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# PSYCHOSOCIAL PREDICTORS OF QUALITY OF LIFE IN INDIVIDUALS WITH PSORIASIS OR ILLNESS PERCEPTION, APPEARANCE ANXIETY AND PERCEIVED STRESS AS PREDICTORS OF QUALITY OF LIFE IN INDIVIDUALS WITH PSORIASIS

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## Abstract

*Psoriasis is a chronic immune-mediated inflammatory skin disease that negatively affects physical, psychological, and social well-being. Due to the visible nature of the disease, individuals with psoriasis often experience negative illness perceptions, appearance-related concerns, stress, stigma, and reduced quality of life. The present study aimed to examine the psychosocial predictors of quality of life in individuals with psoriasis focusing specifically on Illness Perception, Appearance-Related Concerns, and Perceived Stress. The study used a quantitative cross-sectional research approach, guided by Leventhal's Common-Sense Model of Self-Regulation. Purposive sampling was used to select the 115 participants from dermatology department of Govt hospitals. Data was gathered using standardized tools such as the Psoriasis Disability Index (PDI), Perceived Stress Scale (PSS), Appearance Anxiety Inventory (AAI), and Brief Illness Perception Questionnaire (BIPQ). Descriptive statistics were utilized for mean, SD, and frequency and Pearson Product-Moment Correlation was utilized to investigate connections between variables. Multiple regression analysis was performed to identify predictive effects, and demographic and clinical characteristics were also included and reported. It was predicted that perceptions of disease, worries about appearance, perceived stress, and quality of life would all be highly correlated negatively, and that these psychosocial factors would significantly predict lower quality of life. The results were anticipated to support a comprehensive biopsychosocial approach to patient care by highlighting the significance of combining psychological care with dermatological treatment and adding to the scant literature on the psychosocial aspects of psoriasis.*

***Keywords:*** *Psoriasis, Perceived Stress Scale (PSS), Appearance Anxiety Inventory (AAI), Brief Illness Questionnaire (BIPQ), and Psoriasis Disability Index (PDI)*

## INTRODUCTION

Psoriasis is a chronic, immune-mediated, inflammatory skin disease that affects approximately 2–3% of the global population (Griffiths et al., 2021). It is characterized by red, scaly plaques that commonly appear on the scalp, elbows, knees, and lower back. The disease involves dysregulation of immune pathways, specifically the Th1, Th17, and Th22 cytokine axes, leading to hyperproliferation of keratinocytes and chronic inflammation (Lowes et al., 2014).

The most common type is *plaque psoriasis*, accounting for approximately 80–90% of all cases, and is characterised by raised, red patches covered with silvery-white scales, typically appearing on the elbows, knees, scalp and lower back (Mayo Clinic, 2023&Cleveland Clinic, 2024). *Guttate psoriasis* generally affects children and young adults and presents as small, drop-shaped lesions that often follow a streptococcal infection (Mayo Clinic, 2023). *Inverse psoriasis,* which develops in skin folds such as the groin, armpits or under the breasts is marked by shiny,

inflamed patches that usually lack thick scaling due to moisture and friction (Healthline, 2024). *Pustular psoriasis* features sterile, pus-filled blisters surrounded by inflamed skin and may occur in localised or generalised forms, the latter being potentially life-threatening (WebMD, 2024). *Erythrodermic psoriasis*, the rarest and most severe form, involves widespread redness, skin peeling and systemic symptoms such as fever and dehydration, requiring immediate medical attention (Healthline, 2024&WebMD, 2024). *Nail psoriasis* affects fingernails and toenails leading to pitting, discolouration and onycholysis (Mayo Clinic, 2023). Lastly *sebopsoriasis* (seborrheic psoriasis) combines features of psoriasis and seborrheic dermatitis, producing greasy, yellowish scales on the scalp and face (Cleveland Clinic, 2024). All types of psoriasis share a common pathophysiological mechanism involving immune dysregulation and accelerated skin-cell turnover, although presentation and severity vary among individuals.

Psoriasis is commonly acknowledged as a systemic and psychosocial disorder that significantly affects mental health, social functioning, and quality of life, despite the obvious signs being dermatological (Kimball et al., 2018). When lesions are evident on exposed body parts, patients may experience stigma, embarrassment, and social disengagement. The unpredictable nature of flare-ups can result in tension, anxiety, and a loss of confidence. This can create a vicious cycle where psychological distress exacerbates the severity of the disease (Hunter et al., 2013).

The psychological effects of psoriasis are exacerbated in Pakistan and other South Asian nations by societal perceptions on physical beauty. People, especially women, are frequently discriminated against or assessed based on the look of their skin, which causes social isolation and unhappiness related to appearance (Khan et al., 2022). This emphasises how crucial it is to comprehend psychological indicators of wellbeing, such as perceptions of sickness, worries about appearance, and felt stress, in order to assess the quality of life for psoriasis sufferers. In dermatology, the notion of quality of life (QoL) has expanded to encompass psychological, social, and emotional functioning in addition to physical problems.QoL is defined by the World Health Organization (1997) as a person's assessment of their place in life in relation to cultural and value systems. Daily activities, emotional stability, interpersonal interactions, and body image are all impacted by psoriasis (Rapp et al., 1999). Therefore, improving psychological support and patient-centered care in dermatology requires an awareness of psychosocial factors.

Psoriasis is an autoimmune condition that causes inflammation in your skin. Symptoms of psoriasis include thick areas of discolored skin covered with scales. These thick, scaly areas are called plaques. Psoriasis is a chronic skin condition, which means it can flare up unexpectedly and there’s no cure (Cleveland Clinic,2022).

