International Journal of Innovative Technologies in Social Science

e-ISSN: 2544-9435

Scholarly Publisher
RS Global Sp. z O.O.
ISNI: 0000 0004 8495 2390

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ARTICLE TITLE	THE IMPACT OF PSORIASIS ON MENTAL AND SOCIAL WELL-BEING: A LITERATURE REVIEW FROM A PSYCHODERMATOLOGICAL PERSPECTIVE
ARTICLE INFO	Agnieszka Waszczuk, Paweł Sosnowski, Mateusz Świątko, Anna Tokarska, Marcin Grzebyk, Aleksandra Arnista, Joanna Rybak, Katarzyna Gawrońska, Aleksandra Kołodziejczyk, Piotr Łapiński. (2025) The Impact of Psoriasis on Mental and Social Well-Being: A Literature Review From A Psychodermatological Perspective. *International Journal of Innovative Technologies in Social Science*. 2(46). doi: 10.31435/ijitss.2(46).2025.3366
DOI	https://doi.org/10.31435/ijitss.2(46).2025.3366
RECEIVED	23 May 2025
ACCEPTED	17 June 2025
PUBLISHED	30 June 2025
LICENSE	The article is licensed under a **Creative Commons Attribution 4.0 International License.**

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THE IMPACT OF PSORIASIS ON MENTAL AND SOCIAL WELL-BEING: A LITERATURE REVIEW FROM A PSYCHODERMATOLOGICAL PERSPECTIVE

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ABSTRACT

Psoriasis, a chronic inflammatory skin disease, poses challenges not only due to its somatic symptoms but also because of its significant impact on patients' quality of life, mental health, and social and occupational functioning. This review aimed to analyze the multidimensional influence of psoriasis on patients' psychosocial condition, with particular attention to stigmatization, symptoms of depression and anxiety, suicide risk, and factors affecting quality of life. The analysis is based on up-to-date literature from systematic reviews, cross-sectional and qualitative studies published between 2010 and 2025. Findings indicate that patients with psoriasis are significantly more likely to experience depressive and anxiety disorders, often regardless of lesion severity. Subjective factors such as body image perception, social stigma, loss of control over one's body, and limitations in professional life play a crucial role. Importantly, some patients exhibit suicidal ideation at early stages of the disease, even before treatment begins. Simultaneously, evidence points to the necessity of an integrated care model that includes dermatological, psychological, and social support. Incorporating mental health and quality of life assessments into routine clinical practice can significantly improve treatment outcomes and patient well-being. This review emphasizes the need for a holistic approach to psoriasis management that addresses not only physical but also psychological and social dimensions.

KEYWORDS

Psoriasis, Depression, Stigmatization, Quality of Life

CITATION

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Introduction.

Psoriasis, historically classified as a condition limited to the skin, is now recognized as a chronic immunological disease involving abnormal activation of both innate and adaptive immune responses [1]. The skin manifestations, while most visible, are only the external reflection of deeper systemic inflammatory disturbances. The clinical spectrum of psoriasis includes a range of forms—from the most common plaque psoriasis to guttate, inverse, pustular variants, and severe erythroderma, which can be life-threatening. Lesions in sensitive areas such as the face, genitals, nails, and scalp are associated with a significant reduction in quality of life and require an individualized therapeutic approach. Approximately 30% of patients develop psoriatic arthritis, which may coexist with or precede skin symptoms, leading to considerable physical disability [2].

Data from a cross-sectional study conducted among Polish psoriasis patients revealed that the average age of disease onset was just under 28 years, with more than 78% of cases classified as type I, strongly associated with genetic predispositions. A total of 83% of patients reported distressing itching, and the average Dermatology Life Quality Index (DLQI) score of 12 confirmed the substantial impact of the disease on daily functioning and overall quality of life [3].

It is also worth noting that psoriasis affects not only the body but also the psyche of the patient. Many individuals exhibit characteristics of a Type D ("distressed") personality, marked by high levels of negative emotionality and a tendency to suppress emotions in interpersonal relationships [4]. The psychological and social consequences of the disease can be as burdensome as its physical symptoms. Restrictions in professional activity—often due to the need for treatment or social stigmatization—can result in economic difficulties and disruption of family relationships. Consequently, patients are more likely to experience chronic stress, which not only worsens somatic symptoms but also increases the risk of depression, anxiety disorders, and the use of maladaptive coping strategies such as smoking, alcohol abuse, or physical inactivity [5].

In light of these findings, it becomes clear that effective treatment of psoriasis should involve not only the management of dermatological symptoms but also a comprehensive assessment of the patient's mental state and social functioning. Only a holistic approach offers a realistic chance to improve quality of life and minimize the long-term consequences of the disease.

