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Review Article

From skin to mind: the psychological consequences of psoriasis severity and approaches to coping

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ABSTRACT

Psoriasis is a chronic, systemic, inflammatory skin condition that causes red, scaly, and pruritic lesions. Psoriasis can be detrimental to both physical and mental health. The worsening of psoriasis is caused by mental stress, especially depression and anxiety. Approximately 34% of patients with psoriasis exhibit signs of anxiety. Symptoms of anxiety are present in about 34% of patients with psoriasis. Studies reveal that 15% of patients meet the diagnosis for social anxiety disorder, 11% for generalized anxiety disorder, and 9% for unspecified anxiety disorder. Higher rates of depression and anxiety are observed among patients with severe psoriasis compared to those with less severe psoriasis. Psychosocial distress and higher levels of anxiety and depression scores are noted in women and younger patients. The Salford psoriasis index (SPI) and dermatology quality of life index (DQL) are good measures to evaluate the severity of the disease and quality of life (QoL), respectively. Both these indices confirm an inverse relationship between the severity of psoriasis and a decrease in mental health. Psoriasis requires a multidisciplinary plan to treat both psoriasis and the associated mental health conditions. There is evidence-based data for the effectiveness of cognitive-behavioral therapy (CBT) and mindfulness-based therapies in the treatment of psoriasis patients. Having a comprehensive treatment approach to treat psoriasis and mental illness simultaneously may lead to improved patient outcomes and QoL.

Keywords: Psoriasis, Psychological distress, Anxiety, Depression, Quality of life, Cognitive behavioral therapy, Mindfulness-based therapy, Interdisciplinary approach, Salford psoriasis index, Dermatology quality of life index

INTRODUCTION

Psoriasis is a chronic dermatological disease significantly affecting the lives of patients, including physical and psychological aspects. Its pathogenesis is complex, with genetic, environmental, and immunological components. Psoriasis affects about 2-3% of the global population.[1] Although commonly appearing as a skin disease based on red, pruritic, scaly lesions, much of it lies beneath the surface-level appearance.[2]

Psoriasis has been associated with psychosocial effects, psychological morbidity, and a critical reduction in QoL. It can affect interpersonal relationships, personal identity,

and daily life.[3-5] The noticeable skin lesions and long-lasting nature of psoriasis may lead to psychological effects, including social stigma, emotional turmoil, and disruptions in daily activities, spanning social, and work-related aspects.[6,7] Cultural factors such as age, lifestyle, and gender can also influence psychological implications of psoriasis.[6,8,9] Coping with psoriasis frequently involves managing persistent discomfort and feelings of self-consciousness, which can impact mental health and general well-being.[10-12]

Previous research indicates a high level of anxiety among those with psoriasis. For e.g., systematic review and meta-analysis by Jalenques et al found 34% of psoriasis patients reported experiencing anxiety symptoms. Study identified that 15% of patients had social anxiety disorder, 11% suffered from the generalized anxiety disorder and 9% experienced unspecified anxiety disorder.[5]

Research into the relationship between stress and the aggravation of psoriasis indicate that experiences of stress, lack of adequate social support, and avoidance behaviors may contribute to the precipitation of flare-ups, especially in some clinical variants such as diffuse plaque psoriasis.[6,7,12] Remröd et al reports that psoriasis patients who linked their psychological distress to flare-ups, termed "stress reactors," displayed considerably higher levels of state and trait anxiety, depression, and somatic anxiety compared to non-stress reactors.[13] Another study by Homayoon et al showed that increased feelings of “skin shame” correlated with a greater disease burden and reduced QoL in psoriasis patients.[14]

Effective management of psoriasis requires an interdisciplinary approach between dermatologists, psychologists, and other healthcare professionals to mitigate the burden of psoriasis and its psychological comorbidities.[10]

LITERATURE SEARCH

A review of the literature in PubMed and Embase was conducted to include appropriate studies between May 1985 and September 2024. Keywords used in the search were: “psoriasis” OR “dermatology” OR “psychiatry” OR “anxiety” OR “depression” OR “stress” OR “mental illness” OR “treatment” OR “interdisciplinary approach” OR “disease modification” OR “cognitive behavioral therapy” OR “mindfulness-based therapy” OR “lifestyle changes” OR “stigma” OR “age” OR “gender” OR “attitude”. The articles were manually screened by independent reviewers. Reference lists of relevant were publications manually extracted for the related publications.