It is a lifelong immune-mediated inflammatory skin disease, associated with comorbidities such as psoriatic arthropathy, psychological, cardiovascular and hepatic diseases. In 2014, the World Health Organization recognised psoriasis as a serious non-communicable disease and highlighted the distress related to misdiagnosis, inadequate treatment and stigmatization of this disease (Raharja, Mahil, and Barker, 2021).

Psoriasis is not only limited to visible skin plaques or rashes but may also present with a range of additional symptoms that affect overall well-being. Individuals commonly experience itchy skin, cracked and dry skin, and skin pain. Nail changes such as pitting, cracking, or crumbling are also frequent, along with joint pain in some cases. Scratching affected areas can break the skin, increasing the risk of infection. Such infections can be serious, and warning signs include severe pain, swelling, and fever. If these symptoms occur, it is important to seek medical attention

promptly to prevent complications (Cleveland Clinic, 2022).

There are little national population-based epidemiological statistics on psoriasis in Pakistan. The majority of the information that is currently available originates from studies conducted in dermatology clinics or hospitals. According to these studies, 2–5% of dermatology outpatient visits may be related to psoriasis; however, this may not accurately reflect the prevalence in the community (Nadeem et al., 2015).

About 2% to 3% of people worldwide and 3% of people in the US suffer with psoriasis. It is more common in Northern Europe and less common in East Asia, depending on the location and culture. These regional variations imply that the disease's global distribution may be influenced by genetic, environmental, and lifestyle variables (Shaban & Seed, 2024).

Psoriasis can affect people of any age, gender, or race. Millions of people suffer with psoriasis. Psoriasis affects more than 3% of Americans (Cleveland Clinic, 2022).

The prevalence of psoriasis in Pakistan may be between 0.5% and 1.5%, according to available regional research; however, underreporting is probably caused by a lack of national surveillance systems and restricted access to dermatological care in rural regions (WHO, 2016).

The Common-Sense Model of Self-Regulation (Leventhal et al., 1980), which holds that people create cognitive and emotional representations of their illness that direct coping behaviour and emotional reactions, is the source of the idea of illness perception. Beliefs regarding a condition's identification, source, course, effects, and controllability are all included in illness perceptions (Broadbent et al., 2006).

Psoriasis sufferers' opinions of their condition greatly influence how they interpret their symptoms and treat their condition. People who believe that psoriasis is stigmatising, unmanageable, or persistent frequently have lower quality of life and greater psychological discomfort (Fortune et al., 2000&Lobato et al., 2017). For instance, worry and social avoidance may grow if one believes the illness has serious social repercussions. On the other hand, stronger coping mechanisms and adjustment results are associated with the perception of increased personal or treatment control (Moss-Morris et al., 2002).

The quality of life of the psoriasis patients who associated their symptoms with the disease, who had a high PASI score, thought that they were adversely affected by the disease, and who saw personal attributions as the cause of the disease was negatively affected. The quality of life of patients who thought that their disease could be kept under control and who understood their disease was positively affected (Solmaz, Ilhan, and Bulut,2021).

Appearance-related concerns refer to negative self-evaluations and preoccupation with one’s physical appearance, particularly when appearance deviates from perceived social norms (Cash & Pruzinsky, 2002). Due to its prominent visibility, psoriasis frequently results in negative body image, humiliation, and anxiety of being judged negatively (Vardy et al., 2002). Social stigma, media-driven beauty standards, and societal demands emphasising perfect skin all exacerbate these worries. The patient's quality of life may suffer as a result of appearance anxiety, which can cause social avoidance, relational withdrawal, and low self-esteem (Magin et al., 2008). Many people experience a cycle of self-consciousness and emotional anguish as a result of their physical symptoms, which act as continual reminders of their differences.

Psoriasis sufferers frequently experience social anxiety and chronic social avoidance as a result of their visual deformity and skin sores. Social appearance anxiety is the anxiety associated with one's physical appearance and the worry of being negatively judged by others. According to

studies, psoriasis patients have more social appearance anxiety than the general population. This might eventually cause psychological distress and have an impact on mental health (Huang et al., 2024).

For those with psoriasis, appearance-related issues are directly associated with a marked decline in quality of life (QoL). High levels of self-consciousness, humiliation, embarrassment, and fear of stigmatization result from the obvious, frequently deforming character of skin lesions, which can be just as crippling as other serious chronic medical conditions. According to research, more than 84% of patients say that their quality of life is impacted, and obvious symptoms can lead to despair and social isolation (Chen et al., 2023).

A person's subjective assessment of life events as dangerous or overwhelming beyond their ability to cope is known as perceived stress (Cohen et al., 1983). Stress and psoriasis have a reciprocal link; stress can cause flare-ups, and psoriasis exacerbations raise psychological stress, creating a psychodermatological loop (Hunter et al., 2013).

Patients reporting higher stress levels also report greater disease severity, poorer coping, and reduced social functioning (Verhoeven et al., 2009). Thus, perceived stress not only influences disease progression biologically but also mediates the psychological and behavioral consequences of psoriasis.

The quality of life (QoL) in psoriasis encompasses physical comfort, emotional well-being, social functioning and self-perception (Rapp et al., 1999). Dermatological conditions like psoriasis rank among the most distressing chronic diseases in terms of psychological impact. It is estimated that psoriasis impairs QoL to an extent comparable to cancer, diabetes, or depression (Kimball et al., 2018).

