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Original Research Article

STUDY ON SOCIAL ANXIETY AND IT'S IMPACT ON QUALITY OF LIFE AMONG PSORIASIS PATIENTS

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Name of Author:
Karun Babu[1], Pradeep Chandrasekaran[2] and Navakumar Manickam [3]*

Affiliation: *[1]Post Graduate Student, MD Psychiatry Vinayakamission's Kirupananda Variyar Medical college &Hospitals, Salem, Tamil Nadu. Orcid 0009-0003-2659-7343*
[2]Associate professor, Department of Psychiatry Vinayakamission's Kirupananda Variyar Medical College &Hospitals, Salem, Tamil Nadu Orcid 0000-0002-9426-3287
[3]Professor, Department of Dermatology Vinayakamission's Kirupananda Variyar Medical College&Hospitals, Salem, Tamil Nadu

Abstract: Psoriasis along with it's physical impact causes considerable emotional and social distress. Many patients experience social anxiety arising from fear of negative judgment, which can further deteriorate their quality of life. ***Objectives:*** 1. To assess the level of social anxiety among psoriasis patients, 2. To evaluate the overall quality of life among psoriasis patients, 3. To determine the association between social anxiety and quality of life among these patients. ***Methodology:*** A cross-sectional study was carried out among 100 adult psoriasis patients. Sociodemographic and clinical details were recorded using a structured questionnaire. The Liebowitz Social Anxiety Scale was applied to assess fear and avoidance behaviors, and the WHOQOL-BREF tool measured health-related quality of life. Psoriasis severity was scored using the Psoriasis Area and Severity Index. ***Results:*** Participants had a mean age of 38 years, with males forming 75 percent of the sample. Plaque psoriasis was the most frequent subtype. Overall, 56 percent reported marked to very severe anxiety, while only 11 percent exhibited mild anxiety. The average quality of life score was 66.5 ± 6.6. Anxiety levels were significantly higher among those with severe disease, visible lesions, and longer duration of illness, all correlating with poorer quality of life ($p = 0.001$). ***Conclusion:*** Psoriasis exerts a notable psychosocial burden, with social anxiety closely linked to disease severity and visibility. As anxiety markedly diminishes quality of life, comprehensive patient care should integrate psychological evaluation and counselling within routine dermatological management.

Keywords: Psoriasis, Quality of life, Social anxiety

INTRODUCTION

Psoriasis is a chronic, immune mediated inflammatory skin disorder that affects nearly 2–3% of the global population, accounting for about 125 million cases worldwide. It occurs across all ethnicities and age groups but most frequently manifests between the second and fourth decades of life. Clinically, the disease is characterized by well defined erythematous papules and plaques covered with silvery white scales, most commonly distributed symmetrically over the elbows, knees, scalp, and lumbosacral regions. The disease typically follows a chronic, relapsing remitting course with varying severity among patients. Periods of remission are

often associated with exacerbations precipitated by environmental and systemic triggers such as infections, psychological stress, trauma and certain medications. Thus, psoriasis is a result of complex interactions between immune dysregulation, genetic predisposition, and environmental variables, which lead to both systemic and localized inflammatory reactions. 1-3.

Psoriasis has a significant psychological and social impact on those affected. Visible lesions frequently cause social isolation and stigmatization due to feelings of inferiority, self-consciousness and rejection anxiety. Research shows that mood disorders, with anxiety and depression being the most common, can affect up to one-third of patients with dermatological conditions. These psychological comorbidities in psoriasis patients may arise as a direct result of cosmetic impairment, social isolation, and poor interpersonal connections. Furthermore, the sporadic, chronic nature of flare-ups may cause feeling of helplessness and mental discomfort. Through neuroendocrine-immune pathways, psychosocial stress itself may exacerbate psoriatic inflammation, creating a vicious cycle between psychological discomfort and worsening of the illness. 4,5