PSYCHOLOGICAL COMORBIDITIES

While the physical challenges of the disease are often visible, it can lead to immense psychological pressures.[15,16] The presence of psoriasis increases the likelihood of experiencing stress, anxiety, and depressive symptoms due to factors such as the visibility of the disease, its chronic nature, and social stigmatization.[17] Research repeatedly demonstrates that those with severe psoriasis are more prone than those with milder forms to report anxiety and depression. For instance, a cohort study by Kurd et al compared the diagnosis of anxiety, depression, and suicidality among psoriasis patients, which showed increased attributable risk of depression per 1000 person-years for patients with severe psoriasis as compared with patients with mild psoriasis.[18]

In a systematic review by Luna et al a significant association between psoriasis and depression was noted, with the prevalence of depressive symptoms among psoriasis patients ranging from 0.2% to 74.6%, and the incidence between 4.83 and 91.9 per 1,000 person-years.[15] Another cross-sectional study of 219 psoriasis patients reported that increased psychological distress indicated the chance of depression four-fold (OR=4.17, 95% CI=1.79-9.71; $p<0.001$).[19]

Decreased self-esteem, negative body image, and reduced QoL are common psychosocial comorbidities reported in patients with a diagnosis of psoriasis.[20,21] A cross-sectional study by Costeris et al examined the impact of skin conditions, such as psoriasis, on self-esteem and perceived social support. The study had a sample size of 162 adults between the ages of 18 and 35 years, and used the Rosenberg self-esteem scale and the interpersonal support evaluation list (ISEL-40) to measure self-esteem and perceived social support.[21] Results indicated that psoriasis patients had significantly lower perceived social support scores (M=106.17, SD=14.21) than the control group (M=138.54, SD=10.77) before and after dermatological treatment ($p<0.001$).[21] After treatment, perceived social support decreased to 103.52 (SD=13.64) for patients with psoriasis and to 133.89 (SD=10.54) for the control group. However, self-esteem levels did not show significant changes post-treatment, remaining at 24.81 (SD=1.79) before treatment and 24.87 (SD=2.09) after treatment for psoriasis patients ($p>0.05$).[21] The study thereby highlights the importance of psychosocial support for people with psoriasis, aimed at minimizing its chronic social and emotional consequences.

For young women, sociocultural standards of beauty may also be an added source of anxiety because of the perceived pressure to measure up to these standards.[24] In a cross-sectional study by Wojtyna et al., women reported more psychosocial effects of psoriasis than men, which affected both their mental health and their self-esteem. Depressive symptoms and distress were significantly higher ($p<0.001$, $t=3.49$) in women (M=16.48, SD=12.11) than in men (M=11.18, SD=9.68). This data shows that beliefs about the appearance of psoriatic lesions can lead to less self-worth, greater psychological distress, and lower levels of perceived social support for women.[25]

Cultural factors and societal stigma may greatly increase the anxiety level of young adults with anxiety disorders.[26,27] A systematic review by Curcio and Corboy examined data from 18 studies involving 17,066 participants and found that younger age and rural residence are significant correlates of public stigma, while gender and cultural differences were found as influential factors in personal stigma.[26] Additionally, the observational study by Remröd et al showed that 101 younger psoriasis patients (age<20 years) had higher state and trait anxiety than psoriasis patients with a later onset (age≥20 years). The state-trait anxiety inventory (STAI) and the beck depression inventory II (BDI-II) were used to assess anxiety and depressive symptoms, respectively, in patients with early and late onset psoriasis. Younger patients exhibited higher levels of anxiety and depression.[13]

Matthewman et al identified a significant association between psoriasis and an elevated likelihood of both anxiety and depression.[28] Their research, which compared associations within the UK Biobank and linked primary care data, demonstrated that psoriasis was correlated with an increased risk for anxiety and depression.

