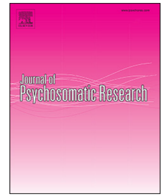
Journal of Psychosomatic Research 114 (2018) 45–49

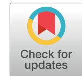
Contents lists available at ScienceDirect

Journal of Psychosomatic Research

journal homepage: www.elsevier.com/locate/jpsychores



Self-esteem is related to anxiety in psoriasis patients: A case control study



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ARTICLE INFO

Keywords:
Anxiety
Psoriasis
Self-esteem
Coping
Coping strategies

ABSTRACT

Objective: In psoriasis, taking steps to improve emotional health is important to bring lasting benefits to patients' physical health and overall well-being. We aimed to identify factors that relate to anxiety in psoriasis and are potentially modifiable and that thus qualify as targets for future planned interventions for improving mental health. In this study, the importance of coping strategies and self-esteem as potential targets were tested.
Methods: A total of 102 patients diagnosed with psoriasis, aged 26–65 years (M = 43.39 years, SD = 10.56) and 98 healthy controls (with an overall age, gender, educational attainment distribution similar to that of the cases) completed the Rosenberg's Self-Esteem Scale, the Coping Inventory for Stressful Situations, and the State-Trait Anxiety Inventory.
Results: Patients with psoriasis compared to healthy controls reported significantly higher rates of anxiety and emotion- and avoidance-oriented coping strategies, presented lower rates of task-oriented coping strategies, and significantly lower levels of self-esteem. Importantly, our results revealed that self-esteem in psoriasis patients was strongly related to anxiety. Moreover, the increased rates of anxiety in psoriasis were not significantly associated with the coping strategies, suggesting that in patients with psoriasis coping strategies are secondary to other factors such as self-image and self-esteem.
Conclusions: The results identify self-esteem as a target to adopt in further interventions for psoriasis patients. Recommendations for future research and intervention development are discussed.

1. Introduction

Psoriasis is a common long-term skin disorder [1,2]. Living with psoriasis may be a challenge for individuals, not only in terms of physical ailments, pain, and skin discomfort, but also in terms of psychological well-being. To date, an extensive literature describes the co-occurrence of psoriasis and anxiety, depression, and suicidal ideation [3–5]. Treatments are often time-consuming, and patients have reported limited effects, moreover, psychological distress and poor mental health is reported as one of the factors exacerbating the disease [4,6–8], reducing treatment effectiveness and adherence to recommended treatment [4,6–11]. Thus, there is a need for tailored evidence-based interventions designed to reduce negative mental health outcomes and improve overall well-being of psoriasis patients.

In this study, we aimed to identify factors associated with anxiety in psoriasis that are potentially modifiable and that thus qualify as targets for future planned interventions. Research on psychological interventions for people with psoriasis has long relied on intuition as a method for determining what targets should be engaged, however, this approach seems to be insufficient [12,13]. Therefore, in the current study, a case-control study design was adopted to extend results from previous studies by identifying specific targets for interventions among psoriasis patients. Building on the theoretical framework of the Cumulative Life Course Impairment (CLCI) [4,11], we tested the importance of key components of the model, such as coping strategies and self-esteem as a global attitude towards the self often altered in psoriasis by stigma.

The concept of burden in psoriasis contains key dimensions contributing to the CLCI [4,11], including inability to cope. Whereas adaptive coping (e.g. seeking information and adhering to treatment regimens) can be beneficial in terms of reducing the burden of the disease [4,14], maladaptive strategies (e.g. avoidance, denial, and alcohol or substance use to alleviate negative emotions) may increase the effect of burden and may have an impact on morbidity [4,11,15]. In the model of human coping with adversity, Endler & Parker [16] distinguished between three basic coping strategies: (1) task-oriented strategies which involve taking problem-solving actions and plans; (2) emotion-oriented strategies which concern thoughts and actions aimed

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https://doi.org/10.1016/j.jpsychores.2018.09.005
Received 1 April 2018; Received in revised form 8 September 2018; Accepted 8 September 2018
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solely at reducing the tension caused by emotional stress; and (3) avoidance-oriented strategies which are described as withdrawal from experiencing and engaging in solving a stressful situation (e.g., seeking distractions, substance use). Previous research has suggested that maladaptive coping strategies such as avoiding being in public, indulging in over-eating, smoking, and alcohol abuse are often among psoriasis patients [4,11]. Coping strategies can be taught explicitly or through modelling and skills training [17], therefore, potential importance of coping strategies was assessed.

The CLCI concept [4,11] also involve patients' self-perception and self-view altered in psoriasis by stigma. Research has suggested [4,11,18–20] that stigmatization associated with psoriasis result in embarrassment and shame, and can negatively affect a patient's self-beliefs and self-evaluation. In the present study, therefore, we also tested the importance of negative/positive self-views. The evaluative component of one's self seems to be potentially modifiable [21–23]. More importantly, with respect to negative beliefs, thoughts, and feelings about self, defusion from self-criticism may be particularly well-suited in which no attempt is made to change the content or frequency of negative thoughts, instead, the focus is on changing how the individual relates to them (decreasing their potency) [24].