One of the most disabling emotional outcomes in psoriasis is social anxiety, characterized by excessive fear of social interactions and perceived scrutiny. Patients often avoid professional, educational or recreational activities due to fear of negative judgment or rejection based on their appearance. This fear of social exposure exacerbates feeling of isolation and vulnerability, ultimately leading to reduced community participation and poor psychosocial adaptation. Such anxiety may also contribute to poor health seeking behavior, reduced treatment compliance, and greater disease burden.6-8 The combined impact of the disease and social anxiety results in deterioration in health-related quality of life among psoriasis patients. The combined effect of psoriasis and psychological burden may lead to emotional distress, affecting daily functioning, interpersonal relations and self-perception. 9,10

Majority of existing literature highlights depressive symptoms as the key psychological comorbidity, while social anxiety related to fear of social judgment and visible difference, receives less focus. Psychological stress and anxiety may act not only as by-products of psoriasis but also as aggravating factors that trigger inflammatory responses through neuro-endocrine-immune pathways. Very few studies have examined these issues in the Indian population, where cultural background, social attitudes, and coping styles differ significantly from other parts of the world. In light of these gaps in the literature, the present study was done with the following objectives:

1. To assess the level of social anxiety among psoriasis patients presenting to Vinayaka Mission's Medical College and Hospital, Salem.
2. To evaluate the overall quality of life among psoriasis patients attending Vinayaka Mission's Medical College and Hospital, Salem.
3. To determine the association between social anxiety and quality of life among these patients.

MATERIAL AND METHODS

A cross-sectional study was conducted from June 2024 to June 2025 at Vinayaka Mission Medical College and Hospital, Salem, Tamil Nadu, India. The study included 100 clinically confirmed psoriasis patients aged 18 years and above who attended the outpatient services during this period. Participants were selected using purposive sampling based on inclusion criteria of being adults (≥18 years) of both sexes diagnosed with psoriasis. Individuals with severe cognitive impairment or major cardiovascular or systemic illnesses that could significantly affect quality of life were excluded from the study.

Data were collected using a structured proforma that included both socio-demographic and clinical variables. Information was recorded on age, sex, religion, educational status, marital status, type and duration of psoriasis, presence of visible lesions, and associated comorbidities. To assess the psychosocial domains, the following instruments was administered:

1. Liebowitz Social Anxiety Scale (LSAS): It is a 24-item instrument designed to assess both fear and avoidance across a variety of social and performance situations. Each item is rated on a 4-point Likert scale for fear (0 = none to 3 = severe) and avoidance (0 = never to 3 = usually). The total score is interpreted to classify levels of social anxiety as mild, moderate, marked, severe, or very severe.
2. World Health Organization Quality of Life Scale (WHOQOL-BREF):

This tool assesses four key domains of health-related quality of life—physical, psychological, social, and environmental well-being. The WHOQOL-BREF is a standardized, globally validated scale suitable for evaluating chronic disease impact on daily functioning and mental health status. Higher scores indicate better quality of life.

Clinical severity of psoriasis was further evaluated using the Psoriasis Area and Severity Index (PASI), which classifies the disease as mild (<10), moderate (10–20), or severe (>20). All instruments were administered in a private and confidential setting under standardized conditions to ensure participant comfort and accuracy of responses.

Ethical Consideration

Ethical clearance was obtained from the institutional ethics committee prior to data collection. (Approval number: XYZ) Eligible participants were informed about the details of the study and written informed consent was obtained. Confidentiality of patient data was maintained throughout the research process.

Statistical Analysis

Data were entered in MS Excel and analyzed using SPSS version 26.0. Descriptive statistics including mean, standard deviation, frequencies, and percentages were computed for all variables. The Chi-square test was applied to assess associations between categorical variables, such as anxiety level with gender or lesion visibility. The independent t-test and one-way analysis of variance (ANOVA) were used to compare mean quality of life scores across levels of anxiety and disease duration. A significance level of $p < 0.05$ was considered statistically significant.