The aim of this review is to analyze the multidimensional impact of psoriasis on patients' mental and social functioning, with particular focus on quality of life, stigmatization, depressive symptoms, and the effectiveness of available psychological interventions. The article seeks to portray psoriasis not merely as a skin condition but as a disorder with significant emotional, relational, and occupational impact. It also considers the role of psychotherapy, social support, and factors influencing treatment effectiveness in daily clinical practice. An additional objective of this work is to formulate practical recommendations that may support the implementation of a more integrated and empathetic care model for psoriasis patients—one that considers both physical and psychological needs.

Methodology

This review is based on an analysis of current and verified scientific sources focusing on psoriasis as a chronic, systemic inflammatory disease. Special emphasis was placed on studies exploring the interrelationship between psoriasis and mental health conditions such as depression, anxiety, and social stigmatization. To ensure the reliability and currency of the data, literature searches were conducted using reputable international databases, including PubMed and Google Scholar. The publication selection process was guided by a well-defined search strategy, applying combinations of English-language keywords such as “psoriasis,” “mental health,” “depression,” “anxiety,” “quality of life,” “stigma,” and “psychosocial impact.”

The review includes articles published between 2010 and 2025, encompassing original studies, systematic reviews, meta-analyses, and guidelines issued by scientific societies. Selection criteria were based on qualitative standards—priority was given to peer-reviewed publications with an impact factor and full-text availability. A critical and synthetic content analysis was conducted, allowing for the identification of key relationships and the recognition of areas that require further investigation.

Results

Depression

Among the numerous health consequences of psoriasis, increasing attention has been paid to its comorbidity with mental disorders, particularly depression. Epidemiological evidence indicates that patients with this chronic dermatosis are significantly more likely to develop severe depressive symptoms, regardless of the severity of their skin lesions. A cross-sectional study using data from the U.S. National Health and Nutrition Examination Survey (NHANES) from 2009–2012, which included a representative sample of adult residents, showed that individuals diagnosed with psoriasis were more likely to meet the clinical criteria for major depression compared to dermatologically healthy individuals. Importantly, the analysis found no correlation between lesion severity and depression, suggesting a dominant role for subjective factors—such as body image perception, experiences of social stigma, and coping strategies—in the development of depressive symptoms [6].

Further empirical evidence was provided by a study by Fabrazzo et al. (2022), which examined the relationship between psoriasis severity and depression among 120 outpatients. The study included both dermatological parameters (PASI and PSOdisk) and psychiatric evaluations. The analysis showed that depression severity increased with the severity of skin lesions, particularly among patients with the highest PSOdisk scores. Notably, these patients more frequently used maladaptive coping strategies, such as behavioral withdrawal, which strongly correlated with poorer mental quality of life and intensified depressive symptoms [7].

Another study conducted in Germany on a broad sample of 722 patients confirmed these findings. The authors focused on a comprehensive assessment of mental well-being among psoriasis patients, showing that the strongest predictors of psychological distress were the subjective assessment of disease severity and current exacerbations. Interestingly, patients with longer disease duration and those who experienced improvement in skin condition demonstrated higher levels of well-being. Factor analysis confirmed that depression and happiness are two distinct psychological constructs, with important clinical implications—improvement in skin condition does not always translate into improved mental health [8].

From a biological perspective, growing evidence suggests common pathophysiological mechanisms between psoriasis and depression. Patients with both conditions exhibit elevated levels of proinflammatory cytokines such as TNF-α, IL-6, and C-reactive protein (CRP), indicating that chronic inflammation may be a shared pathway linking these disorders [9]. Moreover, biologic treatments aimed at reducing systemic inflammation—particularly

TNF-α inhibitors—provide not only dermatologic symptom relief but also significant reductions in depressive symptoms. This effect appears to stem not only from improved appearance and reduced stigma but also from modulation of neuroinflammatory processes affecting the central nervous system [10].

Table 1. Common Inflammatory Biomarkers in Psoriasis and Depression. Source: Auther

