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Psychologic Factors in Psoriasis: Consequences, Mechanisms, and Interventions

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A comprehensive review by Ginsburg [1] addressed psychologic and psychophysiologic aspects of psoriasis. Psoriasis does not have to be visible to other people for the patient to fear and anticipate their censure, and it does not need to be objectively severe to warrant significant disability and distress. A substantial proportion of patients with psoriasis live with the condition as a source of significant psychologic stress. In addition, the belief that such psychologic stress affects the course of the condition tends to have common currency in the experience of patients [2–7]. Although clinical researchers have addressed the first statement with perhaps a keener focus than the latter, researchers have made some increasingly comprehensive attempts to provide at least the beginnings of a focus of investigation into the effects of elements of stress or distress on the expression of psoriasis and on the nature of psychologically informed interventions to combat such negative outcomes. This article reviews the research evidence from 1995 to January 2005 about psychologic factors in psoriasis. The English-language research literature concerning psychologic aspects of psoriasis published since 1995 was identified through searches of Medline, Psychlit, and Cinahl and through hand searching relevant medical and psychologic journals. To be included in this review, articles had to be empirical investigations addressing psychosocial issues in patients with psoriasis. Articles were not included if they were reviews or case studies or if the object of the study was the development of a measure without additional data. This process yielded 121 empirical articles in three broad areas. These three areas are reviewed, followed by an examination of the impact of the condition on patients' psychologic functioning and quality of life. Next this article addresses the link between stress and psoriasis and examines proposed mechanisms. Studies of psychologic interventions for psoriasis are reviewed. Finally, future directions for research that have potential for informing clinical practice are examined.

Consequences

Generally accepted estimates of the prevalence of psoriasis are 2% to 3% of the population [8]. Research has shown that psoriasis has the potential for significant psychologic and social morbidity [1,9–12]; although estimates vary, generally about one in four patients experiences significant psychologic distress [11]. Dermatologists' ability to identify clinically relevant distress in their patients has been shown to be unsatisfactory [10]. Richards and colleagues [13] reported that only 39% of patients

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who had psoriasis with clinically relevant distress were identified correctly by dermatologists. When physicians did identify patients as clinically distressed (anxiety or depression), further action to address such difficulties through referral to appropriate specialists was taken in only one third of cases [13], despite the potential effects of distress on adherence to treatment [14,15] and the effectiveness of treatment [16]. This study is commensurate with the suggestion [17] that for many skin conditions dermatologists may not have an accurate perception of the extent of psychiatric morbidity.

A range of deleterious phenomena has been reported in research studies charting the psychology of the psoriasis patient. In the main, researchers have tended to investigate the impact of this condition in terms of diminution in quality of life and magnification of disability. Such psychologic and social sequelae are complex phenomena, however, and studies reviewed here suggest that the psychologic impact may not be simply reducible to the severity, extent, or duration of disease.

Psychologic impact on patients

Disability and quality of life

The consequences of psoriasis on patients' quality of life have been well documented, and there is general consensus among research studies that objective clinical severity is insufficient as an assessment of the burden of disease [8,18–29]. One study suggests that simply being diagnosed with the condition can carry significant emotional consequences for patients [30], whereas another found psoriasis patients to have better health status than a comparison group of patients with atopic dermatitis [31]. Generally the impact of psoriasis appears comparable with other major diseases, however, and patients with psoriasis have been shown to experience decrements in their quality of life comparable to that found in patients with chronic diseases such as cancer and heart disease [32], to score significantly lower on quality of life measures and disability than healthy controls [33–36], and to be willing to incur significant costs for a cure [9,37,38].

Most studies undertaken in relation to disability have considered hospital-based rather than community-based patients with psoriasis. Community-based studies have shown, however, a high extent of disability in patients [39]. In one of relatively few community-based studies [40], the level of disability in the community sample was only slightly lower than that in hospital-based studies. This finding suggests that the use of hospital-based samples may not overinflate the level of disability experienced by individuals with psoriasis.

Predictors of disability and quality of life. Clinical variables have been shown to have a direct impact on disability. de Jong and colleagues [41] reported that nail involvement contributed to restrictions in daily activities in almost two thirds of individuals. Patients with palmoplantar pustulosis reported significantly greater disability and physical discomfort, but not more psychologic distress, than patients without palmoplantar involvement [42]. Patients with an additional diagnosis of arthritis show greater impairment in quality of life than patients without arthritis [43], although the relationship between clinical severity of psoriasis and health status tends to be greater for younger patients [44]. Older patients [29,45] and patients in a stable relationship [29,46] tend to report less impairment in quality of life. The effects of gender are less clear, with some studies reporting that women experience greater impairment than men [47,48], and other studies reporting no significant differences [25,46].

Studies have suggested that disability or quality of life improves as a result of treatment for psoriasis [48–51]. Although statistically significant, the improvements tend to be modest and, in general, physical clearance of psoriasis by more than 50% needs to occur before meaningful change in quality of life is reported [52]. The results of these studies suggest no clear relationship between quality of life and clinical features of the disease. One study indicated that after successful treatment of psoriasis by psoralen and ultraviolet A radiation photochemotherapy (PUVA), levels of psoriasis-specific disability and life stress improved, but more general levels of distress (anxiety and depression) did not change significantly from baseline [53]. Gupta and colleagues [54] suggested that almost one fifth of patients' disability scores remain stable or worsen despite improvement or clearance of psoriasis.

Two studies [34,55] found that perception of stigmatization was the principal predictor of disability in patients with psoriasis. Similar results of the effects of patients' responses to stigma were reported by Hill and Kennedy [56], who found that anticipatory and avoidance coping behaviors used by patients to deal with the stigma of psoriasis and venting emotions were associated significantly with disability. This study is concordant with the finding of Fortune and colleagues [20,57] that disability is best accounted for by anticipatory and avoidant coping behavior and experiences of rejection. These results illustrate that