Psychosocial Profile of Patients with Psoriasis

Srinivasan Jayaraman[1], **D. Sai Baalasubramanian**[4],
K.S.Arun Narayan Pradeep[4]
[1]Assistant Professor, Department of Clinical Psychology
[4]Assistant Professor, Department of Psychiatry
SRM University, Chennai, Tamil Nadu, India

Thamilselvan Palanichamy[2], **JagadeshChander R**[3]
[2]Assistant Professor, [3]Post graduate Student
Department of Psychology,
PSG College of Arts and Science, Coimbatore, Tamil Nadu, India

OPEN ACCESS

Volume: 6

Issue: 1

Month: July

Year: 2018

ISSN: 2321-788X

Received: 03.07.2018

Accepted: 28.07.2018

Published: 30.07.2018

Citation:
Jayaraman, Srinivasan, et al. "Psychosocial Profile of Patients with Psoriasis." *Shanlax International Journal of Arts, Science and Humanities*, vol. 6, no. 1, 2018, pp. 30–39.

DOI:
https://doi.org/10.5281/zenodo.1323576

Abstract

Background: People's ability to manage Psoriasis, a skin disease which is problematic and it is to be affected by the attitudes and expectations of those around them, especially for those people who live in communities within larger societies because it is proved that psychological, social and cultural factors play a major role in managing the disease and sometimes identification of psychological problem is quite difficult. The impact of Psoriasis varies with different social settings, and it affects the ability of individuals with Psoriasis to manage their condition and to function effectively within their society. Aim: To study the psychosocial profile of patients with Psoriasis. Methods: Brief Illness Perception Questionnaire (BIPQ), Dermatology Life Quality Index (DLQI). During the second session the following tools were given. Multidimensional Scale of Perceived Social Support (MSPSS), Overt Aggression Scale- Modified (OAS-M), Pittsburgh Sleep Quality Index (PSQI) and Arizona Sexual Experiences Scale (ASEX) - M/F were given to 30 women and 30 men with an inclusion criterion- patient diagnosed with psoriasis – all types, age range of 20 - 60 years, 8 years of formal education and only married living with spouse. Results: On quantitative analysis showed that there is no significant relation in genders with respect to illness perception, quality of life, sleep pattern, sexual experience, aggression, irritability and suicidality. Conclusion: The present study concluded that there is positive correlation among aggression, irritability, suicidality; social support and support from family and friends; illness perception and sex.Indicates that patients with poor quality of life have more aggression. There is significant negative correlation in the following variables indicating that more problems in illness perception and less support from friends.

Key words: Psoriasis, Quality of life, Aggression, Illness perception and Irritability.

Introduction

Skin diseases are known to have a major impact on the lives of patients and their families. Skin has a special place in psychiatry and psychology with its responsiveness to emotional stimuli and ability to express emotions such as anger, fear, shame and frustration, and by providing self-esteem, the skin plays important role in the socialization process, which continues from childhood to adulthood.

About 50% of people who develop psoriasis see changes in their fingernails and/or toenails. About 80% of people living with psoriasis have plaque (plak) psoriasis, also called "psoriasis vulgaris" (Cram, David L 2000).

Psoriasis is the second most frequent skin disease following eczema, with a worldwide incidence between 1% and 4%. The average age of diagnosis is 28 years; the distribution of the age at onset in both sexes is bimodal. Early onset of disease (before 30 years) is associated with more severe and extensive cetaceous involvement, a family history of psoriasis, and greater psychosocial impact. The clinical course of psoriasis appears to be less severe in patients with late onset disease (aged >30 years).

Psoriasis is associated with substantial impairment of health-related quality of life (HRQOL), negatively impacting psychological, vocational, social and physical functioning. Interestingly, in one study by Esposito M (2006) reported that neither disease severity nor duration is associated with health-related quality of life rather, stress resulting from anticipation of other people's reactions to their psoriasis predicted patients' disability more than any other medical or health status variable.Psoriasis is chronic skin diseases that can have severe psychosocial effects (Skevington SM, 2006).

Social support may also have a mediating role in the relationship between itch and distress, since lower levels of social support are reported to be associated with higher levels of distress (Picardiet al., 2005). Specificity of the skin disease affects maladaptive negative emotional control and the suggestion is to use psychological treatment in hospitalized psoriasis in particular (Kossakowska, M. M., et al., 2010).