Biomarker	**Role in Psoriasis**	**Role in Depression**	**Clinical Significance**
TNF-α	Major pro-inflammatory cytokine; drives Th1/Th17 response; promotes keratinocyte proliferation	Elevated in patients with depression; may affect neurotransmitter metabolism	Target for biologic therapies; inhibition improves both skin condition and psychological well-being
IL-6	Involved in chronic inflammation; correlates with skin symptom severity	High levels associated with anhedonia and low mood	Can serve as a marker of active inflammation in both conditions
CRP	Acute-phase protein; elevated in patients with active psoriasis	Increased in individuals with somatic-type depression	Systemic inflammation marker; easily measurable indicator of comorbidity risk
IL-1β	Induces inflammation; activates keratinocytes and dendritic cells	May impair neuroplasticity and influence cortisol secretion	Promising therapeutic target; potential use of IL-1β inhibitors in treatment-resistant depression
IL-17 / IL-23	Key Th17-axis cytokines; responsible for chronic inflammation in psoriasis	Role in depression under investigation; may modulate HPA axis and microglia	Main targets of modern biologic drugs in dermatology
BDNF	Less studied in psoriasis; potentially reduced when depression is comorbid	Reduced BDNF strongly linked to depression and impaired neurogenesis	May explain the cognitive and mood effects of inflammation
Melatonin / Vitamin D3	Low levels may occur in psoriasis patients	Deficiency linked to seasonal depression and mood disorders	Supplementation may have supportive effects in both disorders by correcting deficiencies that can influence inflammatory and neuroendocrine pathways

Strong evidence supporting this association is provided by the PSOLAR (Psoriasis Longitudinal Assessment and Registry), a multicenter cohort study involving over 12,000 patients from 16 countries. An analysis of data from 7,490 participants who had no prior history or symptoms of depression at baseline revealed that among all biologic agents, only adalimumab was significantly associated with a reduced risk of developing depression. Moreover, protective factors included higher education and private health insurance, while comorbid conditions such as COPD, anxiety disorders, or inflammatory joint diseases, as well as greater skin severity assessed by physicians, were identified as significant risk factors for depression development [11].

Suicidality

An increasing body of evidence indicates that psoriasis, as a chronic systemic disease, may significantly elevate the risk of severe psychiatric disorders, including suicidal ideation and behavior. A literature review published in 2023 by Ghani, Tan, and Abramowitz summarized the current state of knowledge on the association between psoriasis and suicide risk. The findings revealed that patients with severe psoriasis, long-standing disease duration, and co-occurring mental disorders such as depression or anxiety are particularly vulnerable. Alarmingly, suicidal ideation can emerge in some patients early in the disease course—even before dermatological treatment is initiated—highlighting the importance of early psychiatric screening and routine suicide risk assessment in this population. The authors emphasized the need to closely monitor patients exhibiting symptoms of anhedonia, low mood, or social withdrawal [12].

This correlation was further substantiated by a comparative study conducted by Pompili et al. (2016), involving 157 outpatients admitted to the dermatology clinic of the University of Rome "La Sapienza." Among them, 91 were diagnosed with psoriasis, while the remaining 66 had other dermatological conditions, including melanoma and allergic skin diseases. All participants underwent comprehensive psychiatric evaluation using standardized psychometric tools such as the Hamilton Depression Rating Scale (HAM-D) and Hamilton Anxiety Rating Scale (HAM-A), along with detailed sociodemographic questionnaires. Results showed that patients with psoriasis were more likely to report major life stressors in the year preceding disease onset (73.6% vs. 56.1%), and a higher prevalence of prior psychiatric history (38.5% vs. 16.7%). Notably, 37.4% of psoriasis patients reported past suicidal thoughts, compared to 16.7% in the control group. Although no statistically significant differences were found in anxiety levels measured by the HAM-A, the authors emphasized a strong association between psoriasis and psychological burden, including suicide risk [13].

These findings underline the need for a comprehensive treatment model for psoriasis patients that not only addresses skin symptoms but also includes mental health assessments, particularly for depressive symptoms and suicidality. The integration of dermatology and psychiatric care through interdisciplinary models is not only justified but essential for improving prognosis and quality of life in this patient population.

Anxiety

Although less visible than skin lesions, anxiety disorders are an essential component of the psychological burden associated with psoriasis. In a meta-analysis conducted by Jalenques and colleagues (2022), encompassing as many as 101 studies, the prevalence of anxiety symptoms and formal clinical diagnoses among individuals with this dermatosis was examined in detail. The authors distinguished between anxiety symptomatology and clinical diagnoses, emphasizing their distinct impacts on patients' daily functioning. The findings clearly indicate that anxiety symptoms affect approximately 34% of individuals with psoriasis, while anxiety disorders are diagnosed in 9–15% of this population, depending on the type of disorder. The most frequently diagnosed conditions were generalized anxiety disorder (11%) and social phobia (15%). Notably, psoriasis patients were more than twice as likely to experience anxiety symptoms compared to those without the skin condition (OR = 2.51), and they also had an increased risk of unspecified anxiety disorders (OR = 1.48). These results underscore the importance of early diagnosis of anxiety symptoms, which may not only improve quality of life but also enhance the effectiveness of dermatological treatment [14].

