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Editorial

DEPRESSION AND SKIN DISEASE

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Skin shares a common embryological origin with brain and has a complex relationship with the mind. The emotional factors play a vital role in modulating the skin problems. Whether emotional factors play a primary pathogenic role or cause exacerbation of skin disease secondarily, is difficult to ascertain.

Skin diseases are commonly associated with psychological problems, particularly depression[1]. Cutaneous disorders e.g. acne, port-wine stain[2,3] and alopecia areata[4], which affect important body image areas, cause a profound lowering of confidence and self-esteem leading to reactive depressive illness and suicidal attempts. Cotterill and Cunliffe[5] reported 16 cases of suicide among skin patients, seven of which had acne. Not only the life-threatening skin diseases but the chronic and difficult to treat dermatoses like psoriasis, chronic urticaria and eczema are also associated with depression and suicidal ideation[6]. In susceptible individuals, these can seriously impair quality of life and cause depression[7]. Gupta *et al*[8] reported that about 10% of their psoriatic patients wished to be dead whereas 5.5% had active suicidal ideation at the time of study.

The relationship between skin disease and depression may be coincidental; each having its own primary reasons for existence. The skin disease can cause depression or primary depression may exacerbate an underlying skin condition. Both skin lesions and psychiatric symptoms may coexist in some systemic diseases e.g systemic lupus erythematosus and porphyria. Systemic drugs used in dermatology e.g. corticosteroids, retinoids and antiandrogens may cause depression as a side effect. Antidepressants can also cause or exacerbate a range of skin conditions including acne, psoriasis and alopecia[9].

Less commonly, the dermatologist may encounter disorders of obsessive compulsive neurosis, trichotillomania, dysmorphophobia, delusions of parasitosis and factitious dermatoses which are primarily psychiatric in nature but present with dermatological manifestations.

Skin conditions affecting psychologically important parts of the body e.g. the face, scalp, breasts and genitalia – are particularly associated with depressive illness. In such cases, the severity of skin disease may seem relatively minor to the observer. Thus a pre-morbid personality is particularly vulnerable to adverse change, and relatively trivial problems may induce severe depression and attempts at suicide.

As dermatologists act as the primary care physicians for skin patients, it is important to recognize psychiatric morbidity and to take appropriate measures.

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