

Psychological Differences Between Seborrheic Dermatitis Patients and Healthy Controls

Emirhan Emir¹, Betül Taş², Kader Bahayi³

¹ Haydarpaşa Numune Training and Research Hospital, University of Health Sciences, Istanbul, Turkey

² Dermatology and Venereology, University of Health Sciences, Bağcılar Training and Research Hospital, Istanbul, Turkey

³ Department of Clinical Psychology, Faculty of Humanities and Social Sciences, Okan University, Istanbul, Turkey

Key words: Seborrheic dermatitis, Psychology, Alexithymia

Citation: Emir E, Taş B, Bahayi K. Psychological Differences Between Seborrheic Dermatitis Patients and Healthy Controls. *Dermatol Pract Concept.* 2026;16(1):5880. DOI: <https://doi.org/10.5826/dpc.1601a5880>

Accepted: September 7, 2025; **Published:** January 2026

Copyright: ©2026 Marzola et al. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (BY-NC-4.0), <https://creativecommons.org/licenses/by-nc/4.0/>, which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original authors and source are credited.

Funding: None.

Competing Interests: None.

Authorship: All authors have contributed significantly to this publication.

Corresponding Author: Emirhan Emir, Selimiye mah. Tibbiye cad. no:23 Uskudar, Istanbul, Turkey. ORCID ID: 0000-0002-5607-4039. E-mail: emiremir@stu.okan.edu.tr

Introduction

Seborrheic dermatitis (SD) is associated with significant psychological distress, including elevated anxiety and depression and quality-of-life impairment [1]. Psychological stress is frequently reported by patients as a precipitating factor for flare-ups, with symptom intensity often worsening during stressful periods [2]. While difficulties in emotion regulation have been linked to stress-related inflammatory processes in SD [3], trait anger and anger expression remain understudied, despite evidence from other inflammatory skin diseases suggesting that maladaptive anger expression may exacerbate stress responses [4]. Findings on alexithymia in SD are also inconsistent, with some studies reporting elevated scores and others showing no difference compared with healthy controls [5,6]. To address these gaps, we examined multiple psychological dimensions, including emotion regulation, trait anger, anger expression, alexithymia, depression, and anxiety, in SD patients and healthy controls, aiming to clarify their associations with disease severity and inform integrated care strategies.

Findings

A total of 134 individuals participated, including 67 patients with SD consecutively recruited from the Bağcılar Training and Research Hospital Dermatology Clinic and 67 age- and sex-matched healthy controls. Patients were diagnosed by the same dermatologist, disease severity was assessed with the Seborrheic Dermatitis Area and Severity Index (SDASI), and both groups completed standardized questionnaires assessing anxiety, depression, stress, emotion regulation, trait anger, anger expression, and alexithymia. Groups were comparable in age and sex, but controls had significantly higher educational attainment, which was included as a covariate in subsequent analyses.

Mean disease severity in the patient group was 8.28 (standard deviation (SD)=2.30), with male patients reporting higher severity than females ($P=0.02$). As shown in Table 1, patients with SD reported significantly higher levels of alexithymia, anxiety, expressive suppression, and trait anger compared to controls. The difference in alexithymia remained significant after adjusting for education. Subscale

Table 1. Group comparisons of psychological variables between patients with seborrheic dermatitis and healthy controls.

Variable	Patients M (SD)	Control M (SD)	Test Statistic (df)	p-value	Effect Size
Depression (DASS-21)	5.33 (4.83)	5.12 (4.71)	t(132) = .25	p > .05	—
Anxiety (DASS-21)	6.18 (4.89)	3.77 (4.19)	U = 1484, Z = -3.40	<.001*	r = .29
Stress (DASS-21)	7.22 (5.33)	5.61 (4.45)	t(132) = 1.90	p > .05	—
Expressive suppression (ERQ)	4.07 (1.30)	3.31 (1.46)	t(132) = 3.20	.002*	d = .55
Cognitive reappraisal (ERQ)	4.76 (1.27)	4.64 (1.29)	t(132) = .56	p > .05	—
Trait anger (TA)	2.13 (.76)	1.92 (.45)	t(107.89) = 1.99	.049*	d = .34
Anger-in (AES)	2.05 (.56)	1.99 (.55)	t(132) = .58	p > .05	—
Anger-out (AES)	1.89 (.46)	1.85 (.41)	t(132) = .55	p > .05	—
Anger control (AES)	2.65 (.64)	2.77 (.58)	t(132) = 1.09	p > .05	—
Total alexithymia (TAS-20)	2.88 (.67)	2.42 (.64)	t(132) = 4.05	<.001*	d = .70
DIF (TAS-20)	2.77 (1.02)	2.19 (.93)	t(132) = 3.43	<.001*	d = .59
DDF (TAS-20)	2.77 (.85)	2.42 (.90)	t(132) = 2.32	.02*	d = .40
EOT (TAS-20)	3.04 (.55)	2.62 (.51)	t(132) = 4.59	<.001*	d = .79

