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Psychiatric morbidity in pemphigus and psoriasis: A comparative study from India

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ABSTRACT

Aim: This study was designed to examine the prevalence of psychiatric morbidity and its psychosocial and psychopathological correlates in patients with pemphigus in comparison to those with psoriasis.
Materials and methods: Patients with pemphigus ($n = 50$), group matched for demography, with those with psoriasis ($n = 30$), and healthy controls ($n = 30$), were subjected to cross-sectional assessment for duration, severity, and impact of dermatological disorder, attitude to appearance, social support, coping strategies, disability, quality of life, and psychiatric morbidity and diagnosis.
Results: The pemphigus group recorded the psychiatric morbidity rates at 40% by GHQ-12 and 26% by ICD-10; the ICD-10 diagnoses included adjustment disorder (16%), depressive episode (8%), and acute and transient psychosis (2%). This comorbidity was not very different from that of the psoriasis group at 46.7% by GHQ-12 and 36.7% by ICD-10; the ICD-10 diagnoses including adjustment disorder (13.3%), depressive episode (10.0%), alcohol dependence (6.6%), paranoid schizophrenia (3.3%), and delusional disorder plus severe depressive episode with psychotic symptoms (3.3%). The pemphigus group scored higher on disability, despite the dermatological severity and psychosocial profile being similar. Dermatological severity, psychopathology, and certain psychosocial variables were correlated in the pemphigus group, as also in the psoriasis group.
Conclusions: The high psychiatric and psychosocial morbidity in pemphigus and other chronic and severe dermatologic disorders indicates a need for more studies on the psychosocial aspect of these disorders and for sensitization by the dealing physicians with this aspect.

1. Introduction

Chronic and severe dermatological disorders are often associated with psychiatric comorbidity (Mattoo et al., 2005; Bharath et al., 1997; Hughes et al., 1983), personality characteristics (al-Abadie et al., 1994), psychosocial stress (al-Abadie et al., 1994), sexual and psychosocial distress (Porter et al., 1986, 1990), and impaired quality of life (QOL) (Vardy et al., 2002; Gupta and Gupta, 1995). While most of the available psychodermatological research is from Western countries, the research from the developing countries focuses mostly on psoriasis, vitiligo and leprosy (Chaturvedi et al., 2005; Mattoo et al., 2001; Gaekwad et al., 2006; Ahmed et al., 2007).

Pemphigus is a chronic severe autoimmune disorder with genetic and environmental susceptibility factors and a predominantly dermal presentation. Compared to other dermatological disorders, psychodermatological research on pemphigus is relatively sparse, and there are no Indian studies in this area (Aboobaker et al., 2001; Cremniter et al., 1998; Tabolli et al., 2008; Morell-Dubois et al., 2008; Paradisi et al., 2009).

Hence, the present paper aimed to study the psychiatric morbidity associated with pemphigus in India. The objective was to study the prevalence of psychiatric morbidity, and its correlates in terms of specified demographic, clinical, psychosocial, and psychopathological variables.

2. Materials and methods

2.1. Setting

The study was carried out at a multispecialty teaching hospital in north India. As an MD thesis of the first author (VK),

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the study was time bound. This study was approved by the Institute Ethics Committee. All the subjects were recruited on the basis of written informed consent. Only one subject (a 45-year-old female patient with pemphigus) had refused to participate in the study. The data collection was completed between July 2006 and September 2007.

2.2. Sample

The sample consisted of three groups: two inpatient groups from the Dermatology wards diagnosed with pemphigus ($N = 50$) and psoriasis ($N = 30$), and a group of healthy controls ($N = 30$).

While VK, the lead investigator, could not spare time from his daytime work schedule to assess outpatients, he could assess inpatients in the evenings or on weekends/off-work days. Coupled with the time bound nature of the study, this necessitated a small non-consecutive inpatient sample.

This sampling approach influenced the severity of the dermatological cases included. Psoriasis cases were all admitted because of severity. Pemphigus cases were admitted either because of severity or for administering pulse steroid therapy for logistic reasons (time/cost constraints for non-local cases).

The patients selected by the inclusion criteria were of either gender, aged ≥15 years, literate for Hindi language, had a clinical diagnosis with active lesions, and consented to participate in the study.

The healthy controls were recruited from the attendants/relatives of the patients. In view of the planned group-matching, they were selected individually when similar to the patient (not necessarily the same on all parameters) for age, sex, locality and religion, and were free from any major physical or psychiatric illness, as per anamnestic recall.

2.3. Assessment

The cross-sectional assessment was guided by the assumption that as a chronic and severe dermatological disorder pemphigus, like psoriasis, will be associated with psychiatric morbidity which might be related to demographic variables, disease variables (including the severity and the impact of dermatological disorder), and psychosocial variables (attitude to appearance, social support, coping strategies, disability, and QOL).