Clinical severity of psoriasis increases among very elderly patients and is associated with different levels of skin-related QoL and psychological distress (Sampogna, F., et al. (2007). Randomised controlled trials of treatments for skin conditions are few and rarely measure sleep as an outcome, either subjectively or objectively (Thorburn, P. T., et al., 2009). 49% of psoriasis patients say their skin disease interferes with sleep, and 11.3% report it does so on more than 15 nights per month (Jancin Hong, 2008). Patients with neurodermatitis and psoriasis have sexual dysfunction and depression in the course of these chronic diseases and the higher frequency of sexual problems was seen in patients with neurodermatitis (Mercan, S.,et al., 2008).

Psychiatric co-morbidity, especially depression, among dermatology patients and indicate that in some instances even clinically mild to moderate disease such as non-cystic facial acne can be associated with significant depression and suicidal ideation (Gupta MA & Gupta AK, 1998). Hence, these are the findings of earlier studies done in the area of psoriasis in relation to psychological variables, which has given a clear understanding to formulate the present study.

Psoriasis is a chronic skin disease which has great impact on life of a patient; like any other chronic illness. It has many co-morbid conditions, like arthritis, cardiac conditions, etc and affects various spheres of functioning. Though there are major physical complications, the impact on psychological aspects is much evident. The prevalence rate of psoriasis is now on the increase. Various studies focus on the impact of onset, but not much is studied in the Indian population in relation to a broad spectrum of psychological aspects. Most of the studies done so far are more related to quality of life, clinical depression and anxiety. Since not many studies have focused on other common yet vital aspects like sleep, sex, aggression, irritability, suicidality and social support; this study aimed to evaluate the variables in our community.

Methodology

Aim: To study the psychosocial profile of patients with psoriasis

Objective: To compare the illness perception, quality of life, aggression, sleep quality and sexual experiences of both male and female with early and late onset of psoriasis.

Hypothesis

There is no significant difference between the following variables;

1. Illness perception between males and females with early and late onset of psoriasis.
2. Quality of life between males and females with early and late onset of psoriasis and their spouse.

3. Social support between males and females with early and late onset of psoriasis.
4. Aggression between males and females with early and late onset of psoriasis.
5. Sleep quality between males and females with early and late onset of psoriasis.
6. Sexual experiences between males and females with early and late onset of psoriasis.
7. Illness Perception, Dermatology Life Quality Index, Sleep, Sexual Experience, Aggression and Social Support in psoriasis patients

Sample: The samples were selected from the Outpatient Department of Dermatology, Sri Ramachandra University. 30 males and 30 females diagnosed as psoriasis by the consultant dermatologist were included out of which 21 patients had early onset (Male = 11 and Female = 10) and 39 patients with late onset (Male = 19 and Female = 20). Purposive sampling technique was used. The inclusion criteria are patient diagnosed with psoriasis – all types, age range of 20 - 60 years, 8 years of formal education and only married living with spouse. Patients with other skin diseases, patients with psoriatic co morbid conditions like arthritis, patients with other chronic physical or psychiatric illness, Illiterates, living alone and age range less than 20 and more than 60 years were excluded.

