Mental Health Issues in Dermatology Patients

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Received: April 01, 2023, Manuscript No. DMCR-23-22754; **Editor assigned:** April 03, 2023, PreQC No. DMCR-23-22754 (PQ); **Reviewed:** April 17, 2023, QC No. DMCR-23-22754; **Revised:** July 03, 2023, Manuscript No. DMCR-23-22754 (R); **Published:** July 10, 2023, DOI: 10.35248/2684-124X.23.8(5).010

Introduction

A psychiatric disease known as Body Dysmorphic Disorder (BDD) is characterized by an obsession with a particular component of one's own body or appearance that is seen to be seriously defective and necessitates taking extraordinary measures to hide or cure. According to the Diagnostic and Statistical Manual of mental disorders, fourth edition (DSM-IV), BDD is characterized as an obsession with a fictitious or insignificant flaw in one's appearance that leads to social or professional dysfunction and is not more appropriately explained by another disorder. The DSM-5 adds operational criteria (such repetitive behaviors or intrusive thoughts) and a new subtype of dysmorphia (muscle dysmorphia; perception that one's physique is too tiny, or inadequately muscular or slender) as well as classifies BDD under a new heading called obsessive-compulsive spectrum. In psychiatric settings, BDD patients are frequently co-morbid with other mental illnesses. Major depressive illness has been identified as the most prevalent comorbid disorder, according to a number of researches.

Description

The largest study revealed lifetime and current rates of 58% and 76%, respectively. Co-occurring disorders with BDD include obsessive compulsive disorder, substance use disorder, social phobia, and avoidant personality disorder. Patients with BDD have a low quality of life and unusually high levels of perceived stress. The ability to achieve and maintain a level of general functioning that enables the patient to accomplish their life goals is how the patient perceives their ability to achieve and maintain a high level of health related quality of life, which is a multidimensional construct reflecting overall wellbeing and including both physical and mental health aspects. In a study that used the short form health survey to measure health related quality of life, outpatients with BDD performed worse than the general population and patients with depression across all mental health areas. Poorer men were linked to more severe BDD symptoms with mental quality of life in terms of health. According to empirical research, dermatology and plastic surgery patients are more likely than the general public to have BDD. In total, 12% of patients in dermatology tested positive for BDD, compared to 7%-8% of patients in cosmetic surgery. Dermatologists may be the medical professionals who treat these individuals the most frequently, according to Phillips, et al. Patients undergoing dermatology and aesthetic surgery appear to be more likely to have BDD, highlighting the value of experts who are familiar with BDD's clinical elements. The unclassified dermatoses group had the highest prevalence of BDD symptoms, which were closely connected to psychiatric symptoms and a poor quality of life in our dermatology patients. We will learn more about BDD in dermatological patients *via* studies that include psychiatric interviews to corroborate the diagnosis and symptoms. There is little data on the association between psoriasis and psychiatric illness and quality of life in kids and teenagers. We want to investigate the levels of health related quality of life and depressive and anxiety symptoms in children and adolescents with psoriasis. In this study, 48 outpatients with psoriasis between the ages of 8 and 18 are included. Both the patient and control groups were given the Child Depression Inventory (CDI), State Trait Anxiety Inventories for Children (STAI-C), and Pediatric Quality of Life inventory Parent and Child versions (PedQL-P and C). The Psoriasis Area Severity Index was used to gauge the severity of psoriasis symptoms (PASI). To eliminate the impact of puberty on psychological status, the research and control groups were divided into two age groups: Children (8 years-12 years old) and adolescents (13 years-18 years old). Comparing the children to controls, the mean CDI score was greater, whereas the PedQL-C psychosocial and total scores were lower. The total PedQL-C scores in the child group as well as all PedQL-C scores across the entire sample were negatively impacted by the length of psoriasis. In the adolescent group, the psychosocial and total PedQL-P scores as well as the PedQL-P physical-health scores all revealed a negative connection with psoriasis severity. In children, psoriasis is linked to depression and lower quality of life. Children with psoriasis should have a mental evaluation, and the depressive symptoms they experience should not be disregarded. The incidence of psychiatric disorders among dermatology outpatients is considerable (30%-40%), and the prevalence of psychiatric morbidity is higher among dermatology inpatients than among general medical inpatients. Dermatology patients may have psychiatric symptoms as comorbid conditions from fundamental psychiatric diseases including Body Dysmorphic Disorder (BDD), anxiety, sadness, substance abuse, or schizophrenia or from a psychotic illness such delusional parasitosis. They frequently appear to the dermatologist as dermatitis artifact. Secondary to the distress of having a disfiguring, persistent, frequently relapsing and remitting skin condition like acne, eczema, or psoriasis are anxiety and depression. When patients are anxious, their skin conditions frequently get worse. An attempt at suicide may result from distress in some circumstances. Due to the stigma attached to mental illness and the requirement to see a psychiatrist, it can be challenging for the dermatologist to convince the patient that they need psychiatric help, which further complicates the matter. Whether the patient can be convinced to seek psychiatric or psychological treatment primarily relies on how they perceive their dermatological issues: As a physical disease that just affects them, or as a physical disease that also affects them psychologically. When a patient declines a psychiatric referral, dermatologists are frequently forced to seek psychotropic therapy.

Conclusion

The treating dermatologist must have thorough understanding of prevalent mental diseases, how to diagnose them, and what the best psychopharmacological treatments are in order to effectively assist the patient in this condition. This is essential to maintain continuity of care, trust, and a therapeutic alliance with the patient, and is typically preferred to referring the patient back to the primary care physician or community mental health team because doing so can cause major time delays and compliance issues.

Cite this article: Kim HJ. "Mental Health Issues in Dermatology Patients". Dermatol Case Rep, 2023, 8(5), 1.