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Assess Psychological Status among Skin Disorder Client Attending Skin OPD in Selected Hospital

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Abstract

Introduction: The relationship between skin health and psychological status is multifaceted and significant, as both dermatological conditions and mental health disorders can influence each other. Skin conditions such as acne, eczema, and psoriasis have been shown to contribute to psychological distress, including anxiety, depression, and lower self-esteem. These psychological effects are often linked to the visibility of skin conditions, social stigma, and altered body image. Conversely, mental health issues can exacerbate skin conditions, with stress, anxiety, and depression potentially triggering or worsening conditions like eczema or psoriasis. The bidirectional nature of this relationship emphasizes the importance of integrated care that addresses both dermatological and psychological aspects to improve overall patient well-being, with studies showing that up to 30% of patients presenting to dermatology clinics have comorbid psychiatric diseases. Understanding the psychological impact of skin health is crucial in developing comprehensive treatment approaches that foster both physical and mental healing.

Objectives:

The objectives of this study were:

1. To assess the psychological status among skin disorder client.
2. To find out the association between psychological status among skin disorder client with selected demographic variables.

Methods: This study used a Quantitative research approach to compare the psychological status of skin disorder client. A non-experimental descriptive research design was used.

Results; The findings of the present study indicated regarding psychological status among skin disorder client, the results show that, majority of the skin disorder client had average psychological status. Area wise distribution of Mean is (14.71) and Standard deviation is (4.85) on Assessment of psychological status of skin disorder client shows that majority (60%) of the client had average psychological status, (22%) had poor psychological status and (18%) had good psychological status.

Chi square values are calculated to find out association between psychological status regarding skin disorder client with demographic variables, the finding revealed that there was not significant association between psychological status and socio-demographic variables

like Age, gender, religion, type of family, residential area, occupation, monthly income, marital status, habit and previous psychological status.

Hence the stated Null Hypothesis (H02) was accepted and alternative hypothesis are being rejected.

Conclusion: The finding of present study indicates that psychological status among skin disorder client attending skin OPD in selected hospital, depicting that the majority of person had average psychological status.

Keywords: Assess, psychological status, skin disorder and hospital

Introduction

The skin, the largest organ in the body, is composed of three layers: epidermis, dermis, and hypodermis. It serves as the body's initial barrier against pathogens, UV light, chemicals, and mechanical injury. It also regulates temperature and water release. Skin thickness varies by region and is influenced by the thickness of the epidermal and dermal layers. Hairless skin in the palms and soles of the feet is the thickest due to the presence of the stratum lucidum, an extra layer in the epidermis. Thin skin lacks this extra layer. The back has the thickest skin due to a thick epidermis. The skin's barrier function makes it susceptible to various inflammatory and infectious conditions, as well as wound healing, sensory changes, and cosmesis.[1]

Structure of skin

Epidermis

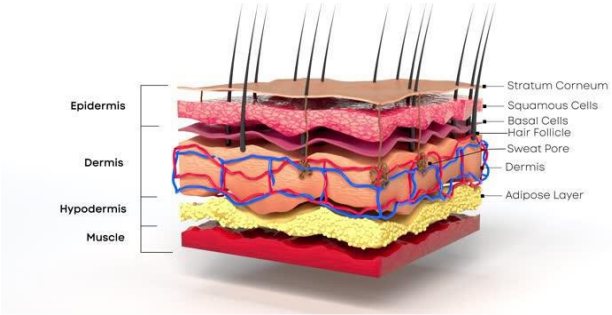
The epidermis is the top layer of skin, divided into four layers: stratum basale, stratum spinosum, stratum granulosum, and stratum corneum. The thick skin on the palms and soles of the feet has an additional layer called stratum lucidum. Keratin, a protein produced by epidermis cells, gives skin its toughness and strength. The epidermis is constantly renewed as dead skin cells are shed daily, and new cells form at the bottom, taking about one month to reach the top layer. Melanocytes, which produce melanin, give skin color, suntans, and freckles.

Dermis

The dermis, the middle layer of skin, is the thickest and most dense, containing nerves, blood vessels, sweat glands, oil glands, and hair follicles. It is divided into the papillary and reticular layers, and is primarily composed of collagen, a protein that makes skin stretchy and strong.

