are underlined. Both dermatologic and mental therapy options call for a multidisciplinary approach.

Keywords: Liaison therapy, mind, psychodermatology, quality of life, stress

INTRODUCTION

Due to its reactivity, skin has a unique place in psychiatry ability to respond to emotional cues and convey emotions, including such as rage, anxiety, embarrassment, and frustration, as

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well as through supplying self-esteem, and the importance of the skin in the the process of socialisation, which lasts from childhood through adulthood. The connection between the skin and the brain exists because the brain, as the centre, is more than just a fact. Because psychological processes and skin function are similar the same hormones affect them and are of ectodermal origin in addition to neurotransmitters. [2] Psychodermatology outlines an psychiatry and dermatology's interactions psychology.

According to estimates, between 30 and 60% of dermatology patients have psychological issues. [3].Dermatology is more concerned with the ‘external’ visible disease while psychiatry is more concerned with the "interior" non-visible sickness. The neuro-immuno-cutaneous system, often known as the NICS, is a complex interplay between the immunological and neuroendocrine systems that unites the two fields of study. The release of mediators from NICS has been used to explain the relationship between the immune system, neurological system, and skin.[4] Psychological stress has been shown to disturb the epidermal permeability barrier's homeostasis and may be a trigger for various inflammatory diseases including psoriasis and atopic dermatitis.[5]

Dermatologists have emphasised the importance of psychiatric consultation in general, and psychological elements may be especially important in chronic, intractable dermatologic disorders such eczema, prurigo, and psoriasis.[6,7]

Many occurrences of skin illness are thought to be brought on by psychological stress, linked to particular personality features, or a consequence of a psychiatric disorder. Although dermatologists are becoming more aware of the issue,[11] co-occurring mental problems are sometimes overlooked and are thought to be less common than they are in many skin conditions. Patients with skin diseases require a biopsychosocial approach. [12,13]Liaison therapy allows for a multidisciplinary approach with dermatological and psychiatric concepts working together, as well as concurrent diagnostic and therapeutic treatments for patients with psychodermatologic diseases.[14]

CLASSIFICATION

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According to how skin conditions and mental problems are related, psychodermatology is categorised into three groups: 1) Psychophysiologic (psychosomatic) disorders brought on by skin conditions that cause different emotional states (stress), but are not directly linked to mental disorders (psoriasis, eczema); 2) primary psychiatric disorders in charge of self-inflicted skin conditions (trichotillomania); and 3) secondary psychiatric disorders brought on by disfiguring skin (of ichthyosis, acne conglobata, vitiligo) [8]

Psoriasis

Psoriasis is a reasonably common skin condition that can occasionally need systemic medication. It is persistent, inflammatory, and hyperproliferative.[16] Psoriasis has long been linked to stress. [17] Numerous psychological issues, including as low self-esteem, sexual dysfunction, anxiety, sadness, and suicidal thoughts, are linked to psoriasis. Health-related quality of life (HRQOL) is significantly impacted by psoriasis, severely affecting psychological, occupational, social, and physical functioning. [18] Disturbances in body image and impairments in social and vocational performance are among the most prevalent psychological symptoms associated with psoriasis. [19]

Since psoriasis requires lifetime therapy and is both chronic and visible, it may have a negative impact on quality of life. There are five aspects of the psoriasis stigma that have been identified: (1) Expecting rejection, (2) Feeling defective, (3) Sensitivity to Social Attitudes, (4) Guilt and Shame, and (5) Secretiveness. [20] Psoriasis frequently had an association with depressive symptoms and suicidal thoughts. [11-16] In general, psychological factors, such as perceived health, stigmatisation beliefs, and depression, are more important predictors of impairment in psoriasis patients than the intensity, location, and duration of the disease. [17] In a recent prospective study of psoriasis patients [18] psychological disturbances became less frequent as the condition's symptoms and clinical severity improved. The disease's functional and emotional impacts may not always be proportionate to how severe it is clinically. [19]

Atopic dermatitis and psychosocial morbidity

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A learned element influencing the manifestation of atopic dermatitis may be psychological stress.[15] People with mental issues who are atopic may experience a vicious cycle of anxiety/depression and dermatological symptoms.

Anxiety and despair are prevalent side effects of the skin condition. The suffering of atopic dermatitis may have a profoundly detrimental impact on children's and their families' health-related quality of life (HRQOL). Children's shame, bullying, and teasing can result in social exclusion and school avoidance.

URTICARIA

Urticaria that already exists may get worse under extreme emotional stress.[17] In more than 20% of cases, increased emotional tension, exhaustion, and stressful life circumstances may be key reasons, and they are contributory in 68% of patients. Other typical issues include trouble expressing anger and a need for approval from others.[18,19] Patients with this illness may have anxiety and depressive symptoms, and it seems that the intensity of pruritus grows as the severity of depression does. [20,21] Wintertime hypomania and recurrent idiopathic urticaria with panic disorder have both been linked to cold urticaria. [22]

Acne scarring

There is no one condition that generates more psychic trauma and more maladjustment between parents and children, more general uneasiness and feelings of inferiority, and bigger sums of psychic assessment than does acne vulgaris, according to Sulzberger and Zaidens' 1948 article.[21] The mental comorbidity of acne excoriée includes body image disorder, depression, anxiety, obsessive-compulsive disorder (OCD), delusional disorders, personality disorders, and social phobias. Acne has a clear relationship with anxiety and depression. [14-17] According to reports, young men with extensive acne scarring are particularly at risk for despair and suicide. [18] Interesting gender disparities in this illness have been noted. In contrast to how self-excoriation in women may be a sign of immaturity and a cry for help, self-excoriation in men is made worse by the presence of despair or anxiety.