The Dermatology Life Quality Index (DLQI) and Psoriasis Disability Index (PDI) are widely used to measure the multidimensional impact of psoriasis. Studies have shown that QoL correlates more strongly with psychological factors (stress, stigma, body image) than with objective disease severity (Fortune et al., 2002). This underscores that addressing psychosocial determinants is essential to improve patient outcomes.

**Theoretical Framework**

Psoriasis can be understood through several psychological and health behavior frameworks that explain how patients adapt to and manage long-term illness. Leventhal's Self-Regulation Model states that people form personal sickness beliefs that impact coping strategies and emotional responses, ultimately affecting quality of life outcomes.

According to the Lazarus & Folkman Stress-Coping Theory, an individual's assessment of their illness and coping mechanisms determine psychological stress; these cognitive assessments have a direct impact on emotional functioning, adjustment, and general well-being.

The Biopsychosocial Model further highlights that psychological reactions, social context, and biological disease processes interact to affect psoriasis outcomes rather than biological variables alone. According to this theory, psychological experiences like stress, coping, and emotional discomfort are crucial in determining how an illness affects a person's quality of life.

The Common-Sense Model of self-regulation, which describes how patients create emotional and cognitive representations of their condition that affect coping strategies and health outcomes, can be used to understand psoriasis.

This model states that people form beliefs about a number of important aspects of the illness,

such as its perceived consequences (impact on life), timeline (whether it is perceived as acute or chronic), personal control (belief in one's capacity to manage it), treatment control (belief in the efficacy of treatment), and illness coherence (how well the illness is understood).

Psoriasis is closely linked to psychosocial issues such as stigmatization, shame, and changed self-image because of its obvious and frequently persistent cutaneous symptoms. There are two types of stigma that people encounter: self-stigma, which occurs when people internalise emotions of shame or embarrassment about their disease, and social stigma, which relates to unfavourable attitudes and responses from others.

Psychological stress has an impact on psoriasis and is both a cause of disease flare-ups and a result of having a persistent visible condition. From a biological standpoint, prolonged stress can exacerbate skin lesions and worsen inflammatory activity by dysregulating the hypothalamic-pituitary-adrenal (HPA) axis and increasing the release of pro-inflammatory cytokines like TNF-α, IL-6, and IL-17.

Psychological stress, however, has a substantial impact on day-to-day functioning and overall wellbeing. Regardless of objective clinical severity, higher levels of felt stress, which are frequently measured with instruments like the Psoriasis Life Stress Inventory, are substantially linked to increased functional impairment and decreased quality of life. This shows that the experience and consequences of a disease can be influenced by psychological burden just as much as by physical symptoms.

Psoriasis-related quality of life (QoL) is frequently evaluated in psychological models of chronic illness using established tools like the Psoriasis Disability Index (PDI) and the Dermatology Life Quality Index (DLQI). This approach highlights that QoL is significantly influenced by cognitive and emotional processes in addition to clinical severity.

Through increased emotional discomfort, social disengagement, and functional impairment, negative sickness perceptions, increased appearance concerns, and elevated perceived stress all have direct implications on quality of life.

**Literature Review**

Numerous empirical research have looked at the perception of sickness and how it relates to quality of life in psoriasis. For instance, a cross-sectional research of 254 patients in Spain (or the Canary Islands) discovered a substantial correlation between QoL as determined by the Dermatology Life Quality Index (DLQI) and a number of illness perception characteristics, including identity, repercussions, emotional representations, and timing. In particular, lower QoL was linked to higher ratings on the "illness identity" (more symptoms related to psoriasis) and "consequences" domains. Additionally, after adjusting for clinical severity (PASI), regression analysis showed that illness identity, treatment-control, and illness coherence (knowledge of the condition) significantly explained variance in QoL ($R^2 = 0.365$).

There is little literature in South Asia and Pakistan. According to some research, stigma, body image issues, and psychological discomfort are very common among dermatological patients (Khan et al., 2022; Ali et al., 2021). Few studies, however, examine appearance concerns, stress assessments, and illness perceptions concurrently with QoL in psoriasis. This disparity highlights the necessity for culturally relevant studies that take into account sociocultural elements that may influence these interactions, such as health literacy, social stigma, and beauty standards.

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.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 (O'Leary et al., 2004).

Negative illness perceptions (strong identity of symptoms, high perceived consequences, low controllability) are associated with poorer QoL.

Elevated appearance-related concerns (body image dissatisfaction, fear of stigmatization, visible lesions) significantly reduce QoL and may mediate severity → QoL relationships.

Perceived stress is higher in psoriasis patients than controls and predicts lower QoL; it may act as a mediator or moderator.

The three constructs are interrelated and likely form a psychosocial network influencing QoL but most studies do not test integrated models of all three simultaneously.

Few studies account for demographics (age, gender, education) and include both objective clinical severity and the entire psychosocial chain (illness perception → appearance worries → stress → QoL).

In order to fill these gaps, the current study examines how quality of life among people with psoriasis in Pakistan is predicted by illness perception, appearance-related worries, and perceived stress. It also controls for clinical severity and demographics and looks into potential moderation by neuroticism and connections to hypertension.

**Rationale of the study**

Patients with psoriasis frequently experience fear, self-consciousness, low self-confidence, social stigma, anxiety, appearance-related beliefs, and stress as a result of noticeable skin changes. These challenges have a detrimental impact on their ability to cope, function, and general well-being. Psychological requirements are neglected in dermatology practice, which mostly concentrates on physical treatment. Better holistic care and psychological support will result from this study's identification of psychological factors of quality of life. Therefore this study hold practical significance as it aims to integrate the biopsychosocial model into dermatological care by identifying how illness perception,appearance related concerns and perceived stress predict quality of life among psoriasis patients in Pakistan.