Hypodermis

The hypodermis, or subcutaneous fat, is the deepest layer of skin, primarily composed of fatty tissue, which insulates the body from heat and cold, cushions internal organs, muscles, and bones, and protects against injuries.[2]



Functions of Skin

Barrier function

The skin serves multiple protective roles, shielding the body from external threats such as water loss, microorganism invasion, mechanical and chemical trauma, and UV light damage. The cell envelope creates the epidermal water barrier, a layer of insoluble proteins on the plasma membrane's inner surface, and the lipid envelope, a hydrophobic layer attached to the outer surface. Keratinocytes in the stratum spinosum produce lamellar bodies containing a mixture of glycosphingolipids, phospholipids, and ceramides, secreted through exocytosis.

Immunological defense

The skin plays a crucial role in both adaptive and innate immunity, initiating T-cell responses and producing antibacterial and antifungal peptides. Skin-associated lymphoid tissue prevents infections, and Langerhans cells present foreign antigens to T cells.

Regulation of homeostasis

The skin regulates body temperature and water balance, controlling heat exchange through blood vessels and sweat glands, and managing water evaporation and absorption.

Endocrine and exocrine functions

Keratinocytes produce vitamin D, regulate skin temperature, and protect against sebum production through sweat and sebaceous glands, while the skin's exocrine functions include vitamin D production.

Sensory functions

The skin's sensory functions, including nociceptors, enable the sensation of touch, heat, cold, and pain, facilitating interaction with the environment and facilitating movement.[3]

Psychological Status

The Mini-Mental State Examination (MMSE) is a widely used tool for assessing cognitive disorders, consisting of 20 tests covering 11 domains and 30 points. It has moderate internal consistency and good test-retest reliability, but its diagnostic validity is a concern. The MMSE performs well in rule-out capacity but not as a confirmatory tool for dementia, mild cognitive impairment, or delirium. More extensive neuropsychological and clinical evaluation is recommended for those scoring below the threshold.[4]

Appearance

A patient's age, clothing, personal cleanliness, grooming, and any scars or tattoos are all included in the area of physical appearance during observation. Individuals who seem younger than their claimed age may be dressed inappropriately or have developmental problems. Elderly individuals may suffer from serious illnesses, substance misuse, or poorly managed mental health issues. The patient's past should be taken into account while discussing grooming and cleanliness. In the context of a diagnosed or suspected mental disorder, poor grooming may be a sign of impaired functioning. Scars and tattoos can reveal a patient's sense of style as well as details about their past, character, and behaviours. Scars can provide information about prior suicide attempts, self-harm, or injury. If trust is established, the interviewer can inquire about the significance of tattoos or scars, providing further insights into the patient's narrative.[5]

Behavior

A doctor should watch how a patient behaves during an interview as part of a psychiatric examination. When interacting with the interviewer, they should record if they are cooperative or irritated, as well as whether they are reacting to organic causes, manic behaviour, or internal stimuli. The patient's suitability for the clinical encounter—such as if the patient has a history of hospital stays or visits—should also be taken into account by the physician. If the patient has come with carers, seeing how they behave both around and away from them may reveal interpersonal connection problems. Context is crucial for behavioral evaluation, and if the subjective and objective do not align, the clinician should remain neutral. This approach helps to provide a comprehensive understanding of the patient's condition and potential treatment options.[5]

Motor Activity

A patient's motor activity may be a sign of a neurological or mental condition, therefore it's important to keep an eye on toxicity and side effects. Movement speed can be either normal, psychomotor agitation/hyperkinesia, or

psychomotor retardation/bradykinesia. Psychomotor agitation may be a sign of manic behaviour or acute stimulant impact, whereas psychomotor retardation may be linked to depression or neurocognitive impairments. It is crucial to watch a patient's gait since ataxic, rigid, or shuffling gait might be signs of an underlying neurological issue. A gait evaluation is utilised during a typical neurological examination. Prolonged posture might be a sign of psychotic illnesses' inflexibility, psychomotor immobility, or catatonia. Akathisia, a restless need to move or an inability to remain still, may be a sign of impulsivity or hyperactivity in attention-deficit hyperactivity disorder. Rigidity, tremors, and tics are additional movement-related signs of extrapyramidal antipsychotic side effects. When laryngeal muscles are implicated, severe abrupt stiffness following antipsychotic medication is referred to as an acute dystonic response, which can be fatal. A neurological disorder known as tardive dyskinesia is brought on by prolonged use of antipsychotic medications.[5]

