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CLINICAL AND PSYCHOLOGICAL CHARACTERISTICS OF PATIENTS WITH PSORIASIS

Sophiko Liluashvili, Tina Kituashvili

Iv. Javakhishvili Tbilisi State University,
D. Tvildiani Medical University;
National Research Center of Dermatology and Venereology,
Tbilisi, Georgia

Psoriasis is a chronic, inflammatory and relapsing psycho-dermatological condition. Psychological factors can trigger and/or exacerbate skin lesions. The disease can be a source of stress and can worsen patients' Quality of Life (QOL). Additionally, coping with psoriasis can create stress. This can become a vicious cycle. In recent studies researchers pay attention to correlation between medical and psychological variables in a psoriasis patient group and compare different dimensions of coping in psoriasis patients depending on the development of severity of psoriasis. The severity of psoriasis asses by the Psoriasis Area and Severity Index (PASI), quality of life by the Dermatology Life Quality Index (DLQI) and the COPE questionnaire for assessment of coping strategies. Knowledge of the relationship between coping and Quality of life dimensions is important in terms of establishment and implementation of appropriate medical and psychological interventions for patients with psoriasis.

Key words: *psoriasis, PASI, quality of life, coping*.

Address for correspondence: *Dr Tina Kituashvili*
National Research Center of Dermatology and Venereology, Tbilisi, Georgia
E-mail: tina.kitushvili@yahoo.com

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Psoriasis is a common, chronic, inflammatory disease, characterized by scaly, erythematous papules and plaques. Nails and joints may be affected. Prevalence varies in different ethnic groups. It affects around 2% of the general population with heterogenous global distribution. The reported prevalence of psoriasis in countries ranges between 0.09% and 11.43%, making psoriasis a serious global problem with at least of 100 million individuals affected worldwide [1]. In the United States psoriasis remains a common, immune-mediated disease, affecting 7.5 million adults [2]. Psoriasis is associated with serious comorbidities, such as cardiovascular disease, metabolic syndrome, depression and psoriatic arthritis [3]. People with psoriasis and psoriatic arthritis are at an elevated risk of developing other chronic and serious health conditions, also known as "comorbidities".

Psoriasis can present at any age and has been reported at birth and in older people of advanced age. Psoriasis has multifactorial etiology including genetic and non-genetic factors, such as drugs, smoking, drinking, diet, infections and mental stress [4]. Now, the role of the interaction between environmental factors and genetics are considered to be a main factor in the pathogenesis of psoriasis [5].

Stress is a common trigger for a psoriasis flare. At the same time, psoriasis flare can cause stress. According to the National Psoriasis Foundation's Mental Health Issue Brief, psoriasis is independently associated with stress-related disorders, such as post-traumatic stress disorder. Women, in particular, seem particularly vulnerable to stress due to psoriasis [6].

There are several types of psoriasis: plaque, guttate, inverse, pustular and erythrodermic [7]. Psoriasis vulgaris (also known as plaque-like psoriasis) is the most common form and affects 85–90% of people with psoriasis. There are many clinical features of psoriasis which is characterized different clinical appearances from a few psoriatic papules to widespread eruptions such as thick scaly, erythematous plaques, papules, or patches that may be painful and itchy, also psoriatic erythroderma, that involves inflammation and exfoliation of the skin over most of the body, and Zumbusch variant of pustular psoriasis, which is accompanied by fever and in addition to the widespread sterile pustules. They may be cause of physical disability and can be fatal due to extreme inflammation and exfoliation. Additional types of psoriasis are nail psoriasis and psoriatic arthritis with stiffness, pain, and progressive joint damage. A diagnosis of psoriasis is usually based on the appearance of the skin.

While no cure is available for psoriasis, many treatment options exist. Topical agents are typically used for mild disease, phototherapy for moderate disease, and systemic agents for severe disease [8]. Scientists continue to study the complex relationship between the immune system and psoriatic disease. Some psoriasis treatments have demonstrated improvements in symptoms of psoriasis as well as in measures of depression and health-related quality of life.

There is no consensus about how to classify the severity of psoriasis. Mild psoriasis has been defined as a percentage of body surface area (BSA)≤10, Psoriasis Area Severity Index (PASI) score ≤10, and a dermatology life quality index (DLQI) score ≤10. Moderate to severe psoriasis was defined by the same group as BSA>10 or PASI score>10 and a DLQI score>10 [9].

