Comorbid psychiatric symptoms in patients with psoriasis

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Introduction
Psoriasis is a chronic inflammatory skin disease. Generally, approximately one in four patients experiences significant psychological distress. Depression and anxiety are the most common disorders that are associated with psoriasis. This study was carried out to assess the psychiatric comorbidities in patients suffering from psoriasis, such as depression, and their effects on the quality of life and the personality characteristics of patients suffering from psoriasis.

Materials and methods
This study is a comparative case–control cross-sectional study. The sample of this study included two groups: cases and controls. The cases consisted of 30 patients with the diagnosis of psoriasis recruited from the outpatient clinic of the Dermatology Department of the Kasr El Aini Hospitals. They represent consecutive referrals of patients fulfiling the criteria for inclusion in the study. The controls consisted of 30 individuals free of any psychiatric and physical disorders; the relatives of the patients were excluded to avoid genetic factors. Controls were age-matched and sex-matched with the psoriasis group. Both groups were subjected to the following: Beck Depression Inventory, Arabic version; Eysenck's Personality Questionnaire, Arabic version; Body Image Scale, Rating Scales for Psychopathological Health Status, and Quality of life Scale, Arabic version.

Results
Twenty-six percent of the patients had major depressive disorder, 23.3% had adjustment disorder with depressed mood, and 13.3% had dythymic disorder. Forty-three percent of the psoriatic patients had severe depression on Beck Depression Inventory, 16.7% had moderate depression, and 16.7% also had mild depression, whereas in 23.3% patients depression was absent. There were statistically significant differences between the two groups ($\chi^2=21.2$, $P=0.000$) regarding the Beck Depression Inventory. There was statistically significant difference between the psoriasis group and controls regarding Neuroticism, Introversion, and Lie, whereas there was no statistical significance difference between the two groups regarding Psychoticism and Criminality. There were statistically significant differences between the two groups ($P=0.000$) regarding the mean of Body Image Scale.

Conclusion
There is high frequency of psychiatric comorbidities in psoriatic patients especially depression, which represents the most frequent psychiatric symptom in psoriasis. The presence of psychiatric comorbidities increases the impairment in quality of life in psoriatic patients. There were no specific personality characteristics for psoriatic patients.

Keywords:
body image, depression, psoriasis

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Introduction

Psoriasis is a chronic inflammatory skin disease that is characterized by thick, red, scaly lesions that may appear on any part of the body. Generally, approximately one in four patients experiences significant psychological distress. In fact, one of the most persuasive indications of a link between stress and psoriasis comes from patients themselves, with studies illustrating that the majority of patients believe that stress or psychological distress is a factor in the manifestations of their condition [1,2]. Depression and anxiety are the most common disorders that are associated with psoriasis, but the proportion of patients meeting criteria for an anxiety disorder is notably higher than that for depression in patients with psoriasis [3]. Psychiatric disturbance and psychosocial impairment are reported in at least 30% of patients who have dermatologic disorders. Major depressive disorder is the most frequently encountered psychiatric disorder in

dermatology and is often associated with suicidal risk. Other psychiatric syndromes comorbid with dermatological disorders include obsessive–compulsive disorder, social phobia, posttraumatic stress disorder, dissociation, conversion disorder, body image pathologies, delusional disorder, and a wide range of personality disorders [4]. Moreover, symptoms of psoriasis, especially pruritus, are related to depression. Similarly, there is evidence that patients who report high levels of stress experience pruritus more frequently than patients with lower stress levels [5,6]. In contrast, patients with psoriasis have significant impairment in their quality of life (QOL). Psoriasis usually does not take lives, but it does ruin them. The impact of psoriasis on QOL is similar to that of other major medical diseases, and it is not only limited to the patients but psoriasis also has a major secondary impact on the lives of family members and partners [7].

The aim of the study was to assess the psychiatric comorbidities in patients suffering from psoriasis such as depression, anxiety, and disturbed body image and their effects on QOL and to assess the personality characteristics of patients suffering from psoriasis.

Patients and methods

This study is a comparative case–control study.

Patients

The sample of this study included two groups: cases and controls.