RESULTS

The study enrolled 100 patients with psoriasis, with a mean age of approximately 38 years (range: 18–60 years). As shown in Table 1, the majority of participants were in the younger age group of 18–30 years (36%), followed by those aged 51–60 years (28%). Males predominated the sample (75%), while females constituted 25%. The religious composition showed that Hindus forming the largest group (85%), followed by Christians (9%) and Muslims (6%). More than half of the participants (54%) had completed only primary education and only 8.0% were graduates. Most participants were married (78.0%).

The clinical characteristics of psoriasis in the study population are summarized in Table 2. The duration of disease was less than 5 years in nearly half of the patients (48%), with 37% having a duration of 5–10 years and 15% exceeding 10 years. Plaque psoriasis was the most prevalent clinical subtype (34%), followed by scalp psoriasis (22%), while other subtypes including guttate, flexural, rupoid, and sebopsoriasis accounted for 11%. Disease severity indicated moderate in 46% of patients, severe in 34%, and mild in 20%. Lesions were present on exposed areas (face, arms, forearms, and hands) in 78% of participants. Notably, no family history of psoriasis was reported in any patient. Diabetes mellitus was present in 33% of the study population.

The psychological burden and quality of life outcomes are detailed in Table 3. On assessing anxiety levels of patients, it revealed that 33% of patients experienced marked anxiety, 23% very severe anxiety, 18% moderate anxiety, 15% severe anxiety and only 11% mild anxiety. The overall mean quality of life (QOL) score was 66.52 ± 6.626 (range: 54–80).

Associations between PASI score categories and key demographic and clinical factors are presented in Table 4. Disease severity showed a significant gender disparity ($P = 0.001$, Chi-square test), with males more evenly distributed across moderate (44.0%) and severe (42.7%) categories, whereas females predominantly had moderate severity (88.0%). Similarly, longer disease duration was strongly linked to higher PASI scores ($P = 0.001$, Chi-square test), particularly with 86.7% of patients having disease duration >10 years exhibiting severe psoriasis, compared to 72.9% moderate severity in those with <5 years duration.

The distribution of social anxiety levels across clinical and demographic variables is outlined in Table 5. Presence of lesions on exposed areas was significantly associated with higher anxiety severity ($P = 0.001$, Chi-square test), with 45.5% of patients with visible lesions reporting very severe anxiety, versus only 16.7% among those without. PASI score also correlated strongly with anxiety ($P = 0.001$, Chi-square test), as 55.9% of patients with severe psoriasis experienced very severe anxiety, in contrast to none in the mild PASI group. Gender differences were evident ($P = 0.001$, Chi-square test), with males showing a higher burden of very severe anxiety (42.7%) compared to females (8%), who had a greater proportion of mild anxiety (60%). Furthermore, anxiety escalated with disease duration ($P = 0.001$, Chi-square test), culminating in 86.7% very severe anxiety among those with >10 years duration.

Factors influencing quality of life scores are summarized in Table 6. Anxiety category had a significant inverse association with QOL ($P = 0.001$, ANOVA), with mean scores declining progressively from 77.27 in mild anxiety to 57.91 in very severe anxiety. Visible lesions on exposed areas were linked to poorer QOL (mean 62.14 vs. 67.76; $P = 0.001$, independent t-test). No significant gender difference was observed in mean QOL scores ($P = 0.17$, independent t-test). However, disease duration significantly impacted QOL ($P = 0.002$, ANOVA), with the lowest mean score (62.00) in patients with >10 years duration.

Tables and Figures

Table 1: Socio-demographic characteristics of study population (n = 100)

Characteristic	Category	Frequency	Percentage
Age Group (years)	18–30	36	36.0
	31–40	20	20.0
	41–50	16	16.0
	51–60	28	28.0
Gender	Male	75	75.0
	Female	25	25.0
Religion	Hindu	85	85.0
	Christian	9	9.0
	Muslim	6	6.0
Educational Status	Primary	54	54.0
	Secondary	20	20.0
	Higher Secondary	18	18.0
	Graduate	8	8.0
Marital Status	Single	22	22.0
	Married	78	78.0

Table 2: Clinical Characteristics of Psoriasis (n=100)