Speech

In a psychiatric interview, verbalisation, fluency, tempo, rhythm, volume, and tone are all taken into account while evaluating speech passively. The speech level of a patient might reveal manic episodes, anxiety, or despair. A patient's first language may not be their first language; fluency refers to a patient's linguistic abilities. Patients who are depressed or impaired may speak slowly, but a pressured speech tempo might be a sign of a manic episode or chemical intoxication. Speech patterns can reveal information about a number of illnesses, including dysarthria and slurred speech. Volume can be lower in depressed or withdrawn patients, or loud in agitated ones, possibly due to neurocognitive disorders or hearing difficulties. The tone of the speech can also indicate a patient's mood, and a child-like tone within isolation could indicate underlying trauma.[5]

Mood

Mood is a patient's subjective description of their feelings, determined by asking them to describe them verbatim, and documented using quotations.[5]

Affect

Clinicians use adjectives like euthymic, joyful, sorrowful, impatient, furious, agitated, confined, muted, flat, wide, odd, full, labile, nervous, brilliant, ecstatic, and euphoric to describe their patients' nonverbal expressions. One way to define the spectrum of symptoms is as mildly annoyed vs very agitated. Affect is a component of an examination and shouldn't be used to make a diagnosis. Because of their impacts, incongruent affects—like those from a medication panel—might be less significant. When evaluating affect, context is essential since it might reveal physical trauma or significant improvements in a patient's circumstances.[5]

Thought process

The term "thought process" describes a patient's structured ideas, which are often linear and goal-oriented. A lack of connection, no train of thought, and pauses in thinking are characteristics of irregular thought processes, including circumstantial, tangential, flight of ideas, loose, perseverance, and thought blockage, which can result in psychosis.[5]

Thought content

The category of thoughts is determined through interview listening, with perseveration-type thought processes being crucial for assessing a patient's preoccupation. Determining suicidal, homicidal, and delusional ideations is essential for assessing thought content.[5]

Perception

Asking patients about their experiences with hallucinations—the impression of something without the

presence of outside stimuli—is one way to gauge their perception. Visual, tactile, gustatory, olfactory, and auditory hallucinations are all possible. Since auditory hallucinations can be either normal or problematic, it is important to distinguish between noises and voices while evaluating them. Enquiring into the appearance and behaviour of visual hallucinations is crucial. For instance, a patient should ask about the look and behaviour of snakes if they report seeing them. It's OK to experience certain visual hallucinations, such as seeing the ghost of a loved one who has passed away. On the other hand, hallucinations that occur when you're sleeping, waking up, or experiencing sleep paralysis are not abnormal and can be regarded as normal.[5]

Cognition

A mental status examination evaluates cognition in areas like alertness, orientation, concentration, memory, and abstract reasoning. If symptoms of a possible neurocognitive disorder are identified, additional evaluation tools like the Mini-Mental State Examination and Montreal Cognitive Assessment can be used.[5]

Alertness

Alertness refers to a patient's level of consciousness, which can be described as alert, somnolent, obtunded, in a stupor, or comatose. Alert means the patient is fully awake and can respond to stimuli, while somnolent means the patient is lethargic or drowsy. Obtunded means mild-to-moderate stimuli may not arouse the patient, and in a stupor, the patient is unresponsive to almost all stimuli. A comatose patient is unresponsive to all stimuli.[5]

Orientation

Orientation is a patient's awareness of their situation and surroundings, assessed by knowing their name, location, and date. Atypical orientation may indicate substance intoxication, primary psychiatric illness, or delirium, which can be easily miscategorized as a primary psychiatric illness.[5]

Concentration

Concentration can be assessed during interviews by observing a patient's focus on questions. Direct testing can be done using various methods, such as tapping their hand when hearing a letter or counting from 100 by 7. Impairment in attention or concentration may be a symptom of anxiety, depression, poor sleep, or a neurocognitive disorder. The clinician can document the patient's performance as poor, limited, fair, or worsening versus improving, and can describe the task and the patient's performance.[5]

Memory

Memory can be categorized into immediate recall, delayed recall, recent memory, and long-term memory. Clinicians can assess these types during evaluation. Immediate recall involves repeating random words or sentences to register new information. Delayed recall requires repeating exact words after a certain time, preventing practice. Recent memory evaluates a patient's ability to recall recent events, such as activities or illness history. Long-term memory assesses a patient's ability to recall distant past events. Impaired recall responses may indicate a neurocognitive disorder requiring further screening. If a patient present with a cognitive complaint, an extensive evaluation should include daily living activities, a neurological examination, and validated instruments like NPI-Q, Functional Activities Questionnaire, GDS, IQCODE, or Memory Impairment Screen.[5]