Cases

Thirty patients with psoriasis were diagnosed by the lecturer and assistant lecturer of dermatology, and were recruited from the outpatient clinic of the Dermatology Department of Kasr El Aini Hospitals. Both sexes were included. Patients' ages ranged from 15 to 45 years, and they were diagnosed with psoriasis vulgaris. The general exclusion criteria were patients suffering from other dermatological diseases, medical condition that would interfere with the assessment, mental subnormality suspected on clinical interview and intelligent quitent assessment by psychometric testing, past history of psychiatric disorders and substance use disorders (before psoriases), comorbidity with other active major medical problems (e.g. renal and hepatic failure), and patients under oral or systemic corticosteroid medication.

Controls

Thirty individuals were selected who were completely free of any psychiatric and physical disorders, and we excluded the relatives of the patients to avoid genetic factors. They have been age-matched and sex-matched with the psoriasis group. Informed oral and written consent were taken from all patients who participated in this study.

Methodology

Both the groups were subjected to the following assessment:

Psychiatric examination

This examination was applied by using the modified clinical sheet of the Psychiatry Department of Cairo University (Kasr El Aini) to diagnose psychiatric disorders according to *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV) criteria [8] using the Structured Clinical Interview for DSM Axis of Disorders (SCID-I): SCID-I provides a broad coverage of Axis I psychiatric diagnosis according to DSM-IV [9]. Relevant data include sociodemographic data, family history, past history, dermatological history, and screening of psychiatric symptoms.

Psychometric tools

Beck Depression Inventory (BDI), [10] *Arabic version*: this inventory used for measuring depression, which is translated to Arabic by Gharib Abdel Fattah, is a self-reported scale designed to assess DSM-IV-defined symptoms of depression. The inventory consists of 21 groups of statements on a four-point scale with the subject selecting the one that best matches the patient's current state. Each statement group corresponding to a specific behavioral manifestation response is scored as 0–3, corresponding to no, mild, moderate, or severe depressive symptomatology in the response. The score range varies from 0 to 63, where higher scores indicate greater depression severity. Scores in the range of 0–13 indicate no or minimal depression; 14–19, mild depression; 20–28, moderate depression; and 29–63, severe depression.

Eysenck's Personality Questionnaire (EPQ), [11] *Arabic version*: it was translated to Arabic by Ahmed Mohamed Abdel Khalek in 1991. It is used to assess Neuroticism, Psychoticism, Introversion/Extroversion, Criminality, and Lie scale. Extraversion is characterized by being outgoing, talkative, high on positive affect (feeling good), and in need of external stimulation. Introverts, in contrast, are chronically overaroused and jittery, and are therefore in need of peace and quiet to bring them up to an optimal level of performance. Neuroticism or Emotionality is characterized by high levels of negative effects such as depression and anxiety. Psychoticism is associated not only with the liability to have a psychotic episode (or break with reality), but also with aggression. Psychotic behavior is rooted in the characteristics of tough mindedness, nonconformity, inconsideration, recklessness, hostility, anger, and impulsiveness. The questionnaire is formed of 99 questions to be answered by yes or no. Each one of the five dimensions has certain questions and each question takes a score; then the total score for each dimension is calculated.

Body Image Scale [12]: this scale is based on the phenomena that body image is the mental picture or presentation of the body at times of rest and movement or either. It is derived from the internal perception of external appearance and internal body, and also from accompanied emotional experiences and its reflection on interactions with self and others. This scale is self rated, formed of 26 items and every patient answers in three grades from totally accepting to totally not accepting with a score from 0 to 2 for each item. The normal range for

male patients is 14 ± 6 and for female patients is 16 ± 6, above which the body image is considered as disturbed.

Rating Scales for Psychopathological Health Status and Quality of Life Scale (PCASEE) [13] *Arabic version*: it is a self-rated scale. Clarify the subjective expression of the QOL of the patients. It consists of six domains to estimate the degree of impairment in the QOL of the patients. These domains are physical, cognitive, affective, social, economic, and ego.

Scoring of the scale was done for each item from 0 to 2, where 0 stands for bad response, 1 for moderate response, and 2 for good response. The results were calculated by multiplying the sum of each domain with 4 to obtain the percentage for QOL. Therefore, 100% means the best QOL.

