

Selected psychological aspects of psoriasis: case study analysis

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Summary

Aim: The aim of the study was to examine selected psychological aspects of psoriasis. We analysed the following factors: stress (trauma), social stigma, cognitive processes, social support, mood, acceptance of the illness and subjective assessment of life quality.

Method: Two persons took part in the study. They were assessed using the following questionnaires: 6-item scale of social stigma (Polish version), Dermatology Life Quality Index (Polish version) and the General Health Questionnaire (GHQ–28). Qualitative analysis was also performed using the psychobiographical method and overt observation).

Results: The emergence of the disease is closely associated with the experience of stress. The size of the affected skin area influences the level of stigma and lowers self-assessed life quality. With lesser skin lesions, the acceptance of the disease increases. The duration of symptoms affects the acceptance of the disease. Family support helps the patient to think positively. In the female patient, psoriasis did not noticeably affect the quality of cognitive processes. However, in the male patient it caused concentration difficulties. The patient presented an attitude of total non-acceptance of the disease, felt low social support, and his mood and life quality assessment were strongly reduced.

Conclusions: Due to the role of psychological factors in the etiopathogenesis of psoriasis, psychoeducation, as well as individual psychotherapy and system psychotherapy for the patient's family should become an important part of illness management.

psoriasis/psychodermatology/dermatosis/stigma

INTRODUCTION

Many authors state that the appearance and necessity of living with psoriasis as a chronic disease is a source of stress for the patient, and there is a two-way relationship between psoriasis and stress [1]. Stress can trigger the occurrence, recurrence or exacerbation of skin lesions.

In turn, the symptoms themselves can be the source of stress (a vicious circle). One of the best known is the model of “vulnerability – stress”, which refers to the susceptibility to the disease constitutional weakness and stress – a pathological response to an important event. Psychosomatic disorder occurs when the body exhibits physical weakness and when the stress is greater than the capacity of general adaptation [2].

Researches indicate that patients with histrionic and narcissistic disturbances, due to excessive concentration on physical attractiveness, ap-

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proval-seeking and sensitivity to external opinions, have a particular difficulty in adapting to changes in their body. Patients with borderline personality disorder perceive skin changes as a huge threat to their body image and autonomy [2]. Affected women with lower level of acceptance of the disease showed a stronger tendency towards "type A behaviours". Complications are not a differentiating factor for the prevalence of type A behaviour and its elements. Type A behaviour significantly affects patient's functioning and its intensity exacerbates the difficulties with illness acceptance [3].

People with psoriasis scored significantly lower than healthy people in neuropsychological tests assessing two aspects of working memory. They also have a reduced psychomotor speed, worse efficiency control and switching between the two processes, and worse visual working memory [4]. They feel depressed and embarrassed more often than healthy people and describe their mood as negative. Both groups do not differ significantly when it comes to anger and fatigue. Newly diagnosed patients notice a greater impact of the disease on mood, are more embarrassed, tense and depressed. The patient's mood is constantly changing depending on factors such as illness duration and intensity of psoriatic lesions. Women and newly diagnosed people experience negative mood more often than men and patients who have been ill for a long time [5]. Approximately 30% of patients have depressive mood disorders and anxiety disorders [6]. Linking depressive symptoms with the possibility of the emergence of suicidal thoughts may be helpful in identifying patients at increased risk of suicide [7,8].

Stigma occurs when the following interrelated factors coexist: labelling (identifying and naming some of the important social differences), stereotyping (linking social differences to stereotypes), separating "us" from "them" on the basis of established stereotypes (increasing social distance), loss of social status and discrimination (experienced by the stigmatized person). Stigma can affect people with chronic psoriasis whose illness differentiates them from the rest of society. They can face fear and prejudice from other people, reactions often based on misconceptions about "infectivity" of psoriasis. Stigma increases personal suffering and social isolation;

it can create interpersonal problems and hamper access to employment. It may also discourage people from seeking help for fear of rejection. Sometimes, the patient may be the source of negative beliefs about their illness and he may "expect" rejection [9,10].

