Overcoming the Stigmata of Psoriasis

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Stigmata and their Clinical Implications in Psoriasis:

Emotional and stress reactions to psoriasis are associated with physiological correlates, which in turn act upon organ vulnerability and debility resulting in flare-ups and exacerbations. In patients with psoriasis, stress in the form of stigmata has been indicated as a principal predictor of disability (Richards et al., 2001, Vardy et al., 2002).

Stigma and self stigma may affect the course of illness exacerbation and/or relative acquiescence in psoriasis. Fortune et al. (1997) noted that disability in psoriasis was best accounted for by anticipatory and maladaptive avoidance coping behaviour and experiences of rejection. Depression, common in psoriasis patients decreases the threshold for itch perception via increasing central nervous system opiate levels (Gupta, 1999). Yet, depression was found to have only a moderate correlation with symptom severity. Instead depression was more accurately predicted by perceived stigma associated with deprivation of social touch (Gupta et al. 1998), being female, a stronger belief in perceived severity of the consequences of psoriasis, and poor coping strategies (Fortune et al., 2002). Likewise, presence of distress in the form of uncontrolled and excessive worrying slowed clearance of psoriasis using a standard therapy of psoralen plus ultraviolet A treatment while combined standard therapy plus psychological management yielded superior results at up to 6 months follow-up (Fortune et al., 2003).

Goffman (1963) cautioned that stigma “is deeply discrediting”, and a stigmatised person may be reduced “from a whole and usual person to a tainted, discounted one”. Link, Yang, Phelan, and Collins (2004) further noted that labelling, stereotyping, cognitive separation, emotional reactions, status loss and discrimination may all be involved. Psoriasis may be more accurately seen as a recurrent medical condition as well as an adverse and salient social (and internal) stimulus for the afflicted. The adverse consequences of psoriasis include not only physical sufferings, but also the precarious management of visible regions, coping with a subjectively all-consuming disease, psychological morbidity, and social vulnerability (Schmid-ott et al., 2005). Multiple interpersonal concerns were reported by psoriasis patients. Krueger et al. (2001) provided survey results which indicated that 27% of the patients had difficulties with sexual activities, 81% were embarrassed with visible psoriasis, and 88% expressed concerns about the disease worsening. Likewise, Langley et al. (2005) in their review of the literature indicated that up to a third of patients with psoriasis suffered from pathological worry and anxiety which impinge on “all aspects” of the patients’ daily life.

Stigmata are multi-faceted. A useful tool for measuring stigma is the Questionnaire on Experience with Skin Complaints (QES) by Ginsburg & Link (1989). Six dimensions of stigmata were measured including:

- Interference of skin symptoms and self-esteem: feelings of being worthless, alone or unclean;
- Outward appearance and situation-caused retreat: experience of lack of physical attractiveness or sexual desirability, special ways of dressing, avoidance of public situations;
- Rejection and devaluation: anticipated and perceived negative reactions of others;
- Composure: calmness and confidence in a satisfactory life despite the psoriasis;
- Concealment: tendencies toward hiding the diagnosis and keeping the disease secret;
- Experienced refusal: feelings of stigmatisation in specific situations such as shopping or usual public transport.

An all Encompassing Clinical Management Approach Advocated

Psoriasis is thus more effectively managed with a combined medical as well as social learning perspective, incorporating variables such as the perceived degree of social rejection, suspicion and misguided fear of infection. Indeed, Vardy et al. (2002) provided data to indicate that severity of perceived stigma mediated the impact of severity of psoriasis on quality of life. Effective management and harm containment of the all-encompassing adverse impact of psoriasis should best incorporate an understanding from an insider’s perspective on “how it is like” to live with psoriasis. Therapeutic aims should include targeted attempts to reduce the challenges of psoriasis on the person’s self image, social functioning and emotional reactions.

Illness management is more effective to the extent that the external signs of psoriasis detrimental to the social standing (stigma) and self esteem (self stigmata) could be reduced. The two interlinking processes are likely to be mutually potentiating. Perceived stigma and social rejection prompt fear, self depreciation, avoidance,
anxiety, uncertainty, insecurity feelings, depression and demoralisation. Self stigma that arises from the patients’ own rejection of the condition as well as projection of rejection by others may aggravate self devaluation and "spread" of negativity. The phenomenon of spread has been well reported in the health psychology literature. Spread refers to rejection and devaluation of the entire person over and beyond the confines of the symptoms. Pain and itchiness aside, psoriasis diminishes a person’s social standing and self esteem. Personal weaknesses may be further opened up leading to a vicious cycle of fixation and worry about the sight, pruritus and uncertain prognosis of psoriasis, anxiety and depressed mood, reduced quality of life, enhanced physiological stress reactions, negative fixation, symptom flare-ups and exacerbations. On the other hand, overcoming and accepting the sometimes unavoidable stigmata of psoriasis may lead to greater peace of mind, less emotional upheavals, and greater treatment adherence.

On a broader consideration, today’s terminology has discarded the term “psychosomatic illness” which implicated only a limited number of disease conditions as having a psychosomatic origin. Instead of a cross-sectional approach where symptoms are managed as and when they arise, a longitudinal approach to psoriasis with understanding of the individual patient’s vulnerability, high stress points, and exacerbations.

**The Unity of Mind and Body**

The unity of mind and body and their inevitable interactions is very well illustrated in conditions such as psoriasis. Few clinicians would disagree that psychological or behavioural factors play a role in almost every medical condition, especially in conditions that are visible and stigmatising and those with accompanying adverse psychological aftermaths of low self esteem, depression, anxiety, avoidance, and social awkwardness.

