Addressing the Relationship Between Depression and Skin Disease

By Richard G. Fried, MD, PhD
That a relationship exists between skin disease and depression seems intuitive. Living with the demands, intrusions, dysesthesias, and visible signs of common skin disorders such as eczema, psoriasis, rosacea, acne, alopecia, and HSV can certainly be distressing. Furthermore, the potential for social rejection and stigmatization can be overwhelming for some. Conversely, it is known that psychological distress can result in elevated levels of neuropeptides and other pro-inflammatory cytokines that can exacerbate existing skin disease.

Objectively speaking, many will agree that persons suffering with skin disease have a right to be angry, anxious, and clinically depressed. And indeed, many of them are. The literature is replete with references supporting the contention that psychiatric disturbance and psychosocial impairment are reported in at least 30 percent of patients with dermatologic disorders. Given the reciprocal relationship between skin disease and psychologic distress, the chicken or the egg question frequently arises. Which came first? Was the depression present that served to initiate or worsen skin disease? Or alternatively, did the depression have its onset or exacerbation as a consequence of the skin disease? Even more importantly, does it matter in our evaluation and management of patients with common skin disease?

What is Depression?
Depression is a negative emotional state that affects all of us to some degree. It can usurp our happiness and substantially diminish our quality of life. Depression can be conceptualized along a continuum ranging from mild sadness and lack of vivre to intense misery, despair, and unwavering desire to die. It frequently disrupts functional capacity and can result in poorer scholastic, vocational, interpersonal, and intimate functioning. Depressed persons frequently experience decreased energy levels, impaired attention and concentration, somatic complaints, and preoccupation with bodily concerns. This often results in impaired personal hygiene and poor compliance with treatment regimens. Certainly, this constellation of psychiatric and somatic impairment can easily lead to a cycle of deleterious perpetuation in which sadness worsens skin disease, and the consequent burden of worsening skin disease exacerbates depression. Therefore, in theory, dermatologic intervention alone can help to break the cycle if adequate adherence to treatment regimens can be achieved. However, there is little question that better and more rapid clinical improvement can be seen when the emotional aspects are concomitantly addressed. Combined treatment can diminish the likelihood of protracted psychologic suffering that can theoretically jeopardize job status, marital status, friendships, and even in the case of suicide, one’s life.

Any discussion of depression must address the issue of suicide. Suicide is the greatest feared outcome of a depressive disorder. About 50 percent of persons who kill themselves were known to have been depressed, and 15 percent of depressed patients eventually kill themselves. It is reported that about 35,000 individuals commit suicide every year in the United States while 250,000 attempt it. Women attempt suicide four times more frequently than men, but men are three times more successful. The suicide rate in the United States is 12 per hundred thousand. Among men, the suicide rate peaks after age 45, and among women after age 65. Overall suicide rates increase with age.
A frightening statistic is that the most rapid rise in suicide rates in recent years is among males 15 to 24 years of age. This is of particular concern, since acne has its peak occurrence during this age. A 5.6 to 7.2 percent prevalence of active suicidal ideation was observed among psoriasis and acne patients. This is higher than the 2.4 to 3.3 percent prevalence in general medical patients. Para-suicidal behavior is defined as repeated self-harm or injury. Examples include dermatitis artefacta, carving or self-cutting behavior, burning of the skin, or excoriating to the point of scarring or disfigurement. This type of behavior should never be minimized and always be viewed as a possible indicator of depression and harbinger of present or future risk for suicide.

**Manifestations of Depression**

The DSM-IV published by the American Psychiatric Association provides concrete diagnostic criteria for dysthymia and other variants of depression. These criteria include poor appetite or over eating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness, etc. While we see patients with these classic signs of depression in dermatology, more often we see either depressive equivalents or subclinical depression.

Depressive equivalents can include pain, burning, and other dysesthesias without identifiable organic basis. Alternatively, depressed patients can present with excessive concern and preoccupation about minor dermatologic problems such as minimal hair loss, enlarged pores, fine wrinkles, minimal acne, etc. They often express feelings of low self worth and unattractiveness in association with their dermatologic complaint. Their preoccupations can consume a great deal of time and energy, which dramatically impairs psychosocial functioning.

In severe cases of depression, there can be mood congruent delusions that include gross distortions in bodily perception. There can also be morbid preoccupation with delusions of ill health, such as having cancer or a sexually transmitted disease; delusions of skin deterioration; or delusions regarding malodorous emissions from the skin. While the above symptoms may indeed reflect depression, the consideration of an atypical neuropathy or paraneoplastic process must always be kept in the differential diagnosis both at the time of presentation as well as throughout the course of the patient’s treatment. Appropriate imaging studies, skin biopsies, and serologic studies should be performed on a periodic basis.

Subclinical depression refers to a group of patients who fail to meet the classic DSM diagnostic criteria but are indeed suffering from depression. Common symptoms include a subtle decrease in energy and enthusiasm, mild fatigue, a narrowing of leisure interests, and obsessive preoccupations. Other clues relate to diminished sensory enjoyment. Individuals seem blasé, lacking enthusiasm about daily life events. Patients do not perceive themselves as being depressed, usually denying any persistent feelings of sadness or depression.