Note. Values are presented as mean (SD). DASS-21 = Depression Anxiety Stress Scale; ERQ = Emotion Regulation Questionnaire; TA = trait anger; AES = Anger Expression Scale (subscales: Anger-in, Anger-out, Anger-Control); TAS-20 = Toronto Alexithymia Scale; DIF = Difficulty Identifying Feelings, DDF = Difficulty Describing Feelings, EOT = Externally Oriented Thinking (all TAS-20 subscales). Effect sizes are reported as Cohen's d or r. ns. = non-significant. *P<0.05.

analyses indicated that difficulty identifying feelings (DIF) and externally oriented thinking (EOT) were elevated in patients even after controlling for education, whereas difficulty describing feelings (DDF) did not remain significant. In contrast, no significant group difference was observed for depression, stress, cognitive reappraisal, or anger expression subscales (anger-in, anger-out, anger-control).

Disease severity was positively correlated with several psychological variables, most strongly with anxiety ($\rho=0.49$, $P<0.001$) and trait anger ($r=0.41$, $P<0.001$), with additional associations observed for depression, stress, suppression, alexithymia, anger-in, anger-out, DIF, and DDF. A repeated measures ANOVA on anger expression indicated overall differences between anger-in, anger-out, and anger-control ($P<0.001$), but no significant group effect or interaction, suggesting that the pattern of anger expression did not differ between patients and controls.

Conclusion

SD patients demonstrated significantly higher levels of anxiety, trait anger, expressive suppression, and alexithymia

compared to controls. Among these, anxiety and trait anger showed the strongest associations with disease severity. These findings emphasize the psychological burden of SD and suggest that maladaptive regulation strategies may contribute to symptom exacerbation. Incorporating routine psychological assessment and supportive interventions into dermatological care may improve both clinical outcomes and quality of life for affected patients.

References

- Ozcan Y, Sungur MA, Ozcan BY, Eyup Y, Ozlu E. The Psychosocial Impact of Chronic Facial Dermatoses in Adults. *Dermatol Pract Concept*. 2023;13(1):e2023029. Published 2023 Jan 1. DOI:10.5826/dpc.1301a29. PMID: 36892338
- Misery L, Touboul S, Vinçot C, et al. Stress and seborrheic dermatitis. *Ann Dermatol Venereol*. 2007;134(11):833-837. DOI:10.1016/S0151-9638(07)92826-4. PMID: 18033062
- Ciuluvica C, Amerio P, Fulcheri M. Emotion regulation strategies and quality of life in dermatologic patients. *Procedia-Social and Behavioral Sciences* 127 (2014): 661-665. DOI: 10.1016/j.sbspro.2014.03.331
- Gupta MA, Gupta AK. Psychiatric and psychological comorbidity in patients with dermatologic disorders: epidemiology

- and management. *Am J Clin Dermatol.* 2003;4(12):833-842. DOI:10.2165/00128071-200304120-00003
5. Bozkurt A, Köse O, Karlıdere T, Erdem M, Ak M, Özmenler KN. Seboreik dermatitli hastalarda aleksitimi. *Anadolu Psikiyatri Derg.* 2011;12(1):44-50.
6. Cömert A, Akbaş B, Kılıç EZ, et al. Psychiatric comorbidities and alexithymia in patients with seborrheic dermatitis: a questionnaire study in Turkey. *Am J Clin Dermatol.* 2013;14(4):335-342. DOI:10.1007/s40257-013-0019-7