Understanding the illness helps patients with psoriasis to better control their impulses and emotional tensions. It enhances their resilience to stress. It also helps in adjusting their lifestyle to minimise adverse stressful events and motivates them to a regular use of recommended dermatological therapy. Patients with higher levels of awareness will avoid engaging in behaviours that pose a risk of relapse, i.e. stopping dermatological therapy without consulting with a doctor and exposure to situations that give rise to new emotional tension [11,12].

The support that the patient receives in specially created groups is particularly important for those who often experience rejection by others due to the visible nature of their disease. Patients with skin diseases feel socially isolated and experience problems with interpersonal relationships. Self-help groups are spaces where patients can share their fears and concerns. Researches also show that people who have friends with similar hobbies cope with the disease much better and better assess their health. External appearance affects the quality of interpersonal relations, well-being and mood, lowering or increasing self-assessment and self-esteem [13,14].

The concept of the quality of life is now widely discussed in the medical literature. Related quality of life is sometimes defined as an effect of a disease and its treatment on the patient. Quality of life is also combined with well-being, happiness, contentment and welfare (mental, physical and social). It is stressed that the impact of psoriasis on life quality is strongly related to the psychological and social dimension. Patients believe that psoriasis significantly reduces their happiness and contributes to the feeling that nothing in their lives works out. They feel physically and sexually unattractive during periods of illness exacerbation, they feel embarrassment and shame because of skin lesions. In social situations, patients report work difficulties. In many cases, the disease forces them to take sick leave. Patients feel that psoriasis affects their relationships with other people, causing problems with

partners or friends. It also hinders them from meeting new people. Problems associated with psoriasis impede travelling and holidays. Many patients give up swimming and sunbathing because of their condition. They avoid going to the hairdresser's or doing sports. In extreme cases, patients avoid leaving home altogether. In over 50% of cases the disease affects the type of clothes the patient wears. Approximately 11% of patients do not want to have children for fear of passing on the disease. In addition, psoriasis is associated with financial burden, which increases with increasing severity of the disease [15,16].

It was observed that psoriasis has a negative impact on psychosocial functioning and the presence of psychopathological symptoms. Patients with psoriasis in a better mental state have a greater level of acceptance of the disease, whereas lack of acceptance of the disease causes: increased tension, anxiety, depression, exhausting and obsessive thoughts, feelings of inferiority, unattractiveness in dealing with others, isolation, distancing themselves from their emotions, and anhedonia [17].

The aim of the study was to determine selected psychological aspects of psoriasis. We analysed factors such as stress (life trauma), stigma, cognitive processes, social support, mood, acceptance of the illness and subjective assessment of life quality.

MATERIALS AND METHODS

Two persons took part in the study, a 48-year-old woman and a 23-year-old man. The inclusion criteria were: patients diagnosed with psoriasis, chosen by the Head of Dermatology Department of a specialist hospital in southwestern Poland, expressing written consent to participate in the study and capable of performing psychological tests independently. The exclusion criteria were: lack of informed consent to participate in research and inability to self-complete psychological tests. First, the patients

were asked to fill out three questionnaires, followed by a structured interview combined with direct observation.

The psychobiographical method of qualitative analysis used in the study enables to discover an objective sense – of motives, reasons, aspects – associated psychologically with the problem. The three questionnaires were:

- 1) *6-item scale of social stigma – Polish version*, based on the 6-item scale by Evers & Ginsburg. The questionnaire consist of six statements and the patient is asked to say how often they are exposed to each described situation. Stigma severity ranges from 0 points (no stigma) to 18 points (maximum severe stigmatization).
- (2) *Dermatology Life Quality Index (DLQI), Polish version*. The Polish version of the questionnaire was validated under the guidance of J. Szepietowski. The DLQI is used to assess the impact of dermatological diseases on patient's life quality. It consists of ten questions about the importance of various skin ailments in the person's life. To get a reliable result the patient has to respond to a minimum of seven questions. The total number of points determines the degree of reduction in the quality of life: 0–1 points, normal quality of life; 2–5 points, slightly reduced quality of life; 6–10 points, moderately reduced quality of life; 11–20 points, strongly reduced quality of life; 21–30 points, extremely reduced quality of life.
- (3) *General Health Questionnaire (GHQ–28)* consists of four subscales: somatic symptoms, symptoms of anxiety and insomnia, function disorders and symptoms of depression. It can be considered as a scale of many responses or as a Likert scale with weight assigned to each item, or it can be treated as a dichotomous scale that screens for pathological deviations from the norm. This paper presents the results of the "standard ten" (sten) scale and the Likert scale.