Characteristic	Category	Frequency	Percentage
Duration of Psoriasis	Less than 5 years	48	48.0
	5 to 10 years	37	37.0
	More than 10 years	15	15.0
Clinical Type	Plaque	34	34.0
	Guttate	11	11.0
	Flexural	11	11.0
	Rupoid	11	11.0
	Scalp	22	22.0
	Sebopsoriasis	11	11.0
Severity (PASI Score)	Mild (<10)	20	20.0
	Moderate (10–20)	46	46.0
	Severe (>20)	34	34.0
Lesions on Exposed Areas	Absent	22	22.0
	Present	78	78.0
Family History of Psoriasis	Absent	100	100.0
Past Medical History (DM)	Absent	67	67.0
	Present	33	33.0

Table 3: Psychological Burden and Quality of Life

Anxiety Category	Category	Frequency	Percentage
	Mild	11	11.0
	Moderate	18	18.0
	Marked	33	33.0
	Severe	15	15.0
	Very Severe	23	23.0
Quality of Life (QOL) Score	**Minimum**	**Maximum**	**Mean ± SD**
	54	80	66.52 ± 6.626

Table 4: PASI Score by Clinical and Demographic Factors

Factor/Category	Mild (<10) (%)	Moderate (10–20) (%)	Severe (>20) (%)	Total (%)	P-value
Gender					
Male	10 (13.3)	33 (44.0)	32 (42.7)	75 (100.0)	0.001 (Chi-square)
Female	1 (4.0)	22 (88.0)	2 (8.0)	25 (100.0)	
Disease Duration					
<5 years	0 (0.0)	35 (72.9)	13 (27.1)	48 (100.0)	0.001 (Chi-square)
5–10 years	11 (29.7)	18 (48.6)	8 (21.6)	37 (100.0)	
>10 years	0 (0.0)	2 (13.3)	13 (86.7)	15 (100.0)	
Total	20 (20.0)	46 (46.0)	34 (34.0)	100 (100.0)	

Table 5: Associations of Social Anxiety with Clinical and Demographic Factors

Factor/Category	Mild (%)	Moderate (%)	Marked (%)	Severe (%)	Very Severe (%)	Total (%)	P-value
Lesions on Exposed Areas							
Present	0 (0.0)	1 (4.5)	3 (13.6)	8 (36.4)	10 (45.5)	22 (100.0)	0.001 (Chi-square)
Absent	11 (14.1)	17 (21.8)	30 (38.5)	7 (9.0)	13 (16.7)	78 (100.0)	
PASI Score Category							
Mild (<10)	10 (50.0)	4 (20.0)	6 (30.0)	0 (0.0)	0 (0.0)	20 (100.0)	0.001 (Chi-square)
Moderate (10–20)	1 (2.2)	12 (26.1)	18 (39.1)	11 (23.9)	4 (8.7)	46 (100.0)	
Severe (>20)	0 (0.0)	2 (5.9)	9 (26.5)	4 (11.8)	19 (55.9)	34 (100.0)	
Gender							
Male	4 (5.3)	10 (13.3)	20 (26.7)	9 (12.0)	32 (42.7)	75 (100.0)	0.001 (Chi-square)
Female	15 (60.0)	2 (8.0)	4 (16.0)	2 (8.0)	2 (8.0)	25 (100.0)	
Disease Duration							
<5 years	14 (29.2)	11 (22.9)	2 (4.2)	8 (16.7)	13 (27.1)	48 (100.0)	0.001 (Chi-square)
5–10 years	4 (10.8)	1 (2.7)	22 (59.5)	2 (5.4)	8 (21.6)	37 (100.0)	
>10 years	1 (6.7)	0 (0.0)	0 (0.0)	1 (6.7)	13 (86.7)	15 (100.0)	
Total	11 (11.0)	18 (18.0)	33 (33.0)	15 (15.0)	23 (23.0)	100 (100.0)	