Tools Used

1. Socio Demographic Data Sheet: This has been developed especially for the study to collect the basic identification, illness and treatment details, family and other socio demographic and relevant clinical details of the patient.
2. Consent Form: Written informed consent form was obtained from the patient for the current study, after explaining the purpose and confidentiality of the study.
3. Brief Illness Perception Questionnaire (BIPQ): Developed by Broadbent et al. in 2006. It provides a rapid assessment of illness perception. It consists of 9 items; consequences, timeline, personal control, treatment control, identity, concern, emotion, illness comprehensibility, Assessment of the causal representation is by an open-ended response item adapted from the IPQ-R (Weinman j et al 1996) which asks patient to list three most important casual factors in their illness. The BIPQ showed good test – retest reliability (above 0.60) for all itemsdisplaying good discriminant validity and content validity.
4. Dermatology Life Quality Index (DLQI): Developed by A. Y. Finaly and G. K. Khan in 1992. DLQI has been used widely as a health-related quality of life measure for a variety of dermatological diseases. The DLQI consist of 10 items, designed for use in adults (patients over age of 16). Internal consistency and reliability for the DLQI has been demonstrated (Cronbach's alpha) ranging from 0.83 to 0.93 in various studies. It has been used in parallel with other dermatology specific measures and with general health measures.
5. Multidimensional Scale of Perceived Social Support (MSPSS): Developed by Zimet et al., in 1988. It is a 12-item scale that measures perceived support from three domains: family, friends, and a significant other. Internal reliability estimates of .93 for the total score and 0.91, 0.89 and 0.91 for the Family, Friends, and Significant Others subscales. Factor analysis of the MSPSS with their sample confirmed the three-factor structure of the measure.
6. Overt Aggression Scale- Modified (OAS-M): Developed by E Coccaro and collaborators in 1991 to assess aggressive behaviour in outpatients. The scale is a 25-iteams, semi structured interview with nine sub scales. (1) Aggression – verbal assault/aggression, assault/aggression against object, assault/aggression against others, assault/aggression against self. (2) Irritability – global subjective irritability, global overt irritability. (3) Suicidality – suicidal tendencies, intent of attempt, lethality of attempt. Both data on reliability and validity are limited with high intraclass correlation (>0.091) and moderate test retest reliability (0.46-0.54).
7. Pittsburgh Sleep Quality Index (PSQI): It is a subjective measure of sleep used measure the quality and patterns of sleep. Developed by

Daniel.J Buysee et al (1989), it differentiates "poor" from "good" sleep by measuring seven areas: subjective sleep, quality sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medication, and daytime dysfunction over the likert scale. It has internal consistency and a reliability coefficient (Cronbach's alpha) of 0.83 for its seven components. The validity of the scale in terms of sensitivity is of 89.6% and in terms specificity it's of 85.6% of patient's versus control group.

8. Arizona Sexual Experiences: Developed by McGahuey et al. in the University of Arizona. The ASEX is a brief 5-item questionnaire designed to measure sexual functioning in the following domains: sexual drive, arousal, penile erection/vaginal lubrification, ability to reach orgasm, and satisfaction with orgasm over the past week, including today. The scale shows an excellent internal consistency and reliability with a Cronbach's Alpha of 0.9055 and a strong test – retest reliability. The ASEX has very good validity and the items correlate relatively well with the items of other more extensive scales such as the Brief Index of Sexual Functioning.

Procedure

The first session initially started with establishing rapport with the subject. Socio Demographic Data Sheet and Written Informed Consent Form were obtained from the sample and the tools were administered in the following order - Brief Illness Perception Questionnaire (BIPQ), Dermatology Life Quality Index (DLQI). During the second session the following tools were given. Multidimensional Scale of Perceived Social Support (MSPSS), Overt Aggression Scale- Modified (OAS-M), Pittsburgh Sleep Quality Index (PSQI) and Arizona Sexual Experiences Scale (ASEX) - M/F. The data was collected in two sessions with 1-2-hour duration.

Results and Discussion

On analyzing the data, Statistical packaged for social sciences -16 (SPSS-16) were used. The analysis of data collected was done by using percentages, mean, t tests and correlation. In this analysis the samples are evaluated on various psychological variables and compared based on the onset of illness and gender. The following results were drawn.

Table 1 shows the demographic details of all 60 samples selected for the present study with regard to age, education, socioeconomic status, years of marriage and illness duration. The sample consists of 30 male patients – 11 with early and 19 with late onset psoriasis and 30 females – 10 early and 20 late onset psoriasis. With regard to age it is evident that all patients with early onset belong to the age group of 20 to 40 years whereas majority of the sample with late onset belong to the age group of 31 to 60 years.

Majority of the samples were educated up to high school level in which females (11.66 % - early onset and 26.66% - late onset) were more than males (6.66% - early onset and 18.33 - late onset). The percentage of males who have completed graduation (UG and PG) were more than females. Most of the sample falls in the lower socioeconomic status, out of which majority are males.

With regards to years of marriage, most of the participants both male and female in the early onset group have been married for less than 20 years. In illness duration, most of them have been suffering with psoriasis from 1 to 5 years. It is also evident that the patients with late onset (6.66%) have long years of illness duration (1 female with 10-20 years and 2 males + 1 females with more than 20 years) when compared to early onset (3.33%) psoriasis patients (2 males with 10-20 years).