This constellation of symptoms can lead to weight gain, poor adherence with treatment, diminished functional capacity, increased psychosocial stress; all of which can impede effective treatment. Patients with subclinical depression often respond very favorably to cognitive behavioral psychotherapy with or without concomitant antidepressant medications.

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**Summary of Depressive Types and Symptoms**

See text for details and discussion.

**Dysthymia and other variants of depression:** Criteria include poor appetite or over eating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness, etc.

**Depressive equivalents:** Can include pain, burning, other dysesthesias without identifiable organic basis. Alternately, patients can present with excessive concern, preoccupation about minor dermatologic problems such as minimal hair loss, enlarged pores, fine wrinkles, minimal acne, etc. Often express feelings of low self worth and unattractiveness in association with their dermatologic complaint.

**Severe depression:** There can be mood congruent delusions that include gross distortions in bodily perception. There can also be morbid preoccupation with delusions of ill health, such as having cancer or an STD; delusions of skin deterioration; or delusions regarding malodorous emissions from the skin.

**Subclinical depression:** Patients who fail to meet the classic DSM diagnostic criteria but are suffering from depression. Common symptoms include a subtle decrease in energy and enthusiasm, mild fatigue, a narrowing of leisure interests, and obsessive preoccupations. Other clues relate to diminished sensory enjoyment. Individuals seem blasé, lacking enthusiasm about daily life events. Patients do not perceive themselves as being depressed, usually denying any persistent feelings of sadness or depression.

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ment. Patients may report a diminished experience of gustatory and olfactory richness when eating food or smelling flowers, and sexual interest and gratification often have diminished. These are individuals who seem blasé, lacking enthusiasm about daily life events. Individuals with subclinical depression freely endorse the idea that life inevitably loses its shine as time passes.

It is noteworthy that these patients do not perceive themselves as being depressed, usually denying any persistent feelings of sadness or depression. This constellation of symptoms can lead to weight gain, poor adherence with treatment regimens, diminished functional capacity, and increased psychosocial stress, all of which can impede effective treatment outcomes. In clinical practice, subclinical depression may present as these may be the eczema, psoriasis, rosacea, or acne patients with disease that is unusually refractory to treatment. Patients with subclinical depression often respond very favorably to cognitive behavioral psychotherapy with or without concomitant antidepressant medications. Studies have demonstrated improved treatment outcomes and diminished need for topical, oral, and ultraviolet therapies when relaxation techniques and cognitive behavioral psychotherapy were incorporated. Only in retrospect, after treatment, do these individuals recognize that they were in fact depressed.

**Specific Skin Disorders**

**Psoriasis.** Psoriasis patients who feel stigmatized experience higher levels of depression as do those who experience greater touch deprivation in social situations as a result of psoriasis. Depression, anger, high anxiety, oppositionality, and difficulties with verbal expression of emotions have all been reported among psoriasis suffers. Psychiatric symptoms frequently but not always correlate with disease severity. A 7.2 percent prevalence of suicidal ideation was observed in patients with severe psoriasis, while those with mild disease had a 2.5 percent suicidal ideation occurrence.

**Atopic dermatitis.** Higher levels of anxiety and depression have been reported in patients with atopic dermatitis. Anxiety has been observed as the presenting symptom of depression. Adult atopics are often chronically anxious and report difficulty in handling anger. Depression severity has been shown to directly correlate with the severity of pruritus.

**Alopecia areata.** Patients with AA report there appeared to be exacerbation of hair loss by stress when depression was at higher levels. This may suggest that comorbid depression may render the condition more stress reactive. Surveys of patients with AA revealed up to a 74 percent lifetime prevalence of one or more psychiatric disorders with an 8.8 percent to 39 percent prevalence of major depression.

**Acne.** Quality-of-life studies have shown that the stress and emotional impact resulting from acne is similar to chronic disorders such as diabetes and asthma. Emotional and functional impact does not necessarily correlate with severity. Acne patients, even those with mild disease, can be severely psychologically disabled by the disorder. Mild to moderate acne has been associated with significant psychological morbidity including depression, suicidal ideation, and completed suicide. A 5.6 percent prevalence of suicidal ideation was observed, even in those patients with non-cystic facial acne.

**Rosacea.** Surveys conducted by the National Rosacea Society have consistently shown higher levels of depression, anxiety, embarrassment, and social withdrawal in patients with rosacea. Patients with more severe flush-blush reactions, as one would expect, are often more emotionally affected. Pulse dye laser, IPL, biofeedback and selective use
of psychotropic medicines have demonstrated effectiveness in ameliorating objective clinical symptoms and emotional symptoms.

Life spectrum disorders. The inevitable physical signs that are the stigmata of aging are often interpreted as harbingers of our inevitable deterioration, decline, and demise. Many benign skin lesions have symbolic significance for our patients. The casual dismissal of a seborrheic keratosis as “nothing to worry about” can leave the patient feeling devastated because he or she has recollections of a parent or grandparent literally encrusted with these “benign growths.” Thus, we must be aware of the symbolic significance of dyspigmentation, benign neoplasms, vascular proliferations, etc. There is no doubt that well-chosen cosmetic interventions can effectively avert or improve depression.