Statistical analysis

All statistical calculations were done using computer programs Microsoft Excel 2007 (Microsoft Corporation, New York, USA) and SPSS (Statistical Package for the Social Science; SPSS Inc., Chicago, Illinois, USA) version 15 for Microsoft Windows. Descriptive statistics was used for illustrating the mean and standard deviation of quantitative data. Statistical tests were used to find out the significant differences between the two groups. The student *t*-test was used for quantitative variables, for example, age, BDI, Beck Anxiety Inventory, Quality of Life Scale, and Body Image Scale. The χ^2-test was used for qualitative variables, for example, sex, education, occupation, marital status, socioeconomic level, and EPQ. Correlation coefficient test was used for correlation between depression (BDI) and Quality –of Life Scale. Probability level (P value < 0.05) was considered to be statistically significant [14].

Results

Sociodemographic data

There were no statistically significant differences regarding age, sex, marital status, education, and occupation.

Clinical profile of the psoriasis group

The age of onset of psoriasis ranges from 14 to 44 years, with a mean of 28.93 years and a standard deviation of + 9.4 years. The duration of illness in psoriatic patients ranges from 1 to 28 years, with a mean of 9.3 years and a standard deviation of + 7.97 years. Twenty psoriatic patients had lesions on their face and hands (66.7%), which were absent in 10 patients (33.3%). In contrast, eight patients had nail involvement (26.7%), which was absent in 22 patients (73.3%). Four psoriatic patients had joint involvement (13.3%), which was absent in 26 patients (86.7%).

Table 1 Distribution of psychiatric symptoms in patients with psoriasis

	Psoriasis patients $n=30$	
Psychiatric symptoms	*N*	Percentage
Depressed mood	20	66.7
Suicidal ideation	2	6.7
Suicidal attempt	1	3.3
Obsessions	4	13.3
Panic attacks	4	13.3
Worry from chronicity	17	56.7
Worry from recurrence	18	60.0
Sexual dysfunctions	18	60.0

N, numbers.

Table 2 Psychiatric diagnosis in patients with psoriases

Psychiatric diagnosis in psoriasis group ($n=30$)	*N*	Percentage
Major depressive disorder	8	26.7
Adjustment disorder with depressed mood	7	23.3
Dythymic disorder	4	13.3
Mixed anxiety and depression	1	3.3
Bipolar I disorder	1	3.3
No psychiatric diagnosis	9	30.0
Total	30	100

N, numbers.

Table 1 shows that depression is the most presenting psychiatric symptoms in patients with psoriasis and as shown in table 3 the score of depression in Beck depression inventory was higher in patients than control and the difference was statistically significant. Table 4 also shows that 43% of patients with psoriasis has severe depression.

Table 2 shows that 21 psoriatic patients (70%) had psychiatric diagnoses according to the DSM-IV and SCID-I [8,9].

Table 5 shows that there is a statistically significant difference between the psoriasis group and controls regarding Neuroticism, Introversion, and Lie Scales.

Table 6 shows that there is a statistical significant deference between the two groups as regards the disturbed body image

Table 7 shows that there is a statistically significant difference between the two groups regarding the physical, cognitive, affective, social, economic, and ego problems.

As regards depression and site of the lesion, patients with psoriatic lesions on their hand and face had a higher score on BDI, with a mean of 32.2 and standard deviation of ± 15.5 compared with those without lesions on their hand and face, with a mean of 19.9 and standard deviation of ± 15.4. There were statistically significant differences between the two groups ($P = 0.04$).

There is a statistically significant difference between the psoriasis group with disturbed body image and the

Table 3 Beck depression inventory in the psoriasis group and the control group

Beck depression inventory	Psoriasis group $n=30$	Control group $n=30$	*P*
Mean	28.1	10.03	
Standard deviation	±16.3	±7.1	0.000*

N, numbers.
$P<0.05$ is statistically significant.

Table 4 The severity of beck depression inventory (BDI) in the patients group and controls

	Psoriasis group $n=30$		Control group $n=30$			
Beck depression inventory	*N*	%	*N*	%	χ^2	*P*
Absent	7	23.3	20	66.7		
Mild	5	16.7	10	33.3		
Moderate	5	16.7	0	0.0	21.2	0.000*
Severe	13	43.3	0	0.0		
Total	30	100.0	30	100.0		

N, numbers.
*$P<0.05$ is statistically significant.

psoriasis group without disturbed body image as regards Neuroticism and Introversion, whereas there is no statistically significanct difference between the two groups regarding Psychoticism, Criminality, and Lie.