A cross-sectional study conducted in Malaysia by Bakar and colleagues (2021) assessed the prevalence of anxiety symptoms in outpatient psoriasis patients and their impact on quality of life. The study included 164 clinically confirmed adult participants. Standardized tools were used: the Hospital Anxiety and Depression Scale (HADS) to assess psychological symptoms and the Dermatology Life Quality Index (DLQI) to measure the impact of the skin disease on daily functioning. Analysis revealed that anxiety symptoms were present in 17.1% of participants, with more than half experiencing moderate to severe levels of intensity. Interestingly, anxiety was not correlated with disease duration or place of residence but was significantly more prevalent among patients with lower education levels and poorer socioeconomic status—individuals without stable income reported markedly higher psychological distress [15].

The pathophysiological and psychosocial foundations of this phenomenon are complex. Anxiety disorders in psoriasis may develop independently of the severity of skin symptoms, highlighting the importance of non-cutaneous mechanisms. Chronic emotional stress plays a key role, activating the hypothalamic–pituitary–adrenal (HPA) axis and the sympathetic nervous system, leading to increased production of proinflammatory cytokines such as TNF-α and IL-6. These cytokines, acting on the nervous system, may contribute to the emergence of anxiety symptoms, creating a biological foundation for the psychodermatological feedback loop. Additional burdens come from social factors—stigmatization, fear of rejection, or difficulties with self-acceptance—especially when skin lesions are visible on the face, hands, or genital area. Studies also show that women and individuals living alone are at higher risk of developing anxiety disorders in the context of psoriasis, suggesting the importance of demographic factors in shaping the psychological response to the disease [16].

Quality of Life

Although rarely life-threatening, skin diseases can significantly reduce patients' quality of life—both in private and professional domains. Findings from a large international population-based study conducted in 27 European countries by Gisondi et al. (2023) revealed that 43% of adult Europeans reported experiencing symptoms of skin diseases within the past year [17]. The study, involving nearly 20,000 participants, examined the impact of dermatological conditions—including psoriasis—on quality of life, work activity, and the level of stigmatization. The standardized Dermatology Life Quality Index (DLQI) was used to objectively assess the daily-life impact of skin diseases.

Results showed that over 40% of respondents rated the impact of their skin condition on daily functioning as moderate to very high, particularly in cases involving visible areas such as the face or hands. Such manifestations carried profound psychosocial consequences—80% of participants perceived their disease as shameful in personal contexts, and 83% reported similar feelings in professional environments. Approximately 15–20% of respondents experienced social rejection or negative judgment, and nearly half reported workplace difficulties—including job changes, promotion limitations, or declined employment opportunities [17].

A distinct, qualitative approach to this issue was presented by Meneguin and colleagues (2020), who analyzed statements from 81 patients with psoriasis collected in Brazil using the "Collective Subject Discourse" method [18]. Participants viewed quality of life not as a medical term, but rather as an emotional and existential concept—related to well-being, interpersonal relationships, professional fulfillment, spiritual balance, and absence of stress. They indicated that psoriasis limited their freedom, e.g., in clothing choices, participation in social life, or romantic relationships—generating emotional tension, a sense of alienation, and even permanent disruption of social bonds. These experiences often led to depressive symptoms, feelings of shame, and a loss of control over their own bodies and everyday lives. Particularly burdensome were the routine, time-consuming therapeutic procedures and the constant need to monitor symptoms.

The psychosocial dimension of the disease was also demonstrated by a study conducted by Jung and co-authors (2018), which aimed to identify socioeconomic and clinical factors affecting the quality of life of patients with psoriasis [19]. The analysis included 299 individuals who completed questionnaires regarding their social status, location of skin lesions, symptom severity, and therapies used. The DLQI scale was used to assess quality of life, with a score of ≥11 indicating significant impairment. The results showed that over half of the patients (53.8%) reached this threshold. Factors negatively affecting quality of life included female gender (OR = 2.00), skin lesions on the neck (OR = 2.30), low income, and previous experience of resigning from work due to the disease (OR = 2.16). Individuals using oral or herbal treatments also reported greater disease-related burden. Interestingly, a higher socioeconomic status appeared to be a protective factor, which may be explained by better access to effective therapies—including biologics—and less financial stress.

In summary, the above studies clearly indicate that psoriasis—beyond its clinical aspect—significantly affects patients' quality of life, including their mental well-being, ability to work, and social relationships. Including these aspects in the therapeutic process should be an integral part of patient care.