While the diathesis or illness susceptibility is clearly of genetic origin, some individuals may become more vulnerable and may even be designated as being skin reactors. Individuals with alexithymia having more difficulties in identifying feelings and describing feelings, with poor emotional regulation and excessive preoccupation with physical symptoms and external events were implicated as being at greater risk (Richards et al., 2005).

On a broader consideration, today’s terminology has discarded the term “psychosomatic illness” which implicated only a limited number of disease conditions as having a psychosomatic origin. Instead of the DSM diagnostic nomenclature (APA, 1994), further delineates the multifarious psychosomatic processes under the diagnostic category of "psychological factors affecting general medical condition". Specifically, psychological factors may affect a medical condition through exacerbating the underlying disorder, reducing coping effectiveness, prompting maladaptive behaviours, intensify stress related physiological responses and lead to further outbreaks of the underlying disorder. In psoriasis, psycho-behavioural-neuro-immunological factors implicating chronic inflammatory changes, symptom exacerbation, IL-22, TH-17 cells, and depression may be implicated in its recurrent cycle of initiation, progression, aggravation and relative acquiescence (Leibovici et al, 2010).

**Improved Awareness and Training Required in Detecting Psychological Distress**

A misleading feature of psoriasis is that it does not even have to be visible for the patient to fear and anticipate social rejection, and also that it does not need to be objectively severe to warrant severe disability and distress (Ginsburg, 1995). It is thus not surprising to note that while most clinicians would agree that psychological factors may affect the course and management of psoriasis, they are also poor in detecting psychological distress in their patients. A low consensus between the respective patients’ and their physicians’ reports of presence of severe psychological distress was noted (Richards et al., 2004). Indeed regardless of the doctor’s empathy level, severe psychological distress in 61% of their patients was not identified. Even when severe anxiety and depressive reactions were noted, in the majority of cases, no further action was taken following the consultation. Sampogna et al. (2003) also provided disappointing data to indicate that dermatologists did not have an accurate perception of the extent of psychiatric disturbances in their patients with skin conditions.

Richards et al. (2004) thus asserted that "It is of key importance that psychological distress is appropriately recognised and addressed in a holistic or biopsychosocial approach to patient management". They thus advocated the use of specific guidelines and education in psychological detection skills as well as routine administration of psychometric screening tools such as the HADS.

Janowski and Pietrzak (2008) provided helpful indications to guide clinicians in referring psoriasis patients for psychological interventions including:

- Presence of psychiatric and behavioural disorders (depression and anxiety disorders, suicidal ideation) as co-morbidity with psoriasis;
- History indicating psychological stress as a psoriasis-triggering or aggravating factor;
- Significantly decreased quality of life, where social relationships, sexual functioning and self-esteem are seriously affected;
- Increased pruritus;
- Increased feelings of stigmatisation as indicated by sensitised attention to potential rejecting behaviours of others, biased interpretation of others’ behaviours and intentions, or anticipatory expectations of unfavourable reactions from others;
- Psoriasis being unresponsive to standard pharmacological treatments;
- Children and adolescents with psoriasis (given psoriasis being an increased risk for disturbances of normal psychosocial development).

**Concluding Remarks and Recommendations**

Instead of a cross-sectional approach where symptoms are managed as and when they arise, a longitudinal approach to psoriasis with understanding of the individual patient’s vulnerability, high stress points,
sense of stigmata, and factors associated with exacerbation is advocated. The aim is to equip the patient with awareness of aggravating and stress factors inherent in themselves and in their life circumstances, and learn to short-circuit stress responses and aggravations at the earliest stage. Self monitoring of illness aggravating correlates in the form of life events, behavioural and emotional responses are useful. For example, psychological variables may maintain and exacerbate psoriasis by eliciting poor compliance and scratching behaviours. A general attitude of negative affectivity may prompt more helpless and depressive responses, rendering adherence to treatment unreliable (Charman and Horne, 1997).

A systems approach to managing psoriasis is also proposed. The clinician needs to recognise that psoriasis is at the same time a lifelong medical illness as well as an illness with vast social and personal implications. Understanding the patient’s perceptions regarding the illness, his/her unique life circumstances, as well as reactions to psoriasis facilitates better physician-patient communication, trust and collaboration.

Effective management of negative emotions needs to be built into the overall management plan. Anger, depression and anxiety are common emotional conditions of maladjustment. Anger leads to non-adherence, emotional instability, and increased scratching behaviours. Depressed mood leads to and may be aggravated by social avoidance, low self-esteem, sense of helplessness and hopelessness. Anxiety leads to dread, insecurity and uncertainty feelings, inhibition, and reduction in meaning and gratification in daily living. All in all, vulnerability is accentuated by chronic negative emotions, leading to unsatisfactory illness control and management. The cognitive behavioural approach to management of emotions postulates that extreme, distorted and over-inclusive thoughts underlie negative emotions. Understanding and managing the patient’s conceptions about his/her illness and associating coping styles facilitates emotional management and a less stormy illness course (Fortune et al., 2002, 2004; Zachariae et al. 1996).

Specific interventions have also been indicated to be useful. For example, behavioural methods for habit reversal in reducing scratching had been indicated as being useful. Illness control was demonstrated to reverse in reducing scratching had been indicated as being useful. For example, psychological variables may maintain and exacerbate psoriasis by eliciting poor compliance and scratching behaviours. A general attitude of negative affectivity may prompt more helpless and depressive responses, rendering adherence to treatment unreliable (Charman and Horne, 1997).