There are statistically significant negative correlations between BDI and Quality of Life Scale in all its subscales: physical ($P = 0.000$), cognitive ($P = 0.000$), affective ($P = 0.000$), social ($P = 0.001$), economic ($P = 0.037$), and ego problems ($P = 0.000$). This means that the increase in severity of depression is associated with decrease in QOL.

Discussion

In viewing the demographic data of the sample it can be noticed that there were no statistically significant differences between the psoriasis and the control group as regards all the sociodemographic data including age, sex, marital status, education, and occupation. This indicated that the samples were well matched and fit for the study and comparison. Our study indicates that

Table 6 Body image scale in the psoriasis group and the control group

Body image scale	Psoriasis group $n=30$	Control group $n=30$	*P*
Mean	23.03	8.3	
Standard deviation	±10.7	±7.03	0.000*

*$P<0.05$ is statistically significant.

the average age of onset in the psoriasis vulgaris group was 28.9 ± 9.4 years, with a range of 14–44 years and the average duration of illness in patients with psoriasis vulgaris was 9.3 ± 7.9 years. These results correspond with another recent study carried out on 50 consecutive patients with psoriasis in which the average age of onset was 31.1 ± 12.7 years and the duration of illness was 6.7 ± 5.7 years [15].

As regards the psychiatric morbidity, a study of 149 patients referred to liaison psychiatrist from a dermatology clinic reported that 95% warranted psychiatric diagnosis. Of these, depressive illness accounted for 44% and anxiety disorders for 35%, less common psychiatric disorders included social phobia, somatization disorder, alcohol dependence syndrome, obsessive–convulsive disorder, post-traumatic stress disorder, anorexia nervosa, and schizophrenia [16]. Our study revealed that 70% of patients with psoriasis have a psychiatric diagnosis according to DSM-IV, SCID-I [8,9]. Our findings could be compared with another study that found psychiatric comorbidity in 47.6% of the patients with psoriasis vulgaris [17]. Our findings also could be compared with another Egyptian study done on 50 patients with psoriasis identified psychiatric co-morbidity in 38% of them [18]. These differences in the prevalence of psychiatric disorders in psoriasis in the different studies could be explained by the diversity of psychiatric morbidity in psoriasis, which may be related to the sample size, the difference in patient

Table 5 Eysenck personality questionnaire (EPQ) in the psoriasis patients and the control group

	Psoriasis group $n=30$		Control group $n=30$		
Eysenck personality questionnaire (EPQ)	*N*	%	*N*	%	*P*
Psychoticism					
Normal	15	50.0	20	66.7	
Significant	15	50.0	10	33.3	0.295
Total	30	100.0	30	100.0	
Neuroticism					
Normal	9	30.0	21	70.0	
Significant	21	70.0	9	30.0	0.004*
Total	30	100.0	30	100.0	
Introversion					
Normal	12	40.0	26	86.7	
Significant	18	60.0	4	13.3	0.000*
Total	30	100.0	30	100.0	
Lie					
Normal	12	40.0	21	70.0	
Significant	18	60.0	9	30.0	0.018*
Total	30	100.0	30	100.0	
Criminality					
Normal	20	66.7	23	76.7	
Significant	10	33.3	7	23.3	0.567
Total	30	100.0	30	100.0	

N, numbers.
*$P<0.05$ is statistically significant.

Table 7 Quality of life scale in the psoriasis patients and the control group

	Psoriasis group $n=30$		Control group $n=30$		
Quality of life scale	Mean	SD	Mean	SD	*P*
Physical problems	36.7	±23.5	85.0	±12.5	0.000*
Cognitive problems	65.7	±26.5	86.7	±13.7	0.000*
Affective problems	52.0	±26.6	79.3	±15.7	0.000*
Social problems	58.0	±23.1	79.7	±14.7	0.000*
Economic problems	42.0	±27.1	69.7	±16.9	0.000*
Ego problems	51.0	±19.0	71.3	±12.2	0.000*

*$P<0.05$ is statistically significant.

selection, the duration of illness, and the different psychometric measures used with different cutoff scores used. Even studies that used standardized diagnostic criteria do not allow us to come to a conclusion about the relative prevalence of the psychiatric disorders in psoriasis.