**Objectives of the Study**

1. To determine the relationship between illness perception and quality of life among psoriasis patients.
2. To examine the impact of appearance related concerns on the quality of life in individuals with psoriasis.
3. To explore the association between perceived stress and quality of life in psoriasis patients.
4. To identify which psychosocial factor(illness perception, appearance related concerns and perceived stress is the strongest predictor of poor quality of life.

**Hypotheses of the Study**

- There will be a significant negative relationship between illness perception and quality of life in individuals with psoriasis.
- There will be a significant negative relationship between appearance related concerns and quality of life in individuals with psoriasis.
- There will be a significant negative relationship between perceived stress and quality of life in patients of psoriasis.
- Illness perception, appearance related concerns and perceived stress will collectively predict the quality of life among psoriasis patients.

## Method

### Research Design

The study was employ a quantitative correlational research design. This design was appropriate for examining the relationships among psychological variables illness perception, appearance related concerns and perceived stress and their predictive influence on quality of life in individuals with psoriasis. The study was based on the psychosocial model with emphasizes the interplay of biological, psychological and social factors. A correlational design allowed for the identification of statistically significant associations and prediction patterns among variables without manipulating any conditions.

### Sample/Sampling Strategy

A non-probability purposive sampling strategy was used to recruit participants diagnosed with psoriasis. This method was suitable as the study specifically targets individuals who meet clinical diagnostic criteria for psoriasis. The sample size of 119 was determined using G Power analysis for multiple regression analysis with three predictors(illness perception, appearance related concerns, perceived stress). Participants was approached through dermatology inward and outpatient departments in public and private hospitals in Lahore.

### Inclusion Criteria

- Both young adults men and women who diagnosed with psoriasis were included.
- Individuals who clinically diagnosed with psoriasis at least 6 months.
- Data was collected from both Govt and Public sector.
- Hospitalized and Outpatients both were included.

### Exclusion Criteria

- Diagnosed with other comorbid chronic skin conditions(eczema,acne,vitiligo,lupus) was excluded.
- Coexisting chronic physical illness that may interfere the QoL (diabetes,hypertension,arthritis,cancer).
- Pregnant women were excluded due to hormonal variation.
- Participants with no formal education were excluded.
- Incomplete responses.

## Operational Definitions

### Illness Perception

Illness perception referred to the set of beliefs, thoughts, and emotional responses that individuals hold about their illness, including its cause, timeline, consequences, controllability, and symptoms. These perceptions influence how individuals cope with the illness and manage their health (Leventhal, Meyer, & Nerenz, 1980; Broadbent et al., 2006).

Perception of illness is a patient's cognitive appraisal and personal understanding of a medical condition and its potential consequences (Broadbent et al., 2015). Illness perception focuses on how an individual experiences and mentally frames living with a disease (Weinman and Petrie, 1997).

### Appearance-Related Concerns

Appearance-related concerns refer to individuals' worries, dissatisfaction, or negative thoughts and emotions about their physical appearance, including body shape, skin, weight, or facial features, which can affect self-esteem, mental health, and social functioning (Cash & Smolak, 2011; Thompson et al., 2020).

Appearance anxiety has been defined as a preoccupation with one's appearance and a fear that one's appearance (body and face shape, height, and weight) may be negatively evaluated by others (Liao, J., Xia, T., Xu, X., & Pan, L.,2023).

### Perceived Stress

Perceived stress referred to the degree to which individuals feel that their life situations are stressful, overwhelming, or uncontrollable. It reflects a person's appraisal of stressors and their ability to cope with them (Cohen, Kamarck, & Mermelstein, 1983; Cohen, 2021).

Stress refers to a "state of imbalance within a person, elicited by an actual or perceived disparity between environmental demands and the person's capacity to cope with these demands" (Maes, Vingerhoets, & Van Heck, 1987).

### Quality of Life

Quality of life refers to an individual's overall perception of their physical health, psychological state, level of independence, social relationships, personal beliefs, and relationship to important features of their environment (WHO, 1997).

WHO defined Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

## Assessment Measures

### Demographic Information Sheet

Important background information, including as age, gender, birth order, education, marital status, and location of residence, was gathered from psoriasis participants using the Demographic Information Sheet. To comprehend the socioeconomic environment, details about work status, occupation, and monthly family income were also documented. Participants indicated whether they had a nuclear or joint family system and how strong, moderate, or weak they thought their

family support was. To evaluate family duties, the number of dependents was recorded. These demographic characteristics aided in characterising the psoriasis sample and offered background information for analysing their health-related behaviours and experiences.

**Clinical Information Sheet**

The duration and age at which psoriasis first appeared, as well as the type (e.g., plaque, guttate, pustular, inverted, erythrodermic), were noted on the clinical information form. It evaluated the frequency of flare-ups and whether a family history was present. Affected bodily parts were noted, and severity was classified as mild, moderate, or severe. Along with adherence patterns, treatment options included topical, oral, phototherapy, biologics, alternative, or herbal. Additionally noted were comorbid diseases like diabetes, anxiety, depression, and hypertension.