Multiple metrics evaluate the efficacy of psoriasis treatment, especially PASI (Psoriasis Area and Severity Index) [10], which is the most widely used tool to assess psoriasis severity in clinical trials, although it can be exceedingly cumbersome for use in daily clinical practice [11]. PASI reflecting not only the body surface area, but also erythema, induration and scaling [12]. Because the PASI is better validated and more detailed, it remains the score of choice for clinical trials [13]. The body is divided into four sections head (H) (10% of a person's skin); arms (A) (20%); trunk (T) (30%); legs (L) (40%). Each of these areas is scored independently, and then the four scores are combined into the final PASI. Within each area, the severity is estimated by three clinical signs: erythema (redness), induration (thickness) and desquamation (scaling). Severity parameters are measured on a scale of 0 to 4, from none to maximum. The psoriasis area severity index (PASI), which is often used for clinical evaluation, and the dermatology life quality index (DLQI), for quality of life assessment, are the most cited and most often used tools due to their high degree of reliability, applicability and reproducibility.

The skin is always on show, particularly on the visible areas. Psychosocial and physical impact of highly visible, inflammatory skin diseases such as psoriasis may be profound. Skin diseases disrupt school, work and social life. Low self-esteem may affect relationships with the opposite sex as well as prospects of employment. Patients, their families and friends may find it difficult to cope. Patients with chronic scaly skin conditions such as psoriasis, may also have a deep-seated, and probably quite irrational fear of being contagious. This may be reinforced by the reaction of family and friends, who have an equally deep-seated fear of “catching something”.

The patient often feels stigmatized, which further intensifies their lack of self-confidence and self-esteem. Visible skin changes on a patient body may cause aversion, attract negative attention, public rejection, reactions of disgust and can provoke fear of contagion. On a social level, the stigma, feelings of shame, rejection, embarrassment and lack of confidence provoked by the disease, often lead to the discontinuation of daily activities and social withdrawal [14].

Psoriasis has a significant negative impact on patient health-related quality of life. In a survey by the National Psoriasis Foundation almost 75% of patients believed that psoriasis had moderate to large negative impact on their quality of life, with interactions in their daily activities [15]. Visible illness, such as psoriasis, can give rise to negative reactions and avoidance of such patients by social environmental ultimately affects the mental state of the patient [16].

Psoriasis is known to have a negative impact on the quality of life of both the affected person and the individual's family members. Depending on the severity and location of outbreaks, individuals may experience significant physical discomfort and some disability. Itching and pain can interfere with basic functions, such as self-care and sleep [17]. Participation in sporting activities, certain occupations, and caring for family members can become difficult activities for those with plaques located on their hands and feet. Plaques on the scalp can be particularly embarrassing, as flaky plaque in the hair can be mistaken for dandruff. Individuals with psoriasis may feel self-conscious about their appearance and have a poor self-image that stems from fear of public rejection and psychosexual concerns. Psoriasis has been associated with low self-esteem and depression is more common among those with the condition. People with psoriasis often feel prejudiced against due to the commonly held incorrect belief that psoriasis is contagious [18]. Psychological distress can lead to significant depression and social isolation; a high rate of thoughts about suicide has been associated with psoriasis [19]. Many tools exist to measure the quality of life of patients with psoriasis and other dermatological disorders. Clinical research has indicated individuals often experience a diminished quality of life. Children with psoriasis may encounter bullying [20].

Psoriasis has detrimental effect on quality of life, which may be comparable to that of ischemic heart disease, diabetes, depression and cancer [21]. Due to the visibility of psoriatic lesions, the patients often experience feelings of distress and stigmatization [22–23]. The psoriasis-related daily stress represents chronic, recurrent, low-grade stress or hassles that occur largely as a result of having to live with a chronic, disfiguring disease. There is a large body of literature [24–26] about correlation between psoriasis and DLQI in different countries.

According to many studies psoriasis is a long-term skin disorder associated with significant impairment of the patients’ quality of life and self-esteem, and high levels of distress which are frequently under-recognized. There is a need for pharmacologic interventions that should be accompanied by patient education and social and family support.

The Dermatology Life Quality Index (DLQI), developed in 1994, was the first dermatology-specific Quality of Life instrument. It is a sample 10-question validated questionnaire that has been used in over 40 different skin conditions in over 80 countries and is available in over 90 languages.

DLQI is psychometrically sound and responsive measure of psoriasis-specific outcomes and most comprehensively captures the impact of clinical signs and symptoms on patient’s well-being.