Abstract reasoning

Abstract reasoning involves a patient's inference of meaning and concepts, often observed in psychiatric disorders, intellectual disabilities, and neurocognitive disorders. Cognitive assessment depth varies depending

on the clinician's location, with primary care requiring long-term evaluations, emergency assessments requiring a few minutes, and intensive care units or behavioral facilities requiring daily evaluations. These assessments are crucial for assessing patients' cognitive abilities.[5]

Judgment

Judgment is a patient's capacity to make smart judgements, frequently tested by their past and behaviours. Poor, restricted, fair, or deteriorating vs improving are some possible ratings. Repetition of errors or medicine refusal might lead to poor judgement. By taking their prescriptions even if they know they may need to return for inpatient treatment, some patients demonstrate sound judgement. The severity of their mental illness is frequently the cause of their poor judgement. A patient's judgement can be contextualised by carers by taking into account elements such as age and assistance with decision-making.[5]

Insight

The category of insight refers to a patient's understanding of their illness and functionality. It can be poor, limited, fair, or worsening. Fair insight is when a patient acknowledges their symptoms are not real, while poor insight is when they don't recognize their paranoia.[5]

Background of Study

Yi-Jie Jia et al: This study investigates the prevalence of anxiety, depression, sleeping problems, cognitive impairment, and suicidal ideation in people with autoimmune skin diseases (ASDs) such as psoriasis and vitiligo. The research involved 114 studies from 37 countries, including 823,975 participants. The estimated pooled prevalence of anxiety was 33.3%, depression was 33.7%, and sleeping problems were 45.0%. Cognitive impairment and suicidal ideation were 30.8% and 21.6%, respectively. The most common mental disorder in patients with systemic lupus erythematosus and psoriasis was sleeping problems, with 55.9% and 39.0% respectively. The study concluded that anxiety, depression, sleeping problems, cognitive impairment, and suicidal ideation were common among patients with ASDs. The most prevalent mental disorder was sleeping problems. The study suggests that those with ASDs may experience significant psychological burdens, and integrated mental health support is necessary for their treatment.[6]

Methodology

This study used a Quantitative research approach to compare the psychological status of skin disorder client. A non-experimental descriptive research design was used. The tool used to collect data is semi structured tool, which consists of following sections.

Section A: consisting of Socio-demographic variables

Socio- demographic data which consist of age, gender, marital status, religion, type of family, residential area, education etc.

Section B: consisting of the psychological status of skin disorder client

Mini mental status examination scale used to assess the psychological status of skin disorder clients.

To determine the content and construct validity, tool was prepared and given to five experts from various field of faculty and its reliability was confirmed with a Split half method was used to test the reliability of tool. In present study reliability score is r = 0.78.

Pilot study will be conducted on 10% samples of main study. This will be undertaken in order to ensure feasibility and predictability of research methodology and tool. Samples will be selected as per selection criteria and this samples will not be included in main study.

Plan for Data Analysis

1. The obtained data will be analyzed by using statistical techniques that is evaluative.

2. Statistics and frequency distribution to compare and find impact of this study inferential statistics will be used to achieve.
3. Chi square technique will be used to find out association between psychological status with their selected demographic variable.

Results

Socio-demographic variables of people; the majority of skin disorder client were age (50%) in the age group 18-25 years. with (58%) have male. Most were (57%) hindus, (70%) belongs to joint family., (58%) were living in urban area, 40%) are be a government sector, (40%) had monthly income 30000 above, (42%) are be a married, 42%) have been taking alcohol, (50%) has been suffer from anxiety. The findings of the present study indicated regarding psychological status among skin disorder client, shows that (60%) of the client had average psychological status, (22%) had poor psychological status and (18%) had good psychological status.

Assess the psychological status;

Table 1: Assess the psychological status among skin disorder client.

Sr. No	Range of Score	Level of psychological status	Frequency	Percentage
1	0-10	Poor	13	22%
2	11-20	Average	36	60%
3	21-30	Good	11	18%

The findings of the present study indicated regarding psychological status among skin disorder client, The results shows that, majority of the skin disorder client had average psychological status. Area wise distribution of Mean is (14.71) and Standard deviation is (4.85) on Assessment of psychological status of skin disorder client shows that majority (60%) of the client had average psychological status, (22%) had poor psychological status and (18%) had good psychological status.