Taken together, the current study aimed at: (1) recognizing differences between psoriasis patients and healthy individuals; and (2) identifying factors that are specifically related to anxiety in psoriasis patients. It was hypothesised that having psoriasis would moderate the relationships between: coping strategies and anxiety (H1); and between self-esteem and anxiety (H2).

2. Materials and methods

2.1. Participants and study design

Psoriasis patients and healthy individuals, aged between 24 and 65 years (M = 42.2 years, SD = 10.0), were recruited, 49.5% were female. Of the 200 participants, 102 were patients with diagnosed psoriasis. The second group included 98 healthy controls individuals, balanced on gender, age, educational attainment, etc. (see Table 1). In patients, inclusion criteria were age ≥ 18 years and a diagnosis of psoriasis vulgaris (clinically and/or histopathologically proven). Exclusion criteria were the presence of major diseases of the central nervous system; the presence of specific medical conditions (including other immune-mediated diseases sharing the same physiological mechanism as psoriasis) or current major psychiatric disorders (e.g., schizophrenia, hallucinatory, and delusional phenomena). The same criteria used for the patients were used for the healthy control group, however, excluding individuals with a current or past diagnosis of psoriasis and individuals with a positive family history of psoriasis.

The study was conducted according to the ethical guidelines provided by the Helsinki Declaration and the approval of the local Research Ethics Board. All participants provided informed consent and were requested to complete questionnaires assessing coping strategies, self-esteem, and anxiety.

Table 1
Sociodemographic characteristics of the groups.

	Controls	Patients	t or χ^2 test	p
	(N = 98)	(N = 102)		
Age (years), Mean ± SD	41.0 (9.2)	43.3 (10.6)	1.69	0.09
Gender, n (%)				
Female	52 (53.1)	47 (46.1)	0.97	0.32
Male	46 (46.9)	55 (53.9)		
Education, n (%)				
Technical/vocational	14 (14.3)	12 (11.8)	1.20	0.55
Secondary	27 (27.5)	23 (22.5)		
Higher education	57 (58.2)	67 (65.7)		
Marital status, n (%)				
Single	24 (24.5)	22 (21.6)	2.45	0.65
Married	39 (39.8)	47 (46.1)		
Cohabiting	18 (18.4)	15 (14.7)		
Divorced	15 (15.3)	13 (12.7)		
Widowed	2 (2.0)	5 (4.9)		
Work, n (%)				
Employed	95 (96.9)	93 (91.2)	3.94	0.14
Retired	0 (0.0)	3 (2.9)		
Pensioner	3 (3.1)	6 (5.9)		

Table 2
Differences between groups on anxiety, coping strategies, and self-esteem.

	Controls	Patients			
	M (SD)	M (SD)	t	p	Cohen's d
Anxiety	35.89 (7.47)	56.15 (8.97)	−17.39	< 0.0001	2.45
Task-oriented	61.58 (8.33)	54.12 (8.90)	6.13	< 0.0001	0.90
Emotion-oriented	38.39 (8.85)	59.50 (10.41)	−15.47	< 0.0001	2.18
Avoidance-oriented	39.19 (11.31)	42.14 (8.95)	−2.04	0.040	0.31
Global self-esteem	30.94 (4.07)	22.12 (4.10)	15.26	< 0.0001	2.16

Table 3
The results of a three step hierarchical regression model accounting for anxiety (N = 200).

Variable	Step 1	Step 2	Step 3
Age	−0.06	−0.03	−0.01
Gender	0.04	0.05	0.05
Disease	0.78***	0.47***	0.40***
Task-oriented strategy (TOS)		−0.04	−0.09
Emotion-oriented strategy (EOS)		0.02	0.12
Avoidance-oriented strategy (AOS)		0.00	−0.05
Self-esteem		−0.38***	−0.35***
Disease x TOS			0.08
Disease x EOS			−0.10*
Disease x AOS			0.08
Disease x Self-esteem			−0.09*
F	101.53***	57.58***	40.10***
$F\Delta R^2$	101.53***	10.32***	3.68**
R^2 (adj. R^2)	0.61 (0.60)	0.68 (0.67)	0.70 (0.68)
ΔR^2	0.61	0.07	0.02

*** $p < .001$.
** $p < .01$.
* $p < .05$.

2.2. Measures

State-Trait Anxiety Inventory (STAI) [25]. The S-Anxiety subscale from the STAI was used to assess state anxiety. The STAI is among the most widely researched and widely used measures of anxiety and has been reported to have good psychometric properties [25–27].

Coping Inventory for Stressful Situations (CISS) [16]. The CISS is a 48-item instrument to measure three basic coping strategies: Task-Oriented, Emotion-Oriented, and Avoidance. The CISS is widely used and has been reported to have good psychometric properties [16,28,29].

Rosenberg's Self-Esteem Scale (RSES) [30]. The RSES is a 10-item well-validated scale of global self-worth measuring both positive and negative feelings and beliefs about the self. The scale has shown good internal consistency, stability, and construct validity [30,31].

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