Stigmatization

Psoriasis, as a chronic, relapsing inflammatory skin disease, has a significant impact not only on physical health but also on the psychological well-being and social functioning of patients. A study conducted by Jankowiak et al. (2016) analyzed the levels of stigmatization and depressive symptoms in 202 adult patients diagnosed with psoriasis with a PASI score not exceeding 20. The participants had suffered from the disease for at least two years and did not present with comorbid somatic or psychiatric disorders. Stigmatization was assessed using the 6-point Evers scale, while depression severity was measured with the Beck Depression Inventory (BDI). The mean stigmatization score was 7.12 points, indicating a moderate sense of social exclusion. The highest levels were recorded among students (11.4 points), and the lowest among elderly individuals and manual workers. Rural residents more frequently reported a stronger sense of rejection than urban dwellers (8.57 vs. 5.67 points). A major source of concern for patients was the visibility of lesions on the head and neck, which often led to emotional distress even in cases of moderate disease severity. These results suggest that the subjective perception of the disease—rather than its objective severity—plays a crucial role in the development of mood disorders and stigmatization [20].

Similar conclusions were drawn by Zhang et al. (2021), who emphasized that patients with psoriasis frequently experience social exclusion, shame, and limitations in interpersonal relationships. These psychosocial consequences may result in reduced treatment efficacy, intensified depressive and anxiety symptoms, and poorer quality of life. The authors also analyzed the most commonly used tools to assess stigmatization, including the Feelings of Stigmatization Questionnaire, the Questionnaire on Experience with Skin Complaints, and the 6-item Stigmatization Scale. Their findings indicate that individuals at particular risk of stigmatization include younger people, women, patients with lower levels of education, and those living in rural areas. Additional risk factors include skin lesions located in visible or intimate areas (e.g., hands, face, genitals). A significant phenomenon is internalized stigma—i.e., adopting societal stereotypes—which correlates with lower self-esteem, more severe anxiety and depression, and reduced life satisfaction. This pattern leads to avoidance of social relationships and exacerbates difficulties with adaptation [21].

The results of the study conducted by Decean et al. (2022) in Romania reveal an additional dimension of the problem—the role of public misinformation and differences in coping mechanisms across age groups. The study included 218 patients with psoriasis and 374 individuals from a control group. The authors used tools such as COPE-60, SF-12, and DLQI. Misinformation about the disease was widespread—31.6% of healthy respondents believed that psoriasis was caused by poor hygiene, and 17.1% assumed it was a sexually transmitted disease. Moreover, 55.1% of those surveyed stated they would not hire a person with psoriasis for physical work involving contact with others. Young patients (aged 18–30) showed the highest levels of embarrassment and stigmatization, which strongly correlated with lower quality of life. Middle-aged individuals more frequently used active coping strategies, whereas patients over 50 years old more often reported health problems and feelings of loneliness, especially in the sexual domain. These data indicate the need to tailor therapeutic and educational interventions to the patient's age and individual needs [22].

Additionally, Kowalewska et al. (2021) attempted to determine the relationship between skin lesion severity, quality of life, and perceived stigmatization. The study involved 111 individuals with plaque psoriasis, evaluated using the PASI, DLQI, and two stigmatization scales. The results showed that the greater the severity of skin symptoms, the more quality of life deteriorated and feelings of stigmatization increased. Women exhibited a higher level of emotional burden than men. Individuals with higher education reported a more positive outlook on life, which may indicate greater psychological resilience or better access to psychological support [23].

Furthermore, an analysis conducted at the Clinic of Dermatology and Medical Cosmetology in Białystok among 366 patients confirmed that the level of stigmatization strongly correlates with disease acceptance and overall life satisfaction. The study used a set of tools assessing, among others, acceptance of illness (AIS), life satisfaction (SWLS), and quality of life (DLQI). The findings revealed that men scored higher in disease acceptance, whereas women more frequently experienced reduced quality of life. Particularly concerning were the results for patients aged 41–50 and those living in cities, who showed high levels of stigmatization and low life satisfaction. Importantly, statistical analysis showed a strong correlation between these variables—the greater the acceptance of the disease, the lower the level of stigmatization and the higher the level of life satisfaction [24].

Discussion

From a psychological perspective, psoriasis appears not only as an immunologically-based condition but also as a classic example of a psychosomatic disorder, in which chronic stress plays a significant role in symptom exacerbation and limits the effectiveness of treatment. In this context, psychological interventions such as cognitive-behavioral therapy (CBT) or participation in support groups gain particular importance. These strategies have proven highly effective in reducing symptoms of depression and anxiety, which are common components in the clinical picture of chronic psoriasis. Improved mental well-being directly translates into better patient engagement in the therapeutic process—both through enhanced cooperation with the treatment team and increased adherence to medical recommendations [25].

Modern approaches to psoriasis treatment increasingly emphasize the need for a comprehensive and individualized patient-centered strategy that considers not only skin symptoms but also psychological, social, and lifestyle factors. As a result, the formation of interdisciplinary psychodermatological teams is recommended. These teams should integrate the expertise of dermatologists, psychologists, psychiatrists, nurses, and social workers. Beyond providing medical treatment, such teams would be responsible for early identification of risky behaviors and for offering informational and emotional support tailored to patients' specific needs [26].