**Brief Illness Perception Questionnaire**

The Brief Illness Perception Questionnaire (B-IPQ; Broadbent et al., 2006) was used to measure the impression of illness. The B-IPQ assesses people's emotional and cognitive perceptions of their illness. Eight elements spanning themes including illness implications, timing, control, identity, worry, coherence, and emotional response are scored on an 11-point Likert scale (0 = not at all to 10 = excessively). Higher overall scores reflect attitudes of illness as more dangerous or unfavourable. The B-IPQ has shown strong construct validity and internal consistency (α =.78) in populations with psoriasis and other chronic illnesses (Broadbent et al., 2006).For example, "My illness strongly affects my life."
"I get emotional when I think about my illness."

**Appearance Anxiety Inventory**

The Appearance Anxiety Inventory (AAI; Veale et al., 2014) was used to gauge appearance-related worries. A 10-item self-report measure called the AAI was created to evaluate behavioral and cognitive reactions to appearance-related issues, such as avoidance, comparison, and obsession with perceived faults. A 5-point Likert scale is used to rate each item, with 0 representing not at all and 4 representing always. Greater worry or anguish related to appearance is indicated by higher scores. The AAI has demonstrated outstanding test-retest reliability (r =.82) and internal consistency (α =.86). Because it measures anxiety related to appearance rather than just unhappiness, it is particularly appropriate for dermatological patients and individuals with obvious skin disorders (Veale et al., 2014). For example, I check my appearance.
I compare my appearance with other people’s appearance.

**Perceived Stress Scale**

Perceived stress was assessed using the Perceived Stress Scale (PSS-10; Cohen, Kamarck, & Mermelstein, 1983). This 10-item instrument measures the degree to which individuals perceive their lives as unpredictable, uncontrollable, and overloaded. Each item is rated on a 5-point Likert scale (0 = never to 4 = very often). Total scores range from 0 to 40, with higher scores indicating higher perceived stress. The PSS-10 has demonstrated good internal consistency (α = .78–.91) and cross-cultural validity, making it suitable for health psychology and clinical populations (Lee, 2012).e.g “I felt nervous and stressed.”
“I felt unable to control important things in my life.”

**Psoriasis Disability Index**

The Psoriasis Disability Index (PDI; Finlay & Coles, 1995) was used to measure disease-specific quality of life. The PDI consists of 15 items that assess the impact of psoriasis on daily activities, work/school, personal relationships, leisure, and treatment. Items are rated on a 4-point Likert scale (0 = not at all to 3 = very much), and the total score ranges from 0 to 45, with higher scores representing poorer quality of life. The PDI has demonstrated strong psychometric reliability (α = .88) and is frequently used in dermatology research to assess the psychosocial burden of psoriasis (Finlay & Coles, 1995).e.g "How itchy or sore has your skin been?"
"How much has your skin affected social activities?"

**Ethical Considerations**

- Informed consent was taken from all participants after explaining the purpose, procedure and voluntary nature of the study.
- Participants' confidentiality and anonymity was maintained.
- Data was securely stored and used only for academic purposes.
- Participants was informed about their right to withdraw from the study at any stage without penalty.
- No physical or psychological harm was caused to participants.

**Procedure**

The study was followed a systematic procedure to ensure ethical considerations throughout the research process. Prior to data collection, ethical approval was obtained. Approval from the original authors was also be sought for the use of existing Illness Perception, Appearance-related concerns, Perceived Stress, and Quality of life scales related to psoriasis. After receiving all approvals, the questionnaires were translated into Urdu for the understanding and clarity of the participants to respond accurately and easily. Before conducting main study, the piloting was done for the sake of reliability of the translated questionnaires.

Data collection was taken place in selected dermatology departments of public Govt hospitals in Lahore. Participants meeting the inclusion criteria was approached and informed consent was obtained. Few participants were unwilling to participate in the study. So the detail purpose and explanation of this study was given to the participant before involvement that it would not be harmful for participant and information would be used just for study purpose. Out of 130 approached participants, 115 completed the questionnaires, resulting in a response rate of 88.46%.

Data was collected using standardized questionnaires measuring illness perception, appearance-related concerns, perceived stress, and quality of life among individuals with psoriasis.The questionnaires were administered in person. Data was coded and stored confidentially for analysis. Appropriate measures were taken throughout the study to ensure anonymity, privacy, and ethical handling of participants' information.

**Statistically Data Analysis**

Collected data was screened and cleaned for completeness and accuracy. Statistical analyses was conducted using SPSS. Reliability was checked for the measurement scales of Illness Perception,

Appearance Anxiety, Perceived Stress and Quality of Life. Descriptive statistics (mean, SD, frequency) was used to summarize demographic and study variables. Pearson correlation was examined relationships among illness perception, appearance related concerns and perceived stress with quality of life. Multiple regression analysis was determined the predictive role of illness perception, appearance-related concerns, and perceived stress on quality of life.

**Results**

**Descriptive and Psychometric Properties of the Scales**

**Table 1**

***Descriptive and Psychometric Properties of brief illness perception questionnaire, appearance anxiety inventory, perceived stress scale and psoriasis disability index (N = 115)***

| Scales | *k* | *M* | *SD* | Range | | Cronbach's α | Skewness |
|---|---|---|---|---|---|---|---|
| | | | | Minimum | Maximum | | |
| Brief Illness Perception Questionnaire | 8 | 51.03 | 1.11 | 27.00 | 76.00 | .61 | -.04 |
| Appearance Anxiety Inventory | 10 | 16.34 | .68 | 0.00 | 30.00 | .75 | -.40 |
| Perceived Stress Scale | 10 | 21.85 | .45 | 9.00 | 37.00 | .62 | -.02 |
| Psoriasis Disability Index | 15 | 18.17 | .78 | 1.00 | 35.00 | .75 | -.07 |

Note: M=Mean, SD=Standard Deviation, a = alpha

Table 1 presents the descriptive and psychometric properties of the Brief Illness Perception Questionnaire consisting of 8 items, Appearance Anxiety Inventory with 10 items, Perceived Stress Scale have 10 items, and Psoriasis Disability Index consisting 15 items among 115 participants with psoriasis. Cronbach's alpha values ranged from .61 to .75, demonstrating satisfactory to good internal consistency reliability for all scales. Furthermore, skewness values ranged from -0.40 to -0.02, indicating approximately normal data distribution and supporting the suitability of the data for further parametric analyses.