Table 1 shows the structure of the interview.

Table 1. The structure of the interview

Psychological aspect	Research questions
Stress	Do you consider yourself resistant to stress? How do you cope with stress? Do stressful situations affect your mood or health condition? In what way? How often do you feel tension associated with stress? Is the disease itself a source of stress? When is it particularly problematic? What are the symptoms of stressful situations?
Stigma	How does the environment react to your disease? What do you feel because of your ailments in social situations? What do you think other people think when they see your skin lesions? What do you think about these lesions in the context of your relationships with other people? Has the disease ever affected your professional life? In what way?
Social support	Do you have a sense of support from your friends and acquaintances? How do they support you? How does your family refer to your problem that you struggle with every day? Do you participate in a support group? Please tell us about it. How would you define your relationships with others before the disease and now? During skin care (ointment rubbing in hard to reach places), can you rely on the help of others?
Mood	How do you assess your well-being during periods of remission? What kind of mood are you in when skin lesions appear? Do you have periods of irritability? What are the circumstances causing it? Have you had "stupid" thoughts in relation to the disease? Do you feel frustrated, emotionally unstable? In what situations do you feel like this?
Cognitive processes	Do the lesions affect your learning? Have you noticed changes in the memory? What changes? Have you noticed changes in maintaining attention and concentration? What changes? Have you noticed changes in speech? What changes? Have you noticed changes in the language you use? What changes?
Acceptance of the disease	How do you talk about the first appearance of skin lesions? What symptoms accompanied the first skin lesion? How did you cope with them? How often do you see a doctor? Are you happy with its frequency? What do you think is the most problematic about your illness? How do you feel about your experience? Does it cause any barriers, fears?
Assessment of life quality	What is the biggest nuisance of the disease in your opinion? What activities cause you most difficulties due to the illness? What makes you feel better? How do you assess your life satisfaction before the disease and now? Do you experience pain, burning, itching?

RESULTS

Patient 1

Patient 1 was a woman, 48 years old, divorced, with three children, unemployed. She divorced her husband in 2000. They had been married

for 20 years and her husband abused alcohol throughout that period.

The disease first appeared when the patient was 4 years old. She links it with taking penicillin. Since then, she has been treated for psoriasis vulgaris. She recalls how difficult it was for

her to cope with the disease, especially in adolescence. At present, the lesions affect her entire body, except her face. The longest period of remission lasted 10 years. At that time, the patient worked in a butcher's. She links the current rash with her brother's death from pancreatic cancer. She also mentions her mother's disease (shingles), a surgery for the removal of varicose veins and a difficult professional situation (no salary, proceedings in an employment tribunal, currently unemployed). She helps her daughter with childcare and cares for her elderly and ailing mother.

Patient 2

A 23-year-old man, married, one child, miner, professionally active, vocational education. First skin eruption happened 2 years ago, about 3 months into the marriage. Since then, the symptoms have been severe and it has been

hard to achieve remission. He lost his job three times. Each time, he blamed his disease and the fact that his colleagues were wary of his illness. The skin condition also affects his self-esteem. As a husband and head of the family, he wants to provide for his family, but his work problems make that difficult. He believes that his current job affects his skin condition due to high temperatures underground, humidity and dirt. The patient lives with his parents in the same household. His parents criticize him because he is considering changing his job. His wife is helpful and supportive. The biggest nuisance is the itch, which the patient feels mostly at night. It prevents him from deep, peaceful sleep.