In our study, the most common diagnosis was major depressive disorder (26.7%) followed by adjustment disorder with depressed mood (23.3%) then Dythymic disorder (13.3%), and only 3.3% have diagnosis of mixed anxiety and depression and 3.3% have diagnosis of bipolar I disorder. These findings were compared with the results of the study carried out using Mini International Neuro-Psychiatric Interview, and it was found that the most common psychiatric comorbidity in patients with psoriasis vulgaris was depression (28%) followed by suicidality (6%), alcohol abuse and dependence (6%), psychotic disorder and mood disorder with psychotic features (4%), generalized anxiety disorder (4%), social phobia (2%), and dysthymia (2%) [16]. The difference in the prevalence of different psychiatric comorbidities especially anxiety and depression in our study and this study could be due to the difference in the diagnostic systems used. In addition, different methodologies such as difference in population characters could also be the reason (for example the percentage of male patients in this study were 86% which is much higher than that of our study 53.3%, also our study showed higher illiteracy and unemployment than this study). All these factors make the comparison between both studies difficult. Suicidal ideation is a serious problem among sufferers of psoriasis. In our study, the rate of suicidal ideation was 6.7 and 3.3% had attempted suicide. This finding is consistent with that reported in another study carried out by Gupta *et al.* [19] who found that 9.7% of patients with psoriasis expressed a wish to die and 5.5% were experiencing active suicidal ideation at the time of the study. These rates are up to greater than two-folds that are found in the general community [20]. The rate of suicidal ideation among 79 outpatients being treated for psoriasis was 2.5%, consistent with figures seen in other populations with chronic illness [21]. However, among the 138 inpatients in the study, the rate was 7.2%. The difference in percentage of suicidal ideation between the outpatient and the inpatient groups could be explained by the degree of severity of psoriasis, which was extensive in the inpatient group with higher body surface area involved compared with the outpatient group [21]. In a more recent study who found suicidal ideation in 6% of patient with psoriasis and this could be related to the chronic nature of the disease and the limited life style associated with the disease [15]. In contrast, sexual problems and sexual dysfunction are common symptoms that are associated with psoriatic patients. Sixty percent of the psoriatic patients reported had sexual dysfunctions. This finding is consistent with another survey that found that more than 40% of sufferers felt that psoriasis had an adverse effect on their sexual functioning. In this study, joint involvement, more scaling, more pruritus, and higher depression scores were all significantly associated with impaired sexual functioning [22].

Beck Depression Inventory

This study showed that there were statistically significant differences between the group of psoriatic patients and normal control as regards BDI, with a mean of 28.1 ± 16.3 for the psoriasis group compared with 10.03 ± 7.1 for the control group. Many studies support this result; one of the studies found average BDI scores to be 17.96 ± 9.49 for the psoriatic patients and 8.15 ± 6.69 for the controls [23]. This could be explained by the possibility that people with skin diseases, especially psoriasis, suffer limitations in their social and interpersonal relations; they show signs of shame related to their appearance and sense of insecurity with a decreased possibility of finding any job. All these factors have a great impact on the self-esteem of psoriatic patients, which make them more vulnerable to develop depression.

When the BDI scores were assessed on the basis of mild, moderate, and severe depression, we found that overall 16.7% of the patients with psoriasis had scores corresponding to mild depression, 16.7% to moderate depression, and 43.3% to severe depression. Although there are few studies that quantify the level of depression scores, our findings are to be compared with that of another study [23] carried out on 50 patients with psoriases, which did not agree with our results and found that the majority of the patients had scores corresponding to moderate depression (32%) whereas 26% corresponded to severe depression [23]. The difference between the two studies may be interpreted by the different social, educational, and economic factors in addition to the different medical care and the early diagnosis of depression due to the good screening and effective referral system.

Eysenck Personality Questionnaire

Generally, there is no specific personality for psoriasis and the suggestion that patients with psoriasis have an underlying personality style needs further researches. This is why we tried to assess the personality characteristics of the psoriatic patients in our study, and we found that most of the patients in the psoriasis group showed significant higher score in the Neuroticism Scale, Introversion Scale, and Lie Scale. These results are consistent with the findings of another study [24] carried out on 50 Egyptian patients suffering from psoriasis and proved psoriatic patients to score significantly higher than normal regarding Introversion Scale, Neuroticism Scale, and Lie Scale [24].