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**Correlation Analysis**

**Table 2**

***Relationship of Demographic Variables and Clinical Factors with Study Variables (N = 115)***

| *Variables* | *Age* | *Type of Family Support* | *No. Of Dependants* | *Duration of Psoriasis* | *Age at Onset* | *Total AAI* | *Total PSS* | *Total BIPQ* | *Total PDI* |
|---|---|---|---|---|---|---|---|---|---|
| 1. Age | | | | | | | | | |
| 2. Type of Family Support | .098 | | | | | | | | |
| 3. No. Of Dependants | -.053 | -.131 | | | | | | | |
| 4. Duration of Psoriasis | .385** | -.122 | -.063 | | | | | | |
| 5. Age at Onset | .917** | .155 | -.031 | -.014 | | | | | |
| 6. Total AAI | -.036 | .043 | .231* | -.096 | .003 | | | | |
| 7. Total PSS | .004 | .054 | -.050 | .242** | -.100 | -.001 | | | |
| 8. Total BIPQ | .013 | -.023 | -.160 | .243** | -.089 | -.158 | .545** | | |
| 9. Total PDI | .088 | .021 | .196* | -.081 | .129 | .658** | -.167 | -.221* | |

In Table 2, the results suggest that psychological factors, particularly appearance anxiety and illness perception, play a significant role in determining the quality of life of individuals with psoriasis. Higher stress, negative illness perceptions, and greater appearance-related concerns were associated with poorer psychosocial adjustment and reduced wellbeing.

**Multiple Regression**

**Table 3**

***Hierarchical Multiple Regression for predicting the Quality of Life in individual with Psoriasis (N = 115)***

| Variables | $R^2$ | B | SE | *B* | *t* | *p* |
|---|---|---|---|---|---|---|
| Model 1 (Constant) | .314 | 31.42 | 9.25 | | 3.39 | .001 |
| Age | | 1.05 | 5.46 | .68 | .19 | .84 |
| Gender | | -3.03 | 1.97 | -.19 | -1.53 | .12 |
| Education Level | | -1.91 | .94 | -.22 | -2.03 | .04 |
| Marital Status | | 5.87 | 2.37 | .33 | 2.47 | .015 |
| Residence | | .41 | 1.54 | .05 | .27 | .78 |
| Working Status | | -2.05 | 2.21 | -.13 | -.92 | .35 |
| Family System | | .28 | 1.60 | .01 | .18 | .85 |
| Monthly Family Income | | -.93 | 1.22 | -.10 | -.76 | .44 |
| Type of Family Support | | -1.58 | 1.26 | -.11 | -1.25 | .21 |
| Duration of Psoriasis | | -1.40 | 5.41 | -.36 | -.25 | .79 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Age at Onset | | -1.16 | 5.40 | -.70 | -.21 | .83 |
| Type of Psoriasis | | -1.60 | .61 | -.24 | -2.61 | .01 |
| Frequency of Flareups | | -2.20 | 1.31 | -.16 | -1.67 | .09 |
| Family History of Psoriasis | | 1.02 | 1.02 | .09 | 1.00 | .31 |
| Severity | | .31 | 1.18 | .02 | .26 | .79 |
| Body Affected Area | | .62 | .27 | .22 | 2.25 | .02 |
| Treatment Type | | -.17 | .61 | -.03 | -.28 | .77 |
| Adherence to Treatment | | -.38 | 1.19 | -.03 | -.32 | .74 |
| Model 2 | | | | | | |
| (Constant) | .586 | 18.94 | 7.64 | | 2.47 | .01 |
| Age | | 1.24 | 4.37 | .81 | .28 | .77 |
| Gender | | -2.80 | 1.56 | -.17 | -1.7 | .07 |
| Education Level | | -.75 | .83 | -.08 | -.91 | .36 |
| Marital Status | | 3.91 | 1.89 | .22 | 2.06 | .04 |
| Residence | | .94 | 1.24 | .058 | .76 | .44 |
| Working Status | | -1.22 | 1.75 | -.07 | -.69 | .48 |
| Family System | | 1.61 | 1.31 | .09 | 1.22 | .22 |
| Monthly Family Income | | .41 | .97 | .04 | .42 | .67 |
| Type of Family Support | | -.93 | 1.02 | -.07 | -.90 | .36 |
| Duration of Psoriasis | | -1.42 | 4.35 | -.37 | -.32 | .74 |
| Age at Onset | | -1.32 | 4.33 | -.80 | -.30 | .76 |
| Type of Psoriasis | | -.79 | .50 | -.12 | -1.58 | .11 |
| Frequency of Flareups | | -1.30 | 1.05 | -.09 | -1.24 | .21 |
| Family History of Psoriasis | | .37 | .83 | .03 | .44 | .65 |
| Severity | | .33 | .98 | .02 | .33 | .73 |
| Body Affected Area | | .46 | .22 | .17 | 2.10 | .03 |
| Treatment Type | | -.78 | .49 | -.14 | -1.56 | .12 |
| Adherence to Treatment | | -.48 | .95 | -.03 | -.50 | .61 |
| Total AAI | | .62 | .08 | .57 | 7.60 | .000 |
| Total PSS | | -.29 | .15 | -.18 | -1.93 | .05 |
| Total BIPQ | | .01 | .06 | .01 | .19 | .84 |