Table 1: Shows the Socio Demographic Details of Psoriasis Patients

Variables	Early Onset				Late Onset			
	Male		Female		Male		Female	
	N	%	N	%	N	%	N	%
Age:								
20 – 30	6	10.0	6	10.0	0	0	2	3.33
31 – 40	5	8.33	4	6.66	4	6.66	13	21.6
41 – 50	0	0	0	0	9	15.0	2	3.33
51 – 60	0	0	0	0	6	10.0	3	5.00
Education:								
High school	4	6.66	7	11.6	11	18.3	16	26.6
Higher sec.	3	5.00	1	1.47	1	1.47	3	5.00
Under Grad.	2	3.33	2	3.33	6	10.0	0	0
Post Grad.	2	3.33	0	0	1	1.47	1	1.47
Socioeconomic Status:								
Low	6	10.0	5	8.33	12	20.0	10	16.6
Middle	5	8.33	5	8.33	7	11.6	10	16.6
Years of Marriage:								
< 20 years	10	16.6	9	15.0	13	21.6	15	25.0
> 20 years	1	1.47	1	1.47	6	10.0	5	8.33
Illness duration:								
< 1 year	1		2	3.33	4	6.66	5	8.33
1 - 5 years	7	1.47	5	8.33	8	13.3	10	16.6
5 – 10 years	1	11.66	3	5.00	5	8.33	3	5.00
10 - 20 years	2	1.47	0	0	0	0	1	1.47
>20 years	0	3.33	0	0	2	3.33	1	1.47

On compare the early and late onset psoriasis patient on illness perception, the t value is 0.365 indicating no significant difference between the early and late onset psoriasis patients. The mean score indicates that patients with an early onset (31.52) have low illness perception when compared to patients with late onset (32.44), which is due to the less duration of illness in the early onset group. Illness perception is less in this sample which may be due to lack of awareness and negative perception about the nature, course, impact of psoriasis and the treatment outcome.

Table 2: Shows the Mean, SD and Level of Significance between Male and Female Psoriasis Patients on Illness Perception (N =30)

Gender	Mean	Standard Deviation	T	Level of Significance
Male	35.37	6.094	2.917	Significant at 0.005 level
Female	28.87	10.576		

Table 2 shows that mean score and standard deviation of male and female psoriasis patient on illness perception. The t value was found to be 2.917 and there is significant statistical difference (0.005 level) indicating that the male patients (35.37) have more problems and perceive their illness to be highly disturbing than the female psoriasis patients (28.87). Males perceive that their illness will continue inspite of medication or treatment and that they have less control over the symptom manifestation, much concerned and believe that psoriasis affects their life. This is similar to the conclusions made by Donal G et al. (2000) that a considerable number of patients with psoriasis experience high levels of worrying thoughts that are linked more to personal and social evaluative concerns than to the pathophysiology of their disease. Most of the female sample collected in this study are unemployed and this could be one of the reasons why females perceive their illness less disturbing and have less interaction with others, when compared with males.

Hence hypothesis 1 is partially accepted as there was no significant difference between early and late onset of illness in relation to illness perception whereas, there is significant difference in gender as males tends to perceive their illness to be more distressing than females.

On analysis of early and late onset psoriasis patient on Quality of life that, the t value was found to be 1.164 which indicates that there is no significant difference between the early and late onset psoriasis patients on their quality of life. In contrast to most of the studies done in relation to onset of illness, in this present sample the early onset patients (7.57) have better quality of life when compared to late onset patients (6.21). This could be because of the duration of illness or even due to higher age patients in late onset group than the early onset group. The mean scores indicate that this illness has moderate effect on patient's life. This was supported by the findings of De Korte J, et al. (2004) that there was a tendency that higher age was associated with slightly lower levels of physical functioning and slightly higher levels of psychological functioning and overall quality of life.

On comparing the male and female psoriasis patient on Quality of life that the t value was found to be 1.911 indicating no significant difference between the male and female psoriasis patients. While the mean scores indicate that there is a tendency in male (5.63) patients to have better quality of life than female (7.73) patients, because higher the score more the effect on the patient's life. This finding is similar to the study of Gelfand JM, et al. (2004) that female patients and young patients are affected to a greater extent, due to decrement in income. It is observed that all females in this present group are unemployed and are financially dependent, which could be a contributing factor to poor quality of life.

