

## Perceived stress, stress attributions and psychological distress in psoriasis

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Received 7 October 2002; accepted 5 March 2004

### Abstract

**Objective:** The objective of this study was to measure causal beliefs in individuals with psoriasis and to explore their relationship with perceived stress, quality of life, psychological well-being and psoriasis severity. **Methods:** This study was cross-sectional in design, and patients were required to complete validated questionnaires assessing perceptions of illness, quality of life, psoriasis severity, perceived stress and psychological mood. A total of 141 individuals were recruited from two settings: an outpatient skin clinic at King’s College Hospital and the Psoriasis Association. **Results:** A strong belief in stress/psychological attributes as a

causal factor was found in 61% of the sample. This belief was significantly associated with higher levels of anxiety, depression and perceived stress ( $r \geq .38$ ;  $P \leq .0001$ ). Perceived stress in this sample was significantly associated with a poorer level of quality of life, higher levels of anxiety and depression ( $r \geq .27$ ;  $P \leq .002$ ) but not with psoriasis severity. **Conclusions:** The belief that stress is causal was associated with lower levels of psychological well-being. However, there was no association between perceived stress and more objective measures of psoriasis severity.

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**Keywords:** Psoriasis; Stress; Illness perceptions; Causal beliefs

### Introduction

Psoriasis is a chronic, noncontagious skin condition characterised by lesions of inflamed and scaly skin. It affects between 1% and 2% of the UK population, with an equal gender distribution [1]. The most common form is chronic plaque psoriasis, where the lesions are typically round in shape, a few centimetres in diameter, raised and covered in a silvery scale. The severity can range from lesions on the elbows alone to extensive body and scalp coverage. The severity of psoriasis is rarely static. Individuals are likely to cycle between differing levels of severity throughout their lifetime. Many individuals with psoriasis experience ‘spontaneous’ remissions and flare-ups during the course of their condition.

Whilst the pathogenesis of psoriasis is not known, psychological stress has been implicated as a potential trigger in the onset and exacerbation of the condition [2]. One frequently cited study was conducted by Gaston et al. [3]. In this study, five individuals with scalp psoriasis completed several weekly measures over a 20-week period. These included ratings of life events experienced in the prior week, self-reported psychological distress and clinician ratings of psoriasis severity. The results indicated that psoriasis ratings were weakly correlated with the impact of adverse life events (a shared variance of 5%) and also with psychological distress (a shared variance of 10%). Although there are a number of methodological difficulties with this study, it is frequently cited as having demonstrated a conclusive link between psoriasis and stress.

Another study, frequently cited as demonstrating a relationship between stress and psoriasis, compared the psychoendocrine and metabolic reactions of 10 males with psoriasis and 10 healthy controls during a stressful event [4]. The results found that digital pulse rate was higher in the

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controls, the decrease in serum cortisol was significantly greater in individuals with psoriasis, and plasma glucose and adrenaline levels were higher in individuals with psoriasis. These differences, which only just reached statistical significance, may have been related to differences between the two groups other than the presence of psoriasis. The healthy controls were medical students, whilst the individuals with psoriasis were recruited from an outpatient clinic. The two groups differed on their ratings of the stressful procedure, with the individuals with psoriasis finding it significantly more stressful. Arnetz et al. [4] conclude that “the results from the present study should be used with caution”.

Despite the lack of firm evidence, many individuals with psoriasis cite stress as a causal or exacerbating factor. A number of studies have found that high proportions of those with psoriasis report stress as the major precipitating factor in the onset and exacerbation of their condition [5,6]. Al'Abadie et al. [7] found that people with psoriasis were more likely to report a stressful experience as predating the onset or exacerbation than those with other skin conditions, such as acne, alopecia and basal cell carcinoma.

Many people with psoriasis may have been told by their GP or dermatologist that psoriasis is a stress-related condition. One popular self-help book for psoriasis [8] states the following:

Stress or worry can often affect psoriasis. It frequently seems to break out badly just before an examination, or after someone has suffered a sudden severe shock or bereavement.

Such explanations are likely to lead to a cognitive bias in the remembering and reporting of stressful events. Regarding their results of their survey, Al'Abadie et al. [7] state “because severe and stressful life events are common, it is possible that patients who held the prior belief that their disease was stress-related were more likely to cite events than patients who did not hold such a belief. Patients with psoriasis may have been more likely to hold this belief than patients with other conditions, and so could have looked for confirmation”.

In current health psychology research, causal beliefs are often conceptualised as one component of an individual's illness perception, along with beliefs about the length of time that the illness will last, the amount of control they have over the illness and the impact of it [9]. Little research has been carried out looking at the impact of such causal beliefs on treatment outcome and mood. In a review, Sensky [10] suggests that to explain negative or unexpected events, such as an illness, most people tend to look for an environmental cause first and, if this is not available, then for a cause within themselves. Sensky [10] suggests that people who are depressed are more likely to attribute the cause to themselves and that these dispositional attributions are abnormal and potentially pathological. Research with people complaining of fatigue has also supported these hypotheses. Chalder et al. [11] found that those who attributed their tiredness to stress were more

handicapped at follow-up than those who attributed their fatigue to social factors.

Fortune et al. [12] have examined causal beliefs and their association with pathological worry in a psoriasis population. Causal beliefs were divided into two groups, emotional and physical cause perceptions, and a stronger belief in emotional causes was associated with pathological worry. This research suggests that such dispositional attributes in psoriasis populations may have a detrimental impact. This is of particular significance, given that psoriasis is widely attributed to stress and, yet, there is only a small body of evidence to suggest that this is the case.

The present study has two main aims. The first aim is to assess causal beliefs in a psoriasis population and to examine the link between these attributions and mood, quality of life and health status in psoriasis. It is hypothesised that stress as a causal belief is associated with higher levels of psychological distress and poorer levels of quality of life and health status.

The second aim of this study is to measure perceived stress and examine the relationship with psychological well-being and psoriasis severity. It is hypothesised that higher levels of perceived stress are associated with poorer levels of psychological well-being and psoriasis severity.

## Methods

### Procedure

Individuals with psoriasis were recruited from two settings: 40 from an outpatient skin clinic and 101 from the Psoriasis Association. Patients were included if they had current diagnosis of psoriasis provided by a dermatologist, no other chronic skin condition, were able to read and understand the questionnaires and were 16 years of age or older. Ethical committee approval was granted for the study.

(i) The outpatient sample ( $n=40$ ) comprised psoriasis patients attending an outpatient skin clinic. Of the 52 patients who fulfilled entry criteria, 5 patients refused and 7 patients who took questionnaire packs did not return them. Those who agreed to take part were asked to read a patient information sheet and sign a consent form. Patients were assured that their responses would not be seen by any clinic staff and would not affect their treatment. In total, 40 outpatients entered the study and completed the questionnaires.

(ii) The Psoriasis Association sample ( $n=101$ ) were recruited through two adverts placed in the Psoriasis Association newsletter requesting volunteers. A total of 116 individuals responded by writing or telephoning the researcher. A cover letter, a pack of questionnaires and a stamped-addressed envelope in which to return the completed questionnaires were sent to the individuals. Instructions were given to complete the questionnaire alone, and a telephone number was provided in case of

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