A particularly effective form of support is internet-delivered cognitive behavioral therapy (ICBT), which can be a valuable supplement to traditional dermatological care—especially for patients at risk of mental health disorders. It is worth noting that the quality of the therapeutic relationship at the beginning of treatment plays a crucial role in achieving positive outcomes—the more empathetic and tailored to the patient's individual needs this relationship is, the more effective the intervention becomes [27].

In addition to psychological support, lifestyle modifications also play an important role in therapy. Factors such as weight reduction, smoking cessation, and limiting alcohol consumption have been shown to improve pharmacological treatment outcomes and reduce disease severity [28].

Therapeutic preferences of patients may evolve with experience and disease progression. Individuals with longer disease duration often seek therapies that provide lasting effects, while professionally active patients prefer solutions that minimally disrupt daily life. Therefore, involving the patient in the decision-making process is essential, as it increases both engagement and treatment satisfaction—leading to higher adherence and better clinical results [29].

Finally, it is important to emphasize that individually tailored online psychological therapy can significantly reduce mental symptoms—such as depression, anxiety, and feelings of helplessness—even when there is no parallel improvement in the clinical presentation of psoriasis. In this regard, the durability and quality of the therapeutic alliance prove crucial, which—even in remote settings—can be successfully established and maintained, as confirmed by studies using standardized tools for assessing therapeutic relationships [30].

Conclusions

The analysis presented in this study clearly demonstrates that psoriasis should not be viewed solely as a dermatological condition. It is a systemic disorder whose impact extends far beyond visible skin lesions, affecting multiple dimensions of patients' lives—from psychological and relational aspects to occupational and economic concerns. Numerous studies confirm the high prevalence of depressive and anxiety disorders among individuals with psoriasis, with this phenomenon being clinically significant regardless of the extent of skin involvement.

A key determinant of quality of life in patients appears to be not the objective severity of physical symptoms, but rather the subjective perception of those symptoms, experiences of social stigmatization, and the effectiveness of coping mechanisms in managing stress. Many patients exhibit a distinct emotional functioning pattern that may predispose them to mood disorders, even in cases of mild disease. Furthermore, growing evidence suggests the existence of a shared pathophysiological basis between psoriasis and depression—chronic inflammation and elevated levels of proinflammatory cytokines such as TNF-α, IL-6, and CRP imply that immunological processes may directly influence the central nervous system and emotional regulation.

In light of these findings, the implementation of an integrated model of care for patients with psoriasis is essential. This model should include concurrent dermatological and psychiatric assessments, comprehensive psychological support, and educational interventions. Interdisciplinary psychodermatology teams may play a particularly important role in this approach. Through collaboration between dermatologists, psychologists, psychiatrists, nurses, and therapists, such teams can effectively respond to the complex needs of this patient population.

Supportive therapies such as internet-based cognitive behavioral therapy (ICBT), traditional psychotherapy, and interventions aimed at reducing stigmatization show great potential in improving not only mental well-being but also treatment adherence. Building therapeutic relationships grounded in empathy, mutual trust, and shared treatment goals can significantly enhance patient engagement and improve quality of life, especially given the chronic and recurrent nature of the disease.

Importantly, effective psoriasis treatment should address not only the control of skin symptoms but also the monitoring of depression, anxiety, and suicidal behavior risk. Regular assessment of quality of life and patients' subjective perception of their condition should be incorporated into routine clinical practice. Only such a holistic approach can meaningfully improve patient functioning, increase treatment satisfaction, and lead to sustained health outcomes in individuals living with psoriasis.

REFERENCES

1. Boehncke, W.-H., & Schön, M. P. (2015). Psoriasis. *The Lancet, 386*(9997), 983–994. https://doi.org/10.1016/S0140-6736(14)61909-7
2. Raharja, A., Mahil, S. K., & Barker, J. N. (2021). Psoriasis: a brief overview. *Clinical Medicine, 21*(3), 170–173. https://doi.org/10.7861/clinmed.2021-0257
3. Purzycka-Bohdan, D., Kisielnicka, A., Zabłotna, M., Nedoszytko, B., Nowicki, R. J., Reich, A., Samotij, D., Szczech, J., Krasowska, D., Bartosińska, J., Narbutt, J., Lesiak, A., Barasińska, P., Owczarczyk-Saczonek, A., Czerwińska, J., Szepietowski, J. C., Batycka-Baran, A., Czajkowski, R., Górecka-Sokołowska, M., ... Szczerkowska-Dobosz, A. (2022). Chronic plaque psoriasis in Poland: Disease severity, prevalence of comorbidities, and quality of life. *Journal of Clinical Medicine, 11*(5), 1254. https://doi.org/10.3390/jcm11051254
4. Lim, D. S. Y., Bewley, A., & Oon, H. H. (2018). Psychological profile of patients with psoriasis. *Annals, Academy of Medicine, Singapore, 47*(12), 516–522. https://doi.org/10.47102/annals-acadmedsg.v47n12p516
5. Nguyen, C. M., Beroukhim, K., Danesh, M. J., Babikian, A., Koo, J., & Leon, A. (2016). The psychosocial impact of acne, vitiligo, and psoriasis: a review. *Clinical, Cosmetic and Investigational Dermatology, 9*, 383–392. https://doi.org/10.2147/CCID.S76088