In many instances, patients with psoriasis tend to avoid going out in public and getting involved with other people because they fear negative reactions. A cross-sectional study done in India showed that 28% of psoriasis patients participated minimally in domestic and social life.[29] Other common comorbidities include hypersensitivity to social cues, the perception of being judged, and problems establishing new relationships and maintaining existing ones.[6] For instance, Lim et al performed a systematic review to evaluate the psychosocial characteristics of patients with psoriasis and found that these patients frequently develop several psychiatric comorbid disorders. Studies showed that patients with a diagnosis of psoriasis generally have difficulties in identifying and expressing their emotions, have reduced body awareness, and have predispositions to negative emotional states and social inhibition.[30]

TREATMENT

The psychological impact of psoriasis should be treated as an integral part of whole management strategies, including potentially psychological interventions like CBT and mindfulness-based therapy (MBT) to increase QoL.[31]

For young adults with psoriasis, CBT has demonstrated encouraging outcomes in lowering anxiety and enhancing well-being. CBT modifies negative thought patterns, improves coping mechanisms, and encourages adaptive actions, all of which support a more optimistic attitude. A meta-analysis by Wei et al established that psychological interventions have a significant improvement on anxiety symptoms in psoriasis patients.[32] Research indicates that even just 6 weeks of CBT sessions, when combined with standard treatment, leads to substantial improvements in the severity of skin conditions, and reductions in anxiety, depression, stress, and disability. These benefits can persist over time, as one study found that 64% of patients receiving CBT in addition to standard therapies experienced a 75% improvement in their psoriasis, compared with only 23% in the control group.[32,33]

MBT appears to be promising in alleviating the psychosocial burden of psoriasis by relieving patients from stress and hence improving their mental health. A randomized controlled study by Francis et al showed 125 participants with anxiety symptoms undergoing MBT. The baseline DASS-21 scores were 47.12±2.15 and after 8 weeks' course of MBT; the DASS-21 scores showed significant reduction to 37.95±3.13 ($p<0.0001$), indicating decreased anxiety after MBT.[34]

QOL QUESTIONNAIRES

The relationship between SPI and DQL scores is a topic of great interest in the realms of psoriasis research and clinical practice. The SPI is used to assess the severity of psoriasis, and examines the extent of skin involvement, intensity of erythema, presence of scaling, and thickness of the dermis. The DQL is another validated tool that measures psoriasis severity and patients' general well-being. Figure 1 presents the areas analyzed of SPI and DQL indices.

Quality of Life Indices	Specificity	Areas Analyzed
Salford Psoriasis Index (SPI)	Disease specific	Extent of skin involvement Degree of erythema (redness) Presence of scaling Level of induration (thickness)
Dermatology Life Quality Index (DQL)	Dermatology specific	Emotional equilibrium Social functionality

Figure 1: Psoriasis, QoL questionnaires in psoriasis prompt physicians to consider psychological interventions for patients with psoriasis.

This index studies physiological symptoms, psychological well being, and social functioning. The DQL analyzes physical pain, emotional distress, and social functioning. DQL scores highlight the connection that psoriasis has with daily activities, self-confidence, and relationships with others. Studies have displayed a positive correlation between the severity of psoriasis, as assessed by the SPI, and DQL scores.[35] In general, an increase in the clinical severity of psoriasis results in a decrease in patients' QoL. This signifies the importance of considering both the visible signs of psoriasis and the overall impact of the disease; however, this trend is not completely linear.