Hypothesis 2 is accepted as there was no significant difference between early and late onset of illness in both male and female patients with regard to quality of life. Analysis showed that early and late onset psoriasis patient on sleep quality that the t value was found to be 0.285. It is evident that there is no significant difference between the early and late onset psoriasis patients in their quality of sleep and sleep patterns. Scores indicate that all patients have significant sleep disturbances. The mean score indicates that there is a trend in the early onset (9.81) patients to have better quality of sleep than late onset (10.26) patients. As concluded by Duffin, K. C., et al. (2008) that history of psoriatic arthritis, presence of itch and pain of psoriatic lesions, and impact of psoriasis on overall emotional well-being predict sleep interference. In this sample, those with early onset have a better quality of life which may be influencing their quality of sleep also.

Further analysis shows that male and female psoriasis patient on sleep quality that the t value was found to be 1.544, indicating no significant difference between the male and female psoriasis patients. The mean score indicates significant sleep disturbance and between groups, comparatively males (8.97) have better quality of sleep than females (11.23). It is observed that males are more regular and compliant in their medication than females.

On compare the early and late onset psoriasis patient on Sexual experience that the t value was found to be 0.142 indicating no significant difference. The mean score of early onset (13.48) patients and late onset (13.92) patients don't show much of a difference indicating that all patients irrespective of the onset of illness have similar sexual experience or satisfaction. As per the scoring manual, the total score of more than 18 is associated with clinical sexual dysfunction. The mean scores of this sample is less than 18 indicating no sexual dysfunction. This could be because of inhibition or denial due to cultural aspects. While considering the item scores of ASEX, the presence of high scores on significant items in the questionnaire reveals the presence of problems in sexual experiences in all patients with psoriasis, which is similar to the findings ofSampogne et, al in 2007, that a more severe disease and the presence of psychological problems were also associated with sexual impairment.

On analysis of male and female psoriasis patient on Sexual experience that the t value was found to be 1.190 indicating no significant statistical difference in gender. Items scores indicate that both groups have problems in sexual experience. The mean score indicates that male (12.00) patients have better sexual experience than female (15.53) patients as in sexual arousal, performance and satisfaction.

Table 3: Shows the Mean, SD and Level of Significance between Early and Late onset Psoriasis Patients on Aggression, Irritability and Suicidality

Variables	Onset	N	Mean	S.D	t	Level of Sig.
Aggression	Early onset Late onset	21 39	7.43 5.56	4.996 5.462	1.298	N.S
Irritability	Early onset Late onset	21 39	7.10 3.69	4.300 3.071	3.548	0.001 level
Suicidality	Early onset Late onset	21 39	1.14 0.44	1.062 0.680	3.139	0.005 level

Table 3 shows that mean score and standard deviation of early and late onset psoriasis patient on aggression, irritability and suicidality. The t value was found to be 1.298 for aggression, 3.548 for irritability and 3.139 for suicidality. It is seen from the table that there is significant difference between the early and late onset psoriasis patients in Irritability at 0.001 level and Suicidality at 0.005 level. There is no significant difference between the early and late onset psoriasis patients in their level of aggression. Overall scores indicate no clinically significant level of aggression, irritability and suicidality in the present sample. The mean scores of patients with early onset are higher than late onset on all subscales which may be due to the severity of the illness at a younger age. Irritability and aggression is much higher in this current study which correlates with the study of Matussek P, et al (1985) where the psoriatics show a tendency with extremely high scores for outward aggressions and very low ones for auto aggressions.

Earlier studies by Gupta, et al in 1993 and 1998 concluded that co morbidity between depressive symptoms, suicidal ideation, and psoriasis severity is in contrast with reports that severe depression and suicidal ideation is mainly a feature of life-threatening medical disorders such as malignancies.

On analysis shows about male and female psoriasis patient on aggression, irritability and suicidality that, the t value was found to be 1.956 on aggression, 0.297 on irritability and 0.431 on suicidality. The mean scores show that females are more aggressive and irritable than males and males have high scores on suicidality than females which could be because of the extent of intent, planning and medical lethality involved rather than the mere intent of suicide.

With regard to aggression, irritability and suicidality there is no significant difference in aggression. On irritability and suicidality statistical difference in evident only in relation to onset, where patients with early onset gets significant scores than late onset psoriasis patients. Thus, hypothesis 5 is partially accepted.

