

# The Overlooked Burden: Psychodermatologic Needs of Hispanic and Latinx Communities in the United States

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## INTRODUCTION

Hispanic and Latinx communities in the United States face disproportionate psychological burdens from dermatologic disease. Notably, the prevalence of major depression among US Hispanic individuals ranges from 8 to 15%, with an increasing suicide rate over the past decade.<sup>1</sup> Numerous studies investigating the prevalence of psychiatric illnesses resulting from skin disease indicate that Hispanic patients may be more likely to experience psychiatric comorbidities compared to non-Hispanic Whites (NWH), particularly in the context of chronic or stigmatizing skin disorders.<sup>2,3</sup>

For example, according to a retrospective cohort of 502 US adults with chronic urticaria, psychiatric diagnoses were significantly more prevalent among Hispanic patients (15.2%) compared to NWH (8.3%) ( $P < .002$ ).<sup>2</sup> Similarly, a cross-sectional analysis of 1,087 vitiligo patients found that Black and Hispanic patients had significantly higher odds of comorbid depression.<sup>3</sup> Additionally, social determinants of health, such as housing instability and lower socioeconomic status, both more frequently experienced by Hispanic populations, were shown as modulating factors in psychiatric diagnoses associated with dermatologic care utilization.<sup>4,5</sup>

Despite their heightened psychosocial needs, Hispanic and Latinx patients often face systemic barriers to both dermatologic and psychiatric care. According to a report from the Center for American Progress, only one in three Hispanic Americans with mental health concerns receives treatment, compared to one in two NWH.<sup>6</sup> Contributing factors may include language barriers, insurance constraints, and a general lack of referral infrastructure in psychodermatologic care. Moreover, cultural and linguistic challenges—such as limitations in the Spanish translation of self-reported emotional health assessments—can result in underreporting of psychological distress.<sup>7</sup> Miscommunication between patients and providers can also contribute to mistrust in the medical system among Hispanic and Latinx individuals. These disparities may be exacerbated by limited workforce diversity, with only 4.2% of dermatologists identifying as Hispanic.<sup>8</sup> Likewise, access to language-specific education remains limited among dermatology clinics, with shortages of Spanish-language materials and in-person translators.<sup>9</sup>

Without timely intervention, these patients may experience chronic disease exacerbation and diminished quality of life. Additionally, untreated psychiatric comorbidities can impair treatment adherence and perpetuate increased healthcare utilization. These challenges underscore the urgent need for culturally competent psychodermatological care. Implementing tailored screening tools in dermatology practices, increasing funding for underserved hospital programs, and enhancing provider education to improve cross-cultural understanding may facilitate earlier identification and intervention of mental health disorders in at-risk populations. Notably, integrated psychocutaneous care has been shown to improve patient quality of life while simultaneously decreasing healthcare utilization and costs.<sup>10</sup> Therefore, a multidisciplinary approach may be needed to effectively address psychodermatological conditions. Future research should aim to quantify the psychological burden of skin disease in larger Hispanic and Latinx cohorts and to develop community-based models of integrated dermatologic and psychiatric care.

## DISCLOSURES

The authors have no conflicts to disclose.

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