Body Image Scale

Our study showed that there were statistically significant differences between the group of psoriatic patients and controls as regards the Body Image Scale, with a mean of 23.03 ± 10.7 in the psoriasis group and 8.3 ± 7.03 in the control group, which conclude that psoriatic patients showed more disturbed body image than normal. This could be explained by the idea that psoriasis has a great impact on the patients' appearance and perception of their own body, which make a great discrepancy between their perceived body and their ideal body. This finding agrees with the results of another study, which conclude that one of the most common psychiatric symptoms attributed to psoriasis include disturbance in body image, which in turn affect social and occupational functioning [25].

Quality of Life Scale (PCASEE)

In our study, we tried not only to examine the QOL of the patient with psoriasis in general but also to specify the degree of impairment in the QOL in each domain (physical, cognitive, affective, social, economic, and ego problems). We found that the group of patients with psoriasis showed lower score in every domain (physical, cognitive, affective, social, economic, and ego problems) when compared with the control group with a statistically significant difference. This result is consistent with the results of a study carried out on Egyptian patients suffering from psoriasis using the same Quality of Life Scale (PCASEE) and found that Psoriasis had the worst QOL compared with Vitiligo and Alopecia areata [18]. Moreover, the degree of psychosocial disability tended to be disproportionate with the degree of physical disability resulting from psoriasis [26]. In addition, the low score on the economic subscale of the Quality of Life Scale in our results is consistent with the finding that psoriasis also adversely affects patients' occupational capability, which can lead to significant financial difficulty [27].

Relationship between depression and site of lesions

In this study, we found a strong relationship between the presence of psoriatic lesions on the exposed sites, such as hand and face, in addition to nail involvement and depression. The mean BDI in the patients with psoriatic lesions on the hand and face was 32.2 ± 15.5 and on the nails was 39.4 ± 12.6, whereas those without lesions on the hand and face was 19.9 ± 15.4 and on nails was 24 ± 15.7 with a statistically significant difference. The above findings are confirmed by the study by Krueger *et al.* [28], who found that the visible area of involvement resulted in more impact on patients' life than involvement of the same size in other invisible areas. It was reported that nail involvement contributed to restrictions in daily activities in almost two-thirds of individuals, who have their impact on the QOL [29].

Relationship between personality characteristics of psoriatic patients and body image

In our study, we also tried to examine the relationship between the body image and the personality characteristics of patients with psoriasis, which to our knowledge is the first study that has investigated such a relationship. We found that there is statistically significant difference between the psoriasis group who had a disturbed body image and the psoriasis group without a disturbed body image regarding Neuroticism and Introversion. This finding supports the idea that the perception of psoriatic patients to their body influences their emotional experience and interaction with others. This idea is consistent with the findings of Jowett and Ryan's [30] study who reported that 89% of patients with psoriasis felt shame and embarrassment over their appearance, 58% suffered from anxiety, and 42% suffered from lack of confidence.

Correlation between depression, anxiety, and QOL

Currently, there is convincing evidence that depression plays an important role in the QOL in patients with psoriasis. Our study found that there is a statistically significant negative correlation between BDI and Quality of Life Scale in all its subscales: physical, cognitive, affective, social, economic, and ego problems. This means that the increase in severity of depression is associated with decrease in QOL and the same for Beck Anxiety Inventory and QOL. These findings are consistent with the study [18] carried out on 50 Egyptian psoriatic patients using the same Quality of Life Scale (PCASEE) and found that there is strong association between psychiatric morbidity and poorer QOL in psoriasis [18]. This is in agreement with the findings of another study that concurrent depression affects health related QOL of patients suffering from psoriasis at least as much as the clinical severity of their psoriasis [31]. The above results appear to be a strong support for the argument that the subjective experience of psoriasis is a more powerful determinant of QOL than is the degree of objective severity [32].

Limitations

(1) The patients were recruited from dermatology clinic and may therefore not be representative of all patients with psoriasis.
(2) Small sample size lead to smaller subgroups.
(3) We did not compare our results with another skin disease.

Conclusion

Findings of the study and other studies reported in the literature indicate that there is a high frequency of psychiatric comorbidities in patients with psoriasis especially depression, which represents the most frequent psychiatric disorder in psoriasis. The presence of psychiatric comorbidities increases the impairment in QOL in psoriatic patients. Although there are no specific personality characteristics for patients with psoriasis, our study found that the patients with psoriasis showed more neuroticism, introversion, and lie than controls. In addition, the disturbed body image perceived by patients about themselves plays an important role in shaping their personality.

There is no conflict of interest to declare.