The instruments used for the assessment of the selected variables were:

1. Demographic Proforma, constructed for this study, was used to record the relevant sociodemographic data – age, sex, marital status, occupation, education, religion, family type and locality.
2. Clinical Proforma, designed for this study, was used to record the following details – duration of illness, type of onset, course, specified precipitating factors, past and family histories of dermatological and psychiatric disorders.
3. Severity Index for Pemphigus (SIP) (Ikeda et al., 2003) rates the variety and severity of pemphigus lesions as follows: total score <5 as mild, 5–7 as moderate and >7 as severe.
4. Psoriasis Area and Severity Index (PASI) (Fredriksson and Petterson, 1978) assesses the percentage of skin area/body parts involved and three target symptoms of erythema, infiltration and scaling with a severity of illness score range of 0–72; 0–3 for mild, 3–15 for moderate, and 15–72 for severe psoriasis.
5. Impact of Skin Disease Scale (IMPACT) (Wessely and Lewis, 1989) is an 8-item self administered scale that scores changes in behaviour after the onset of illness with a possible score range of 0–8.
6. Attitude to Appearance scale (ATT) (Wessely and Lewis, 1989) is a self administered scale that measures attitude to appearance in dermatological patients. The 5-item yes/no responses give a score range of 0–5, a higher score indicating a more perfectionist attitude.

   We employed the Hindi language versions of tools 5 and 6 which were developed and used at our centre earlier for psoriasis and vitiligo cases (Mattoo et al., 2001).
7. Social Support Questionnaire (SSQ) (Nehra et al., 1998) is a reliable measure of perceived social support as an independent, dependent or intervening variable. It is an Indian adaptation in Hindi language, of the Pollack and Harris (1983) scale with 18 items; a higher score indicating more perceived social support.
8. Coping Strategy Check List (CSCL) (Cooper and Faragher, 1992) is a reliable self-administered yes/no checklist of coping strategies used by people to deal with troublesome situations. It covers all stressors and is not disease specific. The 36 strategies yield five factors: denial, internalize, externalize, emotional outlet, and anger. A higher score indicates greater use of coping strategies. The Hindi language translation used had been developed and used in our centre earlier (Sharma et al., 2003).
9. World Health Organization Disability Assessment Schedule-II (WHODAS-II, 2000) assesses the activity limitations experienced by the individual in the past 30 days irrespective of the medical diagnosis. The domains covered are: understanding and communicating, getting around, self care, getting along with people, life activities, and participation in society. Of the three available forms, the interviewer-administered 36-item short-form was used, with score for each item ranging 1–5, and a higher score indicating greater disability.
10. World Health Organization Quality of Life-BREF (WHOQOL-BREF) (Saxena et al., 1998) is a self-administered cross-cultural tool based on WHOQOL-100 (Group WHOQOL, 1993). It profiles the subjective evaluation (rather than the objective functional status) for the past two weeks for four domains – physical health, psychological health, social relationship, and environment. The 26 items give a total score of 26–130, a higher score indicating better QOL.
11. Comprehensive Psychopathological Rating Scale (CPRS) (Asberg et al., 1978) helps the clinician to assess the full range of psychopathology. The 65 items scored 0–3 are explicitly described, and operationally defined on the basis of intensity, frequency and duration of the symptoms. The skin-disease-reactive psychopathology being predominantly in the realm of anxiety and depression, only the two CPRS-derived indices were used: Anxiety Index (AI) with 7 items and Depression Rating Scale (MADRS) with 10 items.
12. General Health Questionnaire-12 items (GHQ-12) is a derivative of GHQ, a 60-item self-administered reliable screening measure for psychological problems (Goldberg and Williams, 1988). The 4-point item ratings are converted into 0 and 1. As a reliable short form (Gautam et al., 1987; Jacob et al., 1997) GHQ-12 has been used at our centre in psychiatric research including for vitiligo and psoriasis (Mattoo et al., 2001). In the present study GHQ-12 was used with the patients and healthy controls, and the psychiatric morbidity was defined by a cut-off score of ≥2, at which the sensitivity and specificity have been reported to be 73.2% and 83.7% respectively (Cano et al., 2001).
13. International Classification of Diseases-10th Revision (ICD-10) (WHO, 1992), Classification of Mental and Behavioural Disorders, Clinical Descriptions and Diagnostic Guidelines was used first to diagnose psychiatric disorders by VK (a trainee psychiatrist), and later to confirm the diagnosis by the second author, a consultant psychiatrist (SKM). The ICD-10 is