Note: SE = Standard Error, *B*=Beta, *p ≤ .05 level; **p ≤ .01 level; ***p ≤ .001 level

In this Table 3, the first model consisting of demographic and clinical variables explained 31.4% of the variance in quality of life ($R^2 = .314$). Significant predictors including; Education Level ($\beta = -.22$, $p = .04$), Marital Status ($\beta = .33$, $p = .015$), Type of Psoriasis ($\beta = -.24$, $p = .01$), Body Affected Area ($\beta = .22$, $p = .02$).

The second model, incorporating psychological variables, explained 58.6% of the variance in quality of life ($R^2 = .586$), indicating a substantial increase in explained variance. The findings indicate that psychological factors, particularly appearance anxiety, are major determinants of quality of life among individuals with psoriasis. Even after accounting for demographic and clinical characteristics, greater appearance-related concerns were associated with significantly poorer quality of life.

**Discussion**

The present study aimed to investigate the role of Illness Perception, Appearance-related Concerns, and Perceived Stress in predicting quality of life in individuals with psoriasis. The findings revealed that all three psychosocial variables were significantly associated with quality of life, supporting the study hypotheses and highlighting the importance of psychological factors in understanding the experience of psoriasis. Importantly, Appearance-related concerns emerged as the strongest predictor of poor quality of life indicating that concerns regarding physical appearance, fear of negative evaluation, and self-consciousness may contribute more substantially to psychosocial impairment than the physical symptoms of the disease itself. This finding is consistent with previous research demonstrating that visible skin conditions often lead to body image dissatisfaction, social avoidance, and stigmatization, ultimately reducing quality of life (Richards et al., 2001; Fox et al., 2007). In Pakistan, where physical appearance is often closely linked to social acceptance, marriage prospects, and interpersonal relationships, visible skin lesions may further intensify feelings of embarrassment and social exclusion. Therefore, the strong influence of appearance-related concerns observed in the present study may reflect both the visible nature of psoriasis and the sociocultural pressures associated with appearance.

The first objective of the study was to determine the relationship between illness perception and quality of life among psoriasis patients. The findings revealed that negative illness perceptions were significantly associated with poorer quality of life. Individuals who perceived psoriasis as chronic, severe, stigmatizing, and difficult to control reported greater psychological distress and functional impairment. These findings are consistent with the Common-Sense Model of Self-Regulation proposed by Howard Leventhal, which explains that individuals' beliefs and emotional representations regarding illness influence coping behavior and adjustment outcomes. The present findings are also supported by Solmaz et al. (2021), who reported that illness identity, perceived consequences, emotional representations, and low treatment control significantly predicted reduced quality of life among psoriasis patients. Similarly, van Beugen et al. (2017) found that maladaptive illness beliefs were associated with depression, stress, and impaired psychosocial functioning in chronic dermatological conditions. Therefore, the current findings suggest that cognitive perceptions about psoriasis play an important role in determining psychological adjustment and well-being. Similarly research by Qureshi et al. (2024) reported that psoriasis patients frequently experienced emotional distress, self-consciousness, and social withdrawal due to societal misconceptions and negative social reactions toward visible skin conditions.

The second objective explored the impact of appearance-related concerns on quality of life. The results indicated that appearance-related concerns were the strongest predictor of poor quality of life among psoriasis patients. Participants with visible lesions, particularly involving the face and full body, experienced higher levels of embarrassment, self-consciousness, fear of negative evaluation, and social avoidance. These findings support previous literature suggesting that psoriasis-related body image dissatisfaction and stigmatization significantly contribute to emotional distress and social withdrawal. Richards et al. (2001) found that stigmatization and appearance dissatisfaction were strongly related to disability and psychological distress among psoriasis patients. Similarly, Fox et al. (2007) reported that young individuals with psoriasis frequently experienced shame, social isolation, and fear of rejection due to visible skin lesions. The findings are also consistent with Chen et al. (2023), who concluded that visible symptoms and appearance anxiety substantially reduce quality of life and psychosocial functioning in psoriasis patients. Within Western, where

physical appearance and social acceptance are highly valued, visible skin disorders may further intensify feelings of shame and inferiority, thereby worsening psychological well-being. Qualitative findings by Qureshi et al. (2024) also highlighted that Pakistani psoriasis patients often avoided social interactions because of insensitive societal attitudes, labeling, and fear of being judged based on appearance.

The third objective of the study was to explore the association between perceived stress and quality of life in psoriasis patients. The findings demonstrated that perceived stress was positively associated with poorer quality of life, although its predictive strength was comparatively weaker than appearance-related concerns and illness perception. Participants experiencing greater stress reported more emotional burden, poorer coping, and reduced psychosocial functioning. These findings align with the psychodermatological literature emphasizing the bidirectional relationship between stress and psoriasis. O'Leary et al. (2004) reported that higher perceived stress was associated with greater anxiety, depression, and poorer quality of life irrespective of clinical severity. Likewise, Hunter et al. (2013) suggested that chronic stress activates inflammatory pathways and contributes to disease exacerbation, creating a vicious cycle between psychological distress and flareups. The current findings also support Evers et al. (2010), who observed that stress-related activation of the hypothalamic–pituitary–adrenal (HPA) axis increases inflammatory activity and worsens psoriasis symptoms. Thus, perceived stress appears to influence both psychological wellbeing and disease progression among psoriasis patients. In Western, stress may be further intensified by financial difficulties, occupational pressures, family expectations, and limited healthcare access.