Both patients were tested using the three psychometric tests and the results are given in Table 2.

Table 2. The results obtained in psychometric tests

Patient	6-item scale of social stigma	Dermatology Life Quality Index	GHQ-28 Likert scale (sten scores)	GHQ-28 scale GHQ
1	11	18	7	12
2	11	26	9	13

Patient 1

Patient 1 experiences stigma at a medium level, and her life quality is strongly reduced. This is probably due to loneliness, too many responsibilities and the belief that life has dealt her some hard blows. The results of the GHQ-28 test indicate a high risk of psychiatric disorder in the form of somatic symptoms, i.e. itching and relapse after a long period of remission, as well as symptoms of anxiety and insomnia due to the severity of psoriasis. The patient worries about her professional situation, which may also influence the test results.

She comments on the various aspects of psoriasis:

Experiencing stress: "I said: the end of stress, I can manage it, psoriasis, I can handle it."

Stigma: "I avoid it. I don't push myself where... for example, I don't go to the swimming pool or the beach, because I would feel bad and I don't want anybody to feel uncomfortable... I avoid people."

Social support: "My daughter offered to help me because I also need her and she needs me

because of the child. So she said: Mum, you would be with me and (...) I'll put the cream on you... So I know that I have support. (...) [My] children had said that if I needed money, they would help me."

Mood: "Not now, I do not admit any worries into the mind, absolutely. Somehow I have to go on, if it is not this job or [as] a cleaner, my daughter also needs me."

Cognitive processes: "There is no problem, there is no problem. This is so because, for example, if you read something every day, you remember everything. This is how it should be done."

Acceptance of the disease: "It's been many years. I got used to it, but when I saw that I didn't have it, I said: I can finally wear short sleeves. It's a torment, it really destroys the psyche. Because I can manage with it now, but as a child, when I went to school, it was hard..."

Life quality: "I went once on a typing course and I had to give it up, because I had visible red lesions. And as the woman went past me, she

saw them. I felt bad and gave up. Because... you feel embarrassed."

Patient 2

He experiences stigma at a medium level, and his life quality is strongly reduced. Most likely this is because the patient has been ill for a short time, i.e. for 2 years. Continuous failure at work strongly influences his mood and self-esteem. The GHQ-28 test results indicate a high risk of psychiatric disorders in the form of anxiety symptoms and insomnia. It can result from severe stress associated with frustration because of an inability to relieve the symptoms, repeated loss of job, lack of permanent employment contract and conflict with parents. Sleep problems are also associated with intense itching that appears at night. Furthermore, persistent depressed mood, symptoms of anxiety and insomnia may bring about an episode of depression.

The patient comments on the various aspects of psoriasis:

Experiencing stress: "I have noticed that I have larger lesions due to greater stress, when I lose my job, I have to sign a contract with a new employer, when I go in for an interview."

Stigma: "When I go to take a shower at work, others look at me strangely. That's for sure. There is a custom at the mine that after the shift, one worker washes the other worker's back. And sometimes, no one wants to approach me and I have to wash by myself."

Social support: "[My wife] helps me with the cream; unfortunately, I can't reach my back. She got used to the fact that I have this disease."

"My parents are a little strange. Because they worry about my health, they want everything to be OK, but when I want to change my job because it's bad for my health, they say no. They think I can't do it, because my contract has been renewed."

Mood: "I didn't want death, but being away from everything... it happened."

Cognitive processes: "It affects the focus of attention because when I have to do something and focus on it 100%, something stings me, something itches and it annoys me. And it is distracting."

Acceptance of the disease: "I can't stand it no more, it's a problem..."

Life quality: "I lost three jobs and I suppose it happened because of my disease. Certainly

people thought it was infectious, that they may get infected, so they went to the boss. (...) Surely they went to the boss and said he had to do something about it. He fired me because people are scared of such diseases."

"It itches me so much that sometimes I can't sleep, I wake up two or three times at night and I have to get up and rub my lesions. And then I can't get back to sleep..."