6. Cohen, B. E., Martires, K. J., & Ho, R. S. (2016). Psoriasis and the risk of depression in the US population: National Health and Nutrition Examination Survey 2009–2012. *JAMA Dermatology, 152*(1), 73–79. https://doi.org/10.1001/jamadermatol.2015.3605
7. Fabrazzo, M., Romano, F., Arrigo, M., Puca, R. V., Fuschillo, A., De Santis, V., Sampogna, G., Giordano, G. M., Catapano, F., & Lo Schiavo, A. (2022). A multivariate analysis of depression prevalence in psoriasis patients: A cohort study. *International Journal of Environmental Research and Public Health, 19*(4), 2060. https://doi.org/10.3390/ijerph19042060
8. Schuster, B., Peifer, C., Ziehfreund, S., Tizek, L., Biedermann, T., Zink, A., & Schielein, M. C. (2022). Happiness and depression in psoriasis: A cross-sectional study in Germany. *Quality of Life Research, 31*(7), 1761–1773. https://doi.org/10.1007/s11136-021-02991-2
9. Hölsken, S., Krefting, F., Schedlowski, M., & Sondermann, W. (2021). Common fundamentals of psoriasis and depression. *Acta Dermato-Venereologica, 101*, adv00609. https://doi.org/10.2340/actadv.v101.565
10. Sahi, F. M., Masood, A., Danawar, N. A., Mekaiel, A., & Malik, B. H. (2020). Association between psoriasis and depression: A traditional review. *Cureus, 12*(8), e9708. https://doi.org/10.7759/cureus.9708
11. Strober, B., Gooderham, M., de Jong, E. M. G. J., Kimball, A. B., Langley, R. G., Lakdawala, N., ... & Menter, A. (2018). Depressive symptoms, depression, and the effect of biologic therapy among patients in Psoriasis Longitudinal Assessment and Registry (PSOLAR). *Journal of the American Academy of Dermatology, 78*(1), 70–80. https://doi.org/10.1016/j.jaad.2017.08.051
12. Pompili, M., Innamorati, M., Trovarelli, S., Narcisi, A., Bellini, S., Orsini, D., Forte, A., Erbuto, D., Botti, E., Lamis, D. A., Girardi, P., & Costanzo, A. (2016). Suicide risk and psychiatric comorbidity in patients with psoriasis. *Journal of International Medical Research, 44*(1_suppl), 61–66. https://doi.org/10.1177/0300060515593253
13. Ghani, H., Tan, I. J., & Abramowitz, C. (2023). The association between psoriasis and suicide. *Dermatological Reviews, 4*(1), e209. https://doi.org/10.1002/der2.209
14. Jalenques, I., Bourlot, F., Martinez, E., Pereira, B., D'Incan, M., Lauron, S., & Rondepierre, F. (2022). Prevalence and odds of anxiety disorders and anxiety symptoms in children and adults with psoriasis: Systematic review and meta-analysis. *Acta Dermato-Venereologica, 102*, adv00769. https://doi.org/10.2340/actadv.v102.1386
15. Bakar, R. S., Jaapar, S. Z. S., Azmi, A. F., & Aun, Y. C. (2021). Depression and anxiety among patients with psoriasis: A correlation with quality of life and associated factors. *Journal of Taibah University Medical Sciences, 16*(4), 491–496. https://doi.org/10.1016/j.jtumed.2021.02.008
16. Ferreira, B. I. R. C., Abreu, J. L. P. C., dos Reis, J. P. G., & Figueiredo, A. M. C. (2016). Psoriasis and associated psychiatric disorders: A systematic review on etiopathogenesis and clinical correlation. *Journal of Clinical and Aesthetic Dermatology, 9*(6), 36–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928455/
17. Gisondi, P., Puig, L., Richard, M. A., Paul, C., Nijsten, T., Taieb, C., Stratigos, A., Trakatelli, M., Salavastru, C., & EADV Burden of Skin Diseases Project Team. (2023). Quality of life and stigmatization in people with skin diseases in Europe: A large survey from the 'burden of skin diseases' EADV project. *Journal of the European Academy of Dermatology and Venereology, 37*(Suppl. 7), 6–14. https://doi.org/10.1111/jdv.18917
18. Meneguin, S., de Godoy, N. A., Pollo, C. F., Miot, H. A., & de Oliveira, C. (2020). Quality of life of patients living with psoriasis: A qualitative study. *BMC Dermatology, 20*(1), 22. https://doi.org/10.1186/s12895-020-00116-9
19. Jung, S., Lee, S. M., Suh, D., Shin, H. T., & Suh, D. C. (2018). The association of socioeconomic and clinical characteristics with health-related quality of life in patients with psoriasis: a cross-sectional study. *Health and Quality of Life Outcomes, 16*(180). https://doi.org/10.1186/s12955-018-1007-7
20. Jankowiak, B., Kowalewska, B., Khvorik, D. F., Krajewska-Kułak, E., & Niczyporuk, W. (2016). The level of stigmatization and depression of patients with psoriasis. *Iranian Journal of Public Health, 45*(5), 690–692. http://ijph.tums.ac.ir
21. Zhang, H., Yang, Z., Tang, K., Sun, Q., & Jin, H. (2021). Stigmatization in patients with psoriasis: A mini review. *Frontiers in Immunology, 12*, 715839. https://doi.org/10.3389/fimmu.2021.715839
22. Decean, L., Badea, M., Rus, V., Buicu, G., Sasu, A., Pilut, C. N., & Mihai, A. (2022). The implication of misinformation and stigma in age-related quality of life, depression, and coping mechanisms of adult patients with psoriasis. *Medicina, 58*(10), 1420. https://doi.org/10.3390/medicina58101420
23. Kowalewska, B., Jankowiak, B., Cybulski, M., Krajewska-Kułak, E., & Khvorik, D. F. (2021). Effect of disease severity on the quality of life and sense of stigmatization in psoriatics. *Clinical, Cosmetic and Investigational Dermatology, 14*, 107–121. https://doi.org/10.2147/CCID.S286312
24. Kowalewska, B., Cybulski, M., Jankowiak, B., & Krajewska-Kułak, E. (2020). Acceptance of illness, satisfaction with life, sense of stigmatization, and quality of life among people with psoriasis: A cross-sectional study. *Dermatology and Therapy, 10*(1), 413–430. https://doi.org/10.1007/s13555-020-00368-w
25. Yélamos, O., Ros, S., & Puig, L. (2015). Improving patient outcomes in psoriasis: Strategies to ensure treatment adherence. *Psoriasis: Targets and Therapy, 5*, 109–115. https://doi.org/10.2147/PTT.S54070
26. Blackstone, B., Patel, R., & Bewley, A. (2022). Assessing and improving psychological well-being in psoriasis: Considerations for the clinician. *Psoriasis: Targets and Therapy, 12*, 25–33. https://doi.org/10.2147/PTT.S328447

