

Psychiatric Tests in Seborrhoeic Dermatitis

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Sir,

Seborrhoeic dermatitis is a chronic dermatosis, characterized by erythematous, sharp-edged plaques with oily-yellow desquamation. Scalp, face, flexural and presternal areas are predisposed sites for the disease. Remissions and exacerbations are characteristic. It is known that many dermatological disorders may start or exacerbate with psychological stress. Seborrhoeic dermatitis may also be exacerbated by psychological stress (1). In this present study, seborrhoeic dermatitis patients were investigated for anxiety, depression and stress factors with psychiatric tests. The effect of seborrhoeic dermatitis on the quality of life of the patients was also examined.

MATERIALS AND METHODS

Thirty patients with seborrhoeic dermatitis who attended the outpatient clinic of Fatih University Faculty of Medicine, Department of Dermatology and 30 age- and sex-matched healthy volunteers were included in the study. The control group was accepted as healthy after dermatological and clinical psychiatric examination. The patients' age, sex and duration of the disease were recorded. Patient and control groups were asked to fill in the brief symptom inventory (showing predisposition for psychiatric symptoms) (2), dermatology life quality index (DLQI) scale (showing the effect of dermatologic disorders on the quality of life of the patients) (3), the social readjustment rating scale (showing the major experiences in the last 2 years) (4) and the hospital anxiety and depression scale (indicating the risk and level of anxiety and depression) (5).

The results were compared using Microsoft Excel and Statistical Package for Social Sciences v11.0 (SPSS v11.0). The Mann-Whitney test was used to evaluate the statistical significance.

RESULTS

The age and sex distribution were similar in both the patient and control groups (Table I). The average duration of the disease in the patient group was 3.44 ± 0.77 years.

The brief symptom inventory, consisting of Disease Severity Index, Total Symptom Index and Symptom Disease Index and the social readjustment rating scale score were significantly increased in the patient group. The DLQI was found to be significantly decreased when compared with the control group. The hospital anxiety and depression scale did not show any statistical significance between the two groups ($p > 0.05$) (Table I).

DISCUSSION

It is becoming increasingly popular among investigators to evaluate the relationship between stress and skin problems, and how they affect the quality of life. An association between skin disorders and psychiatric diseases has been emphasized by many reports (6, 7). It is believed that at least one-third of the dermatological disorders are correlated with emotional factors (8). Seborrhoeic dermatitis is included in this group affected by psychological factors (1). In our study, the brief symptom inventory showed a statistically significant difference between patient and control groups. This inventory points out the frequency of psychiatric symptoms. The statistically significant differences were detected in all subgroups of this inventory, such as somatization, obsessive compulsive disorder, depression, anxiety, hostility, phobic anxiety, paranoid thoughts and psychoticism.

In the literature, an increased incidence of obsession and depression has been noted in patients with anogenital pruritus (9). Additionally, it is reported that patients with alopecia areata are at high risk for developing major depression, anxiety, social phobia and paranoid disorder (10). Maietta et al. showed a high prevalence of seborrhoeic dermatitis in patients with mood depression (11). However, there have been no studies focusing on the depression potential in seborrhoeic dermatitis patients. Our results show an increased

Table I. Demographic data and results of the various tests studied in the seborrhoeic dermatitis patients and control groups

Parameter	Patients (n=30)	Controls (n=30)
Sex (M/F)	15/15	15/15
Age, mean \pm SD (min-max)	33.4 ± 14.5 (16-72)	35.6 ± 12.4 (19-61)
Disease Severity Index	0.93 ± 0.61	$0.47 \pm 0.38^*$
Total Symptom Index	26.9 ± 9.9	$17.2 \pm 10.6^*$
Symptom Disease Index	1.72 ± 0.62	$1.26 \pm 0.71^*$
Dermatologic quality of life index	3.87 ± 2.84	$1.73 \pm 2.36^*$
Social readjustment rating scale	5.47 ± 3.92	$3.27 \pm 2.96^*$
Hospital anxiety	7.53 ± 3.27	5.73 ± 3.52
Hospital depression	6.07 ± 3.82	5.03 ± 3.32

* $p < 0.05$.

predisposition to depression in seborrhoeic dermatitis patients.

We also examined DLQI. There are reports about chronic urticaria, atopic dermatitis, psoriasis and acne showing a negative effect of the diseases on the quality of life (12–14). In seborrhoeic dermatitis, itching of the scalp and the scales seen in the collarete region may form a social stigma and may cause rejection of the patient in society. Our study showed a statistically significant decrease of DLQI in the patient group.

The social readjustment rating scale is a questionnaire relating to the major events experienced in the last 2 years and the answers are calculated: age, sex, education, family and cultural history, social experiences, psychological maturity, and severity of the stress affect individuals differently (15). In our study, we found a statistically significant increase of the social readjustment rating in the patient group. As the patients also had an impairment in quality of life, this might have increased the probability of facing stressful situations owing to stigma, social rejection or social limitations. Given that our patients had a long duration of disease, we cannot rule out the possibility that the increased number of recent life events they reported was a consequence rather than a cause of the skin disease. In any case, our study highlights the increased level of stress experienced by these patients.

The hospital anxiety and depression scale is used to evaluate the risk and severity of anxiety and depression of the patients. In our study, although we found increased depressive symptoms with the brief symptom inventory, we could not find any statistically significant difference in the hospital anxiety and depression scale between patient and control group. As this scale was originally prepared for patients with physical illnesses such as rheumatoid arthritis and hypertension, psychodermatological disorders should perhaps be evaluated separately.

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