DISCUSSION

In both cases, the appearance of the disease is closely associated with the experience of stress. Stressors affect the ongoing disease process, which aggravates the lesions and itching. Both in men and women, the size of the affected area influences the level of stigma. They feel marked, ugly. These feelings directly lower their self-esteem and self-assessment. They are afraid of uncovering their body because of the fear of rejection. At work, they are often faced with rejection and misunderstanding. This leads to social isolation. They avoid public places, do not use the swimming pool, they use clothing to cover up the affected areas. Often the result is depressed mood, lack of acceptance of the disease and lower life quality. The patients consider themselves unattractive and think they can make other people uncomfortable. This is a source of stress and a vicious circle, which aggravates the disease. The larger the lesions, the lower the patient's mood. This can cause reluctance, impotence, sleeping difficulties, and ultimately, it can lead to depression. It should be also taken into consideration that depressed mood may cause deterioration of the skin condition. The sense of stigma affects the illness. On the one hand, patients try to rationalize their suffering in order to accept the disease, and thereby to normalize their mood. On the other hand, the more often they are met with reluctance, the more difficult it is for them not to react with sadness and despondence.

With regard to patient 1, psoriasis does not perceptibly affect the quality of her cognitive processes. She tries not to think negatively at any cost. Support from her family helps her in that. The closest people do not show disgust or fear. This supports her ability to accept the disease and improves her life quality. With lesser skin chang-

es, the level of acceptance of the disease increases. Duration of symptoms also affects the level of acceptance. Considering patient 2, psoriasis affects his concentration due to distracting physical symptoms. He presents an attitude of total non-acceptance of the disease. He feels he has little social support and his mood and life quality are greatly reduced due to the social and physical factors. Due to low support, he has depressed mood and a stronger sense of stigma.

In both cases, life quality is strongly reduced. It is affected by many factors: difficulties in maintaining a clean appearance because of scaling skin, troublesome and time-consuming application of creams in the morning and evening, itching, burn, pain, feeling unattractive, problems in social relations and even avoiding leaving home. Periodic hospital stays also affect life quality, for instance they are associated with absence from work. This situation generates additional stress and reduces life quality. It is connected with worse financial situation and inability of taking any form of treatment. Stigmatization significantly reduces life quality. Patients feel unattractive, limited in how they can spend their free time. They feel pushed to the margins of society.

People with better skin condition accept their disease much more easily. Perhaps this relationship is reciprocal. It is possible that the acceptance of illness and reconciliation with the situation improves the skin condition. People who no longer get sick and have better social support manifest a higher degree of acceptance of the disease. Often an important role is played by rationalization and positive re-evaluation. A greater level of disease acceptance also results from internal approval for the systematic application of medications, more frequent contact with the doctor and recognition of the patient's limitations associated with the disease. People who know how to discover the positives in their situation, or even approach the subject of illness with humour, experience less depressed mood and refer to the stress they experience less often.

CONCLUSIONS

To minimize the impact of psychological factors on the progressive dynamics of psoriasis,

the systematic therapy should be offered to the patient's family, not only to the patient. To eliminate the destructive effects of stress, the patient needs to develop effective strategies for dealing with it. As a way of counteracting the effects of stress, music therapy or art therapy might be indicated. Reducing misconceptions concerning his/her own person resulting from social relationships also appear to be needed. This might strengthen self-esteem and, consequently, increase self-assessment. The patient's family should be advised on the need to give each other mutual support and, if necessary, to change the prevailing patterns, so that no family member assumes the role of a victim, which usually takes the form of psychosomatic illness. In a situation where reactions are multipath, satisfaction and life quality will certainly increase, and it will be easier for patients to accept their illness.

The second important issue is the prevention and information campaigns designed to educate the public about psoriasis, and that the mental factors play an important part in its etiopathogenesis. Many people do not know that psoriasis is not contagious, and such misconceptions give rise to stigma. In order to increase knowledge in this area, talks could be conducted in schools. They might convey basic information about dermatological illnesses where psychological factors play a significant role.

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