The findings further demonstrated that disease-related characteristics such as severity, frequent flareups, and extensive body involvement were associated with greater psychological burden and poorer quality of life. Participants with erythrodermic psoriasis and full-body involvement reported the greatest impairment in quality of life, highlighting the significant impact of visible and severe disease manifestations on emotional and social functioning. These findings are supported by Griffiths et al. (2021), who noted that severe psoriasis and visible lesions substantially increase psychological distress, social stigma, and functional disability. Similarly, Agarwal et al. (2022) emphasized that quality of life impairment in psoriasis is influenced not only by clinical severity but also by psychosocial burden and disease visibility.

Demographic findings also provided meaningful insights. Male participants reported poorer quality of life compared to female participants, while employed individuals experienced higher perceived stress levels. Furthermore, individuals with higher education reported stronger illness perception and greater stress due to increased awareness regarding the chronic and relapsing nature of psoriasis. Although previous findings regarding gender differences remain inconsistent, the current results suggest that sociocultural expectations and occupational functioning may influence the psychological impact of psoriasis differently across demographic groups.

The correlation findings demonstrated that psychosocial variables were strongly interrelated, suggesting that negative illness perceptions, stress, and appearance concerns collectively contribute to reduced quality of life rather than operating independently.

The findings of the present study indicate that illness perception, appearance-related concerns, perceived stress, and quality of life are closely interrelated among individuals with psoriasis. Correlation analyses revealed that more negative illness perceptions were associated with greater appearance-related concerns, higher levels of perceived stress, and poorer quality of life. Similarly,

individuals who experienced greater appearance anxiety also reported higher stress levels and greater impairment in quality of life. These findings suggest that patients who perceive psoriasis as threatening, uncontrollable, and socially stigmatizing are more likely to become concerned about their appearance, which may subsequently increase psychological stress and negatively affect their overall wellbeing. The results support previous literature suggesting that psychosocial factors operate as an interconnected network rather than as independent variables. Consistent with the Common-Sense Model of Self-Regulation and the biopsychosocial framework, the findings indicate that negative illness beliefs may contribute to appearance-related distress and stress, which together intensify emotional burden and reduce quality of life. Therefore, the relationship among the study variables appears to be cumulative and mutually reinforcing, highlighting the complex psychological impact of psoriasis on affected individuals.

The results support the biopsychosocial model by showing that quality of life in psoriasis is influenced not only by disease severity but also by psychological and social experiences related to the illness. The findings emphasize the importance of integrating psychological interventions within dermatological care because medical treatment alone may not adequately address emotional distress and quality of life impairment in psoriasis patients.

**Limitations and Suggestions**

- Because of the cross-sectional design of the study, it was impossible to establish a causal association between quality of life, perceived stress, appearance-related worries, and disease perception. Longitudinal designs should be used in future research to better understand how psycho-social changes occur over time.
- Self-report questionnaires were used to gather data, which may have raised response bias and socially acceptable answers. Clinical interviews and a mixed technique approach could be used in future studies to improve accuracy.
- The study did not thoroughly evaluate other crucial factors such coping mechanisms, social support, and treatment adherence; instead, it concentrated primarily on psycho-social predictors. For a more thorough knowledge of psoriasis-related suffering, these aspects should be investigated in future studies.
- The participants' emotional response and reporting style may have been influenced by the cultural stigma associated with visible skin diseases. To lessen social prejudice, stigmatization, and misconceptions about psoriasis patients, awareness campaigns are required.

**Implications**

- The study shows that psoriasis has a substantial impact on quality of life and psychological well-being, highlighting the necessity for holistic management that goes beyond physical therapy.
- The largest predictor of poor quality of life was shown to be appearance-related problems, highlighting the significance of addressing social stigma and body image issues in psoriasis patients.
- By showing that psychological and social aspects are important in the experience of chronic skin illnesses, the study supports the biopsychosocial model.
- The results could assist psychologists and dermatologists in identifying high-risk patients who are more susceptible to poor psychosocial adjustment and lower quality of life.

- Programs for psychoeducation and public awareness are necessary in Pakistan to lessen stigmatization, discrimination, and misconceptions about visible skin illnesses.
- The work adds to the little body of indigenous literature on the psychosocial aspects of psoriasis and offers evidence that is culturally appropriate for further research in Pakistan.

**Conclusion**

The current study's findings showed that among psoriasis sufferers, perceived stress, appearance-related worries, and illness perception were all strongly correlated with quality of life. The biggest predictor of poor quality of life was found to be appearance-related concerns, suggesting that psychosocial well-being is significantly impacted by worries about visible skin lesions, self-consciousness, and fear of being negatively judged. The impression of illness also played a major role in impairing quality of life, indicating that people with more unfavourable perceptions about psoriasis had more emotional and functional challenges. The psychological burden of chronic skin disease was shown in the positive correlation between perceived stress and lower quality of life. Additionally, higher psychosocial distress and a lower quality of life were linked to the severity of the disease, apparent bodily involvement, and frequent flare-ups. Overall, the results show that psoriasis patients' lived experiences are significantly influenced by psychological and social aspects.

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