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الملخص العربى

الاعراض النفسيه المصاحبه لمرضي الصدفيه

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يعتبر مرض الصدفية من الأمراض الجلدية الشائعة حيث يصيب ما يقرب من ٢ % من السكان. ومن المعروف أن الصدفية القشرية هى أكثر الأنواع شيوعاً وهى التهاب جلدي غالباً ما يكون مزمناً وتتميز بطبقة محمرة من الجلد تغطيها القشور وقد تكون مصحوبة بألم أو حكة. وقد يصاحب الصدفية التهابات مفصلية شديدة تؤدي إلى تغيرات مزمنة في المفصل فيما يقرب من ٣٠% من المرضى . و تشير أحدث الدراسات أن ما يقرب من ٣٠ % من المرضى المترددين على عيادات الأمراض الجلدية يعانون من أمراض نفسية قد تؤثر على إستجابتهم للعلاج. ويعد مرض الصدفية من أكثر الأمراض الجلدية التى تصاحبها أمراض نفسية .وقد تزايدت فى السنوات الاخيرة الدلائل على وجود العديد من الأعراض النفسية والمشاكل الإجتماعية المصاحبة لداء الصدفية كثيرة و متنوعة منها: الإكتئاب القلق،الأنطواء و الأنعزال الأجتماعى، المشاكل الجنسية و زيادة الميول الإنتحارية مما يكون له بالغ الأثر على نوعية الحياة للمريض. ولقد كانت أهداف البحث هى تحديد نسبة وانواع الأمراض النفسية المصاحبة لمرض الصدفية مثل الأكتئاب والقلق ومدى تأثيرها على نوعية الحياة للمريض . وكذلك دراسة السمات الشخصية لمرضى الصدفية. وقد خضع جميع الأشخاص الذين شملتهم الدراسة إلى: جمع البيانات الديمجرافية مثل : السن والنوع و المهنة و الحالة الإجتماعية .فحص الحالات فحصاً نفسياً اكلينكياً دقيقاً مقياس بيك للإكتئاب .إختبار صورة الجسم.إختبار أيزنك للشخصية . إختبار نوعية الحياة للمريض النفسى. وجد من خلال البحث مايلى: لا توجد إختلافات إيجابية بين مرضى الصدفية والعينة الضابطة من حيث السن والنوع و المهنة و الحالة الإجتماعية والإقتصادية و المستوى التعليمى . وجد أن ٧٠ % من مرضى الصدفية يعانون من أمراض نفسية حيث يمثل الإكتئاب المرض الأكثر شيوعاً . توجد إختلافات إيجابية بين مرضى الصدفية والعينة الضابطة من حيث مقياس بيك للإكتئاب حيث وجد أن نسبة الإكتئاب أعلى عند مرضى الصدفية وذو دلالة إحصائية . توجد إختلافات إيجابية بين مرضى الصدفية والعينة الضابطة من حيث مقياس بيك للقلق حيث وجد أن نسبة القلق أعلى عند مرضى الصدفية وذو دلالة إحصائية .توجد إختلافات إيجابية بين مرضى الصدفية والعينة الضابطة من حيث إختبار صورة الجسم حيث وجد أن نسبة التشوه فى صورةالجسم أعلى عند مرضى الصدفية وذو دلالة إحصائية . توجد إختلافات إيجابية بين مرضى الصدفية والعينة الضابطة من حيث إختبار نوعية الحياة للمريض النفسى حيث وجد أن نوعية الحياة عند مرضى الصدفية اقل مستوى وذو دلالة إحصائية من جميع النواحى المادية و الإجتماعية و المعرفية و الجسدية و المزاجية و الذاتية . فيما يتعلق بالسمات الشخصية بتطبيق إختبار أيزنك للشخصية وجد أن مرضى الصدفية يميلون أكثر إلى الإنطوائية و الكذب وهم أكثر عصابية من العينة الضابطة وذو دلالة إحصائية . توجد علاقة عكسية وذو دلالة إحصائية بين الإكتئاب ونوعية الحياة لمرضى الصدفية .كما توجد أيضاً علاقة عكسية وذو دلالة إحصائية بين القلق ونوعية الحياة لمرضى الصدفية .وأخيراً توجد علاقة طردية إيجابية بين مدة المرض و درجة تشوه صورة الجسم لدى مرضى الصدفية .