Because of patients complain about negative impact of their quality of life, making it difficult for physicians to choose the best treatment strategy [27]. Disease severity affects the financial status of psoriasis patients too, which in turn is a mediator of global QOL impairment [28].

Different studies have investigated the association between occupational problems and the severity of psoriasis, found that psoriasis patients experienced negative impact at work which was directly associated with disease severity [29–30]. In a large survey conducted in the US, income and employment were also found to be associated with severity of psoriasis [31]. Severe psoriasis has an important impact on physical function, vitality, general health perceptions, social function and mental health. Psychological distress is frequent among dermatological patients. The relationship between psychiatry and dermatology is often very complex [32]. Living with psoriasis has unique challenges. The good news is health care providers are becoming more aware of the impact psoriasis can have on a person's quality of life. Researchers are focused more now than ever on finding solutions to those challenges.

Living with the ongoing stressors associated with any chronic condition generally requires the development of skills to regain a sense of equilibrium. In psychology, coping means to invest own conscious effort, to solve personal and interpersonal problems, in order to try to master, minimize or tolerate stress and conflict [33]. Coping is considered one of the core concepts in health psychology and coping strategies are strongly associated with the regulation of emotion, especially anxiety, throughout the disease period.

Coping strategies may be coined as adaptive (which reduce stress) and maladaptive (which increase stress) strategies.

Lazarus and Folkmans model suggest that through a process of primary and secondary appraisal, an individual will make use of a range of coping strategies (emotional, cognitive and behavioral) [34].

The effectiveness of the coping effort depends on the type of stress, the individual, and the circumstances. Coping responses are partly controlled by personality, but also partly by the social environment. Hundreds of coping strategies have been identified. Neiten for instance, identifies four types of coping strategies: Appraisal-focused, Problem-focused, Emotion-focused and Occupational-focused. Typically, people use a mixture of several types of coping strategies, which may change over time.

Appraisal-focused directed towards challenging personal assumptions

People using problem-focused strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress.

Emotion-focused coping is a mechanism to alleviate distress by minimizing, reducing, or preventing, the emotional components of a stressor [35].This mechanism can be applied through a variety of ways, such as: seeking social support, reappraising the stressor in a positive light, accepting responsibility, using avoidance, exercising self-control and distancing.

The focus of this coping mechanism is to change the meaning of the stressor or transfer attention away from it [36]. Emotional approach coping is one form of emotion-focused coping in which emotional expression and processing is used to adaptively manage a response to a stressor.

Occupation-focused: directed towards lasting occupation(s), which generates positive feedback

Positive coping strategies are: anticipation, when one reduces the stress of some difficult challenge by anticipating what it will be like and preparing for how one is going to cope with it. Social coping such as seeking social support from others, and meaning-focused coping, in which the person concentrates on deriving meaning from the stressful experience.

Adaptive coping strategies are also: Adequate nutrition, sleep, exercise and humor. Physiological processes are also influenced within the exercise of humor. For example, laughing may reduce muscle tension, increase the flow of oxygen to the blood, exercise the cardiovascular region, and produce endorphins in the body [37]. Exercised humor can be a sign of positive adjustment as well as drawing support and interaction from others around the loss.

While adaptive coping methods improve functioning, a maladaptive coping technique will just reduce symptoms while maintaining and strengthening the disorder. Maladaptive techniques are more effective in the short term rather than long term coping process. Examples of maladaptive behavior strategies include dissociation, sensitization, safety behaviors, anxious avoidance, and escape (including self-medication).

Dissociation is the ability of the mind to separate and compartmentalize thoughts, memories, and emotions. Sensitization is when a person seeks to learn about, rehearse, and/or anticipate fearful events in a protective effort to prevent these events from occurring in the first place. Safety behaviors are demonstrated when individuals with anxiety disorders come to rely on something, or someone, as a means of coping with their excessive anxiety. Anxious avoidance is when a person avoids anxiety provoking situations by all means. This is the most common strategy. Escape is closely related to avoidance. This technique is often demonstrated by people who experience panic attacks or have phobias. These people want to flee the situation at the first sign of anxiety [38].

In conclusion, physicians managing patients with psoriasis must be aware of the psychological effects of psoriasis and need to use a multifaceted approach to managing this disease, focusing on both the physical and psychological aspects.

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Meeting Calendar

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May 26–29, 2018 Munich, Germany

EUROPEAN ACADEMY OF ALLERGY AND CLINICAL IMMUNOLOGY (EAACI) CONGRESS

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