Personal coping strategies, social support, and innate psychological resilience are examples that can affect how an individual experiences and manages their psoriasis.[35] Two patients with similar SPIs may report different DQL scores based on their individual life situations and support systems. These evaluation metrics have revealed a link between the severity of psoriasis symptoms assessed through clinical scoring systems like the SPI and how the disease impacts patients' QoL, as shown by DQL scores. The clinical severity of psoriasis was positively correlated with adverse effects on QoL.[36] This relationship is neither stable nor absolute. Individuals are unique in their coping strategies, presence or absence of social support systems, and innate psychological resilience. These differences will be present in the way the patient perceives psoriasis in daily life, influencing QoL. An insight into both the SPI and the DQL scores would help in making comprehensive care in psoriasis patients by clinicians more successful. With objective clinical severity indicators and subjective experiences expressed in QoL assessments, healthcare professionals can develop comprehensive treatment plans.

Healthcare professionals can improve patient engagement and compliance with treatment plans in a holistic manner, which could lead to better patient outcomes and higher overall well-being. An increase in QoL indicators should encourage physicians to consider potential psychological intervention benefits for patients.

INTERDISCIPLINARY APPROACH

Effective management of psoriasis requires a collaborative effort between dermatologists, psychologists, and other healthcare professionals. While dermatologists diagnose and treat the physical symptoms of psoriasis using different medical therapies to control skin lesions, the psychological burden of the disease in terms of anxiety, depression, and reduced QoL requires the intervention of mental health professionals.[10,31] Up to 40% of patients with psoriasis report clinical anxiety, and about 12% experience clinical depression based on self-report questionnaires.[8] Psychologists provide support through interventions, including CBT and MBT, which increase well-being.[37]

Evidence supports this interdisciplinary approach. For example, Schmitt et al demonstrated an interdisciplinary treatment program resulting in a mean±SD DQL change of 10.5±9.9 compared with 7.5±7.3 seen with dermatologic treatment alone. Results from patients in the interdisciplinary treatment group with psychiatric comorbidities showed they had a significantly better DQL response (DQL change 14.8±9.7) than individuals who received only dermatologic care (p=0.03).[38]

In general, interdisciplinary collaboration between dermatologists, psychologists, and other healthcare professionals is important for the effective management of psoriasis. This will ensure that treatment is holistic in approach, dealing with both the physical and psychological components, enhancing patient engagement, compliance, and the overall health outcomes.

CONCLUSION

Psoriasis significantly impacts the psychosocial well-being of patients, increasing the development of anxiety and depression. The severity of psoriasis relates to more frequent episodes of anxiety and depression, particularly in young adults at critical stages of development. Societal norms of beauty are more burdensome for women, increasing the psychosocial impact and stigma associated with these conditions, worsening their mental health problems. Patients with early onset psoriasis experience more anxiety and depression. CBT and MBT have been shown to be effective in anxiety treatments and improvement in mental health outcomes. The interdisciplinary approach brings dermatological and psychological care together to target the physical and mental aspects, enhancing the patient's engagement and well-being.

The DQL is a measurement for analyzing and comprehending the impact psoriasis has on overall QoL. It is used to assess physical pain, emotional distress, and social functioning to emphasize the connection between psoriasis and everyday activities. Studies have displayed a positive correlation between psoriasis severity and DQL scores. This correlation is not linear because personal coping strategies, social support, and psychological resilience can affect an individual's experience and management of the disease. Understanding both the SPI and DQL scores can help healthcare professionals develop comprehensive treatment plans, increase patient engagement, and improve health.

Subsequent investigations should concentrate on more detailed comprehension of the biological and psychological mechanisms linking psoriasis with anxiety, in particular, with examination of the contributions by inflammatory cytokines and neuroinflammation to both disorders. It is equally indispensable that future studies investigate the impact of comorbidities-most notably, cardiovascular diseases, metabolic syndrome, and obesity-to develop treatment approaches. Proactive approaches, such as stress management techniques, clinical practices, and comprehensive support systems, may help to prevent and manage psoriasis-related anxiety. The integration of psychological treatments with medical therapies will enable healthcare providers to offer holistic care, which would greatly improve both physical and mental health outcomes for those affected by psoriasis.

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