Treatment—What Can We Do?
I wish to make it abundantly clear that I am not recommending that dermatologists and dermatology physician assistants become psychotherapists. Effective psychological interventions can and do occur all the time in the course of our daily interactions with patients. A second or two of truly connected eye contact conveys a strong message to the patient that you are listening and responding to the thoughts and angst that lives within them. A gentle reassuring touch or a well chosen empathic statement can alleviate a great deal of anxiety and reduce the feelings of unattractiveness and alienation that dermatologic patients so commonly experience.

Statements such as, “I know this can be very difficult to live with,” or “I imagine you must be very frustrated with our inability to cure your psoriasis,” communicate a sense of true understanding and caring. These are what I refer to as the intangible ingredients of caring. Others have referred to it as “being in the moment.” Concrete, optimistic, and realistic treatment plans that promise better control of skin disease can be enormously therapeutic as well, since many patients come to experience pessimism or even futility regarding therapeutic success.

In terms of structured psychotherapeutic interventions, cognitive behavior therapy, behavior therapy, progressive muscle relaxation, guided imagery, mindfulness meditation, yoga, tai chi, and structured breathing techniques all have been associated with improved therapeutic outcomes and improvement in overall well-being. These improvements are probably a combination of true positive amelioration of neuropeptides and other cytokines, improvement in vascular instability, as well as enhancement of a sense of subjective control and focus, all leading to better adherence with treatment regimens.

Perhaps the most difficult challenge is helping patients to “buy into” a psychologic referral or psychologic technique without feeling stigmatized as a psychiatric patient. I routinely explain to patients that stress and unhappiness lead to a hyper-reactive immune response that can make the skin behave in a more angry and labile fashion. Specifically, I tell them about inflammatory chemicals that are released in the skin that can make the skin flair more often and more severely. The concept of skin irritability and immune system over-reactivity is often acceptable to them. I then introduce the concept of a skin/emotion specialist in the community that understands and has experience with skin disease. Patients are informed that there are psychologists and psychiatrists who will introduce and/or prescribe techniques and medications that can help the skin to return to its previously healthy way of responding.

Utilization of self-help CDs, such as Freedom from Acne: Living in Better Skin or Psoriasis and Stress: Relief at Last utilize guided imagery and progressive muscle relaxation techniques and are available through my center at yardleyderm.com. Bibliotherapy incorporating self-help books that are disease-specific, such as my book Healing
Adult Acne: Your Guide to Clear Skin and Self-confidence, provides both an information source regarding the etiology and pathogenesis of acne as well as a self-help book with specific exercises and interventions. Other self-help books such as 8-Minute Meditation, as well as more depression- and anxiety-specific books fill the shelves in local bookstores.

Avoiding Unnecessary Suffering

In summary, depression is commonly seen in dermatology patients and often not recognized by the patient. Presentations can be atypical and “masquerade” as “normal sequelae of middle-age” or as somatic complaints. It is incumbent upon the clinician to be vigilant for depression, since it can rob patients of quality-of-life, functional capacity, and even eventuate in suicide. Obviously, patients deemed to be in acute jeopardy need immediate psychiatric referral.

In the majority of cases, our depressed patients need an empathic physician who offers concrete and effective dermatologic treatment plans. Augmentation of these treatments with complementary treatments, such as progressive muscle relaxation, guided imagery, hypnosis, biofeedback, yoga, Tai Chi, and antidepressant medication, can augment therapeutic outcomes and avoid unnecessary psychic suffering.

Dr. Fried is author of Healing Adult Acne: Your Guide to Clear Skin and Self-confidence (New Harbinger). He has no other relevant disclosures.


In-Office Strategies to Help Patients

• Use meaningful eye contact.
• Offer gentle touch or empathic statements. Be “in the moment.”
• Offer concrete, optimistic, and realistic treatment plans that promise better control of skin disease.
• Recommend structured psychotherapeutic interventions. Cognitive behavior therapy, behavior therapy, progressive muscle relaxation, guided imagery, mindfulness meditation, yoga, tai chi, and structured breathing techniques all have been associated with improved therapeutic outcomes and improvement in overall well-being.
• Recommend appropriate self-help CDs and books, such as, “Freedom from Acne: Living in Better Skin,” “Psoriasis and Stress: Relief at Last,” “Healing Adult Acne: Your Guide to Clear Skin and Self-confidence,” or “8-Minute Meditation.”
• Offer psychological referral when appropriate.

Helping the Patient “Buy Into” A Psychological Referral

• Explain to patients that stress and unhappiness lead to a hyper-reactive immune response that can make the skin behave in a more angry and labile fashion.
• Describe inflammatory chemicals that are released in the skin that can make the skin flare more often and more severely—The concept of skin irritability and immune system over-reactivity is often acceptable.
• Introduce the concept of a skin/emotion specialist in the community that understands and has experience with skin disease.
• Tell the patient that there are psychologists and psychiatrists who will introduce and/or prescribe techniques and medications that can help return the skin to its previously healthy way of responding.

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