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Parasite-related delusions

Delusions of parasitosis are the most typical type of monosymptomatic hypochondriacal psychosis seen in people with skin issues.[23] Delusional parasitosis is a syndrome in which the patient has the mistaken assumption that he is infected with parasites or other creatures. They frequently go into detail about how these organisms multiply, migrate under their skin, spread there, or even leave the skin. It may manifest as the only psychologic issue or it may be accompanied by a physical or psychiatric condition. [14] The psychiatric differential diagnosis includes formication without delusion, in which the patient feels crawling, biting, and stinging sensations without thinking that they are brought on by organisms. Other diagnoses in this category include psychotic depression, psychotic schizophrenia, psychosis in patients with florid mania or drug-induced psychosis, and psychosis in patients with florid mania. [15]

Patients with parasitosis delusion frequently display the matchbox sign, which involves bringing in matchboxes or other containers small pieces of excoriated skin, trash, unrelated insects, or insect parts as evidence of infestation.[21]

Dysmorphophobia

Dermatological non-disease and body dysmorphic disorder are other names for this problem.[14] Patients with this illness have a wealth of symptoms but few organic disease symptoms. Self-reported complaints or concerns typically involve the face, scalp, or genitalia. Excessive redness, blushing, scars, big pores, facial hair, and projecting or sunken facial features are just a few examples of facial symptoms. Hair loss, a red scrotum, urethral discharge, herpes and AIDS phobia are further symptoms. In order to reduce anxiety caused by perceived flaws, people may use a variety of techniques, such as camouflaging lesions, mirror checking, comparing their flaws to the same body parts on others, questioning or seeking confirmation, mirror avoidance, or grooming to hide flaws. [15] Women are more prone than men to pick at their skin, conceal flaws with makeup, be worried with how their hips or weight look, and have bulimia nervosa as a coexisting disorder. Men are more likely than women to be single, drink excessively, worry

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about their genitalia, body image, and hair thinning. [16] Suicidal thoughts may be present in patients with body image issues, particularly those that affect the face. [17] Depression, poor social and vocational performance, social phobias, OCD, skin picking, marital problems, and substance misuse are examples of associated comorbidity with dysmorphophobia. [18,19]

Areata alopecia

There has long been controversy around the contribution of psychological variables to the development of alopecia areata (AA). [18]It is generally known that psychologic factors play a role in the onset, progression, and therapeutic management of alopecia areata. Alopecia areata may be triggered by acute emotional stress, possibly by activating overexpressed type 2b corticotropin-releasing hormone receptors in the hair follicles and causing severe local inflammation.[19]

It has also been discovered that peripheral nerves release substance P in reaction to stress, and patients with alopecia areata exhibit substantial substance P expression in the nerves surrounding their hair follicles.[20] Neutral endopeptidase, an enzyme that breaks down substance P, has been found to be highly expressed in both the acute-progressive and the chronic-stable phases of the illness in the afflicted hair follicles. Major depression, generalised anxiety disorder, phobic states, and paranoid disorder are a few examples of the comorbid mental diseases that are widespread. [22-23]

Vitiligo

Depigmentation of the epidermis is a characteristic of the specific type of leukoderma known as vitiligo. According to several research, vitiligo patients experience much more stressful life events than controls, which raises the possibility that psychologic discomfort may play a role in the disease's genesis. [12] There have been theories linking genetic predisposition, catecholamine-based stress, and a particular personality structure. [13] Typically, one-third of patients are said to have psychiatric morbidity, however in one study, adjustment disorder and depressive disorders affected 56% of the population. [14-15] Vitiligo patients endure discrimination, are terrified of their looks, are ashamed of it, and frequently feel that their needs

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are not met by medical professionals.[24-25] Younger patients and people from poorer socioeconomic backgrounds exhibit poor social adjustment, low self-esteem, and adaptability issues. [16,17]

CONCLUSION

Psychodermatologic disorders are conditions where the mind and the skin interact. They can be divided into three groups: primary psychiatric disorders, secondary psychiatric diseases, and psychosomatic disorders. Among the dermatological psychosomatic disorders with psychogenic manifestation/exacerbation are atopic dermatitis, eczema, urticaria, psoriasis, herpes simplex, alopecia areata, rosacea, etc. It is advised to use a biopsychological model, which, in addition to the primary dermatologic factors, considers social (e.g., impact upon social and occupational functioning) and psychological (e.g., psychiatric comorbidity such as major depression and the impact of skin disorder on the psychological aspects of quality of life) factors. Liaison therapy, which allows for a multidisciplinary approach involving a family physician, dermatologist, psychiatrist, and psychologist, should be used to treat psychodermatological diseases.

It is crucial to train dermatologists in the diagnosis and treatment of psychological problems, which can occasionally coexist with skin conditions. The majority of psychodermatological illnesses are treatable with psychotherapeutic stress- and anxiety-management strategies, cognitive-behavioral psychotherapy, and psychotropic medications. Antipsychotics, mood stabilisers, antidepressants, and anxiolytics are all examples of psychopharmacologic treatment.

The evaluation of the skin manifestation and the underlying social, familial, and occupational problems is necessary for the management of psychodermatologic illnesses. Once the illness has been identified, management calls for a dual strategy that addresses both the dermatologic and psychologic facets of the condition. Many psychiatric patients might benefit from dermatologists and mental health specialists working together in a mutually respectful manner. Therefore, it is crucial to comprehend biopsychosocial techniques and the liaison approach used in this field by general practitioners, psychiatrists, dermatologists, and psychologists.

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