Further analysis showed that support from significant others (0.716), family support (0.092) and support from friends (0.791) between early and late onset psoriasis patients. It is seen from the table there is no significant difference between the early and late onset psoriasis patients on the subscales of social support indicating that irrespective of the onset of illness, psoriatic patients perceive similar kind or intensity of support from others. The scores indicate that these patients perceive less support from others. These findings are similar to the studies done by Picardiet al., in 2005 that patients with psoriasis had lower perceived social support and higher attachment related avoidance.

On comparing male and female psoriasis patient on perceived support from significant others, family support and support from friends that, the t value was found to be 0.925, 0.126 and 0.768 respectively indicating no significant difference between male and female psoriasis patients on all subscales. From the mean it is also evident that females perceive more support from significant others and friends than males, whereas men perceive more support from family than women.

With regard to social support hypothesis 6 is accepted as there is no significant difference between groups with regard to gender or illness onset.

Table 4: Shows the Correlation among Illness Perception, Dermatology Quality Index, Sleep, Sexual Experience, Aggression and Social Support in Psoriasis Patients

		IP	QoL	Sleep	Sex	Aggression			Social Support		
						Agg	Irri	Sui	S.O	Family	Friend
Illness Perception		1	-0.105	-0.179	0.298*	-0.048	-0.137	0.034	-0.142	0.005	--0.330**
Quality of Life		-0.105	1	0.287	-0.083	0.296*	0.166	0.048	0.045	-0.034	-0.057
Sleep		-0.179	0.287	1	0.047	0.197	0.055	0.056	-0.142	-0.100	0.099
Sex		0.298*	-0.083	0.047	1	0.158	0.157	0.220	-0.042	0.142	-0.041
Aggression	Agg	-0.048	.296*	0.197	0.158	1	0.349**	0.260*	-0.087	-0.091	0.149
	Irritab	-0.137	0.166	0.055	0.157	0.349**	1	0.533**	0.119	-0.105	0.179
	Suicid	0.034	0.048	0.056	0.220	0.260*	0.533**	1	-0.016	-0.057	0.116
Social Support	Other	-0.142	0.045	-0.142	-0.042	-0.087	0.119	-0.016	1	0.152	0.310*
	Family	0.005	-0.034	-0.100	0.142	-0.091	-0.105	-0.057	0.152	1	0.282*
	Friend	-.330**	-0.057	0.099	-0.041	0.149	0.179	0.116	0.310*	0.282*	1

** Significant at 0.01 level * Significant at 0.05 level

Table shows the relationship among all variables assessed on all 60 psoriasis patients, irrespective of illness onset and gender. There is significant positive correlation at 0.001 level between irritability and aggression (0.349), irritability and suicidality (0.533). There is significant positive correlation at 0.005 level between aggression and suicidality (0.260), illness perception and sexual experience (0.298), quality of life and aggression, among support from significant others and friends (0.310) and among family and friends (0.282).

Aggression and irritability tends to influence each other due to various stressors in the patient's everyday life. This is also stated by Matussek P, et al., (1985) where the psoriatics show a tendency with extremely high scores for outward aggressions. The current sample reveals that more the tendency to get irritable and aggressive they have a higher suicidal ideation; indicating high inward aggression.

Positive correlation between support from significant others and friends indicate the socio-cultural group and similarly patients who seek more of family prefer support from friends.

There is a significant negative correlation between illness perception and support from friends (- 0.330) at 0.001 level. The higher the problem in perceiving illness the lesser the support they seek form their friends and tend to handle the severity of the illness and related aspects all by themselves.

Hypothesis 7 is partially accepted as there is significant positive correlation among aggression, irritability, suicidality; support from significant others, family and friends; illness perception and sex. Positive correlation in DLQI and OAS-M indicates that patients with poor quality of life have more aggression. There is significant negative correlation between illness perception and support from friends.

Summary and Conclusions

The analysis of the descriptive statistics through SPSS version 16 helped us to obtain the result and the following conclusions were drawn.