27. van Beugen, S., Ferwerda, M., Spillekom-van Koulil, S., Smit, J. V., Zeeuwen-Franssen, M. E. J., Kroft, E. B. M., de Jong, E. M. G. J., Otero, M. E., Donders, A. R. T., van de Kerkhof, P. C. M., van Middendorp, H., & Evers, A. W. M. (2016). Tailored therapist-guided internet-based cognitive behavioral treatment for psoriasis: A randomized controlled trial. *Psychotherapy and Psychosomatics, 85*(5), 297–307. https://doi.org/10.1159/000447267
28. Gisondi, P., Del Giglio, M., & Girolomoni, G. (2017). Treatment approaches to moderate to severe psoriasis. *International Journal of Molecular Sciences, 18*(11), 2427. https://doi.org/10.3390/ijms18112427
29. Belinchón, I., Rivera, R., Blanch, C., Comellas, M., & Lizán, L. (2016). Adherence, satisfaction and preferences for treatment in patients with psoriasis in the European Union: A systematic review of the literature. *Patient Preference and Adherence, 10*, 2357–2367. https://doi.org/10.2147/PPA.S117006
30. Spillekom-van Koulil, S., Ferwerda, M., van Beugen, S., van Middendorp, H., van de Kerkhof, P. C. M., van Riel, P. L. C. M., & Evers, A. W. M. (2018). Tailored therapist-guided internet-based cognitive-behavioural treatment for psoriasis and rheumatoid arthritis: Two case reports. *Acta Dermato-Venereologica, 98*(2), 225–233. https://doi.org/10.2340/00015555-2803