Table 2:

Sr. No	Psychological status	Maximum Score	Mean	Standard Deviation
1	Mini mental status examination	30	14.71	4.85

Area-wise distribution of the assessment of the psychological status of the skin disorder client shows that the maximum score is (30), the mean is (14.71), and the standard deviation is (4.85).

Table 3: To find out the association between psychological status among skin disorder client with selected demographic variables. N=60

Sr. No	Variables	Psychological Status Score			X^2	df	Table valve	Level of significance
		Poor	average	Good				
1	Age							
	18-25	7	16	9	8.45	6	12.59	Not significant
	26-35	1	9	2				
	36-45	4	5	0				
	45 above	3	5	1				
2	Gender							
	Male	7	21	7	0.2	2	5.99	Not significant
	Female	6	15	4				
3	Religion							
	Hindu	7	22	5	7.6	6	12.59	Not significant
	Muslim	1	6	1				
	Christian	3	4	5				
	Other	2	4	0				
4	Type of family							
	Joint	9	27	6	8.19	6	12.59	Not significant
	Nuclear	2	4	2				
	Extended	0	3	3				
	Other	2	2	0				
5	Residential Area							
	Urban	8	19	8	1.4	2	5.99	Not significant
	Rural	5	17	3				
6	Occupation							
	Government	6	14	4	2.6	6	12.59	Not significant
	Private	2	10	4				
	Business	2	8	2				

	Other	3	4	1				
7	**Monthly income**							
	Below 10000	0	6	2	3.38	6	12.59	Not significant
	10-20000	2	8	2				
	20-30000	4	9	3				
	30000 above	7	13	4				
8	**Marital status**							
	Married	7	15	3	9.75	6	12.59	Not significant
	Unmarried	4	10	8				
	Divorced	1	4	0				
	Widow	1	7	0				
9	**Habit**							
	Smoking	3	11	6	3.58	6	12.59	Not significant
	Alcohol	6	16	3				
	Tobacco chewing	3	5	2				
	Other	1	4	0				
10	**Previous psychological disorder**							
	Depression	3	11	1	7.6	6	12.59	Not significant
	Anxiety	7	18	5				
	Phobia	0	4	1				
	Other	3	3	4				

Chi-square values are calculated to find out the association between psychological status regarding skin disorder clients with demographic variables. The finding revealed that there was not a significant association between psychological status and socio-demographic variables like age, gender, religion, type of family, residential area, occupation, monthly income, marital status, habit, and previous psychological status. Hence the stated null hypothesis (H02) was accepted and the alternative hypothesis was rejected.

Discussion

In these test psychological status of skin disorder client. The results shows that, majority of the skin disorder client had average psychological status. Area wise distribution of Mean is (14.71) and Standard deviation is (4.85) on Assessment of psychological status of skin disorder client shows that majority (60%) of the client had average psychological status, (22%) had poor psychological status and (18%) had good psychological status.

Chi square values are calculated to find out association between psychological status regarding skin disorder client with demographic variables, the finding revealed that their was no significant association between psychological status and socio-demographic variables like Age, gender, religion, type of family, residential area, occupation, monthly income, marital status, habit and previous psychological status.

Hence the stated Null Hypothesis (H02) was accepted and alternative hypothesis are being rejected

Conclusion

This study assesses psychological status of skin disorder client in selected OPD of hospital. a descriptive, non-experimental study design was used, with 60 participants selected through non probability convenience sampling technique. Data were collected using demographic questionnaires and mini mental status scale and analyzed through descriptive statistics and chi square tests. Key finding: demographics: the majority of skin disorder client were age (50%) in the age group 18-25 years. with (58%) have male. Most were (57%) hindus, (70%) belongs to joint family., (58%) were living in urban area, 40%) are be a government sector, (40%) had monthly income 30000 above, (42%) are be a married, 42%) have been taking alcohol, (50%) has been suffer from anxiety. The findings of the present study indicated regarding psychological status among skin disorder client, shows that (60%) of the client had average psychological status, (22%) had poor psychological status and (18%) had good psychological status.

Recommendations

Based on the study finding the following recommendations have made for the further study

1. Similar study may be replicated on large samples for wider generalization.
2. Similar study can be conducted in community.
3. Similar study can be conducted through experimental research approach
4. Manuals, information booklets and self-instruction module may be developed in mental health area for general public.

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