1. With regard to illness perception, there is no significant difference in relation to onset of illness but in gender the males get a higher score which is statistically significant than females.
2. On quality of life there is no significant difference between early onset and late onset patients and in relation to gender.
3. With regard to sleep pattern there is no statistical difference between the groups indicating poor sleep pattern in all patients.
4. There is no significant difference on sexual experience irrespective of onset of illness and gender
5. With regard to aggression, irritability and suicidality there is no difference in aggression. On irritability and suicidality statistical

difference in evident only in relation to onset, where patients with early onset gets significant scores than late onset psoriasis patients.

6. With regard to social support there is no significant difference between groups.
7. There is significant positive correlation among aggression, irritability, suicidality; social support and support from family and friends; illness perception and sex. Positive correlation in DLQI and OAS-M indicates that patients with poor quality of life have more aggression. There is significant negative correlation in the following variables indicating that more problems in illness perception and less support from friends.

Limitations of the Present Study

1. The partner/spouse of psoriasis patients could have been included to evaluate their quality of life and to get a better understanding of the patient's sexual experiences and the impact of psoriasis in the couple's sexual/marital life.
2. Details of medication, treatment compliance and other comorbid dermatological or other medical conditions were not considered in the present study.

Recommendations for Further Studies

1. A larger sample can be studied including various other dermatological diseases and co morbid conditions.
2. Profile of unmarried individuals can also be evaluated especially those with early onset of illness.
3. Other psychosocial aspects like coping styles, stigma, discrimination and impairment in functioning can also be assessed.

References

De Korte, J. et. al. (2004). "Quality of life in patients with psoriasis: a systematic literature review".*Journal Investigating Dermatology Symptoms Proc*, (2), pp. 140-7.

Donal, G. F. et. al. (2000). "Pathological worrying, illness perceptions and disease severity in patients with psoriasis". *British Journal of Health Psychology*, 5(1), pp. 71–82.

Duffin, K. C. et. al. (2009). "Psoriatic arthritis is a strong predictor of sleep interference in patients with psoriasis". *Journal of the American Academy of Dermatology,* 60(4), pp. 604-608.

Esposito, M. et. al. (2006). "An Italian study on psoriasis and depression". Dermatology, 212(2), pp. 123-27.

Gelfand, J.M. et. al. (2004). "Determinants of quality of life in patients with psoriasis: a study from the US population". *Journal of America Academic Dermatology,* 51(5), pp. 704-8.

Gupta, M. A. et. al. (1993). "Suicidal ideation in psoriasis". *International Journal of Dermatology,* 32, pp. 188-190.

Gupta, M.A. & Gupta, A. K. (1998). "Depression and suicidal ideation in dermatology patients with acne, alopecia areata, atopic dermatitis and psoriasis". *British Journal of Dermatology,* 139, pp. 846-850.

Hong, J. et. al. (2008). "The psychosocial and occupational impact of chronic skin disease". Dermatologic Therapy, 21, pp. 54-59.

Kossakowska, M.M. et. al. (2010). "Control of negative emotions and its implication for illness perception among psoriasis and vitiligo patients". *Journal of America Academic Dermatology and Venereology,* (4), pp. 429-33.

Matussek, P. et. al. (1985). "Aggression in depressives and psoriatic". *Journal of Psychotherapy and Psychosomatic,* 43(3), pp. 120-5.

Mercan, S. et. al. (2008). "Sexual dysfunctions in patients with neurodermatitis and psoriasis". *Journal of Sex Marital Therapy*, 34(2), pp. 160-8.

Picardi, A. et. al. (2005). "Stress, social support, emotional regulation and exacerbation of diffuse plaque psoriasis". *Journal of Psychosomatics,* 46(6), pp. 556-64.

Sampogna, F. et. al. (2007). *Impairment of Sexual Life in patients with psoriasis.* Dermatology, 214, pp. 144 – 150.

Skevington, S. M. et. al. (2006). "How does psoriasis affect quality of life". Assessing an Ingram-regimen outpatient programme and validating the WHOQOL-100? *British Journal of Dermatology,* 154, pp. 680–91.

Thorburn, P. T. & Riha, R. L. (2009). “Skin disorders and sleep in adults: Where is the evidence?” “*Journal of Sleep Medicine”*, 14(6), pp. 351-358.

Weinman, J. et. al. (1996). “The Illness Perception Questionnaire: A new method for assessing the cognitive representation of illness.” Psychology and Health, 11, pp. 431- 445

Websites

www.faqs.org/periodicals
www.highwirepress.com
www.psoriasis.org
www.pubmed.com