Table 6: Quality of Life by Clinical and Demographic Factors

Factor/Category	N (%)	Mean QOL	Std. Deviation	P-value
Anxiety Category				
Mild	11 (11.0)	77.27	1.421	0.001 (ANOVA)
Moderate	18 (18.0)	72.22	2.533	
Marked	33 (33.0)	67.03	3.423	
Severe	15 (15.0)	63.87	1.995	
Very Severe	23 (23.0)	57.91	2.255	
Lesions on Exposed Areas				
Present	22 (22.0)	62.14	4.998	0.001 (t-test)
Absent	78 (78.0)	67.76	6.527	
Gender				
Male	75 (75.0)	65.67	6.014	0.17 (t-test)

Female	25 (25.0)	67.24	4.475	
Disease Duration				
Less than 5 years	48 (48.0)	67.75	5.685	0.002 (ANOVA)
5 to 10 years	37 (37.0)	65.51	4.253	
More than 10 years	15 (15.0)	62.00	6.751	
Total	100 (100.0)	66.52	6.626	

DISCUSSION

The study found that most psoriasis patients were young to middle-aged adults, predominantly male, and had lower educational attainment. Plaque psoriasis was the most common subtype, and nearly half had the disease for less than five years. Moderate to severe psoriasis constituted the majority, with lesions commonly involving exposed body areas. The psychological assessment revealed a high prevalence of marked to very severe anxiety among participants, while quality of life was moderately impaired. Disease severity and duration showed strong associations with anxiety levels and lower quality of life, and visible lesions on exposed areas further worsened psychosocial outcomes. These findings confirm that greater clinical severity and disease visibility significantly increase social anxiety and negatively affect quality of life in patients with psoriasis.

Comparable results have been documented in several previous studies. Yildirim FE et al.11 also reported significantly higher social anxiety among psoriasis patients compared to controls, with social fear and avoidance subscales showing notable correlations with quality-of-life impairment. However, in contrast to their findings where PASI scores did not correlate with anxiety, the present study demonstrated a strong association between PASI severity and anxiety levels, suggesting that visible and extensive lesions in our sample may have amplified the social distress experienced by patients. Similarly, Schneider G et al.12 found that disease severity and perceived social support collectively explained a large proportion of variance in social anxiety and avoidance, supporting our observation that psychosocial dimensions play a pivotal role in the overall disease burden. The study by Cipolla S et al.13 further emphasized the bidirectional relationship between psoriasis, anxiety and quality of life, identifying pain and sleep disturbances as predictors of psychological morbidity. Although our study did not directly assess these factors, the worsening of quality of life with increasing anxiety severity aligns with their conclusion that addressing psychological symptoms is essential in psoriasis management. Martínez-Ortega JM et al.14 also demonstrated higher anxiety and depression among psoriasis patients, with poorer QOL linked to greater disease severity and specific lesion sites. These findings are consistent with our results showing lower QOL scores among patients with severe and long-standing disease, particularly those with visible lesions, reflecting the psychosocial distress arising from stigmatization and cosmetic disfigurement.

In contrast, Tuman B et al.15 and Yildirim FE et al.11 found no significant correlation between PASI and anxiety parameters, suggesting that psychological distress may occur independently of clinical disease activity. However, the current study identified a clear gradient between disease severity, duration, and anxiety, which may reflect sociocultural differences between study population. Additionally, Bakar RS et al.16 reported notable anxiety and depressive symptoms in their Malaysian cohort, with QOL impairment as a significant predictor, consistent with our current finding. Overall, the present findings states that both disease severity and psychological burden contribute to reduced quality of life.

This study has several notable strengths. It explored both the clinical and psychological aspects of psoriasis using reliable and well-established study tools. Using these standardized measures helped ensure accuracy and allowed comparison with other studies. The inclusion of patients across different age groups, disease durations, and psoriasis subtypes provided a good overview of individuals commonly seen in tertiary care settings in South India. This study confirms that psoriasis is more than just a skin problem; it also has a big impact on the mental and social well-being of patients. The results show that more severe and visible skin lesions are linked to higher levels of social anxiety and a lower quality of life. Unlike some earlier studies, which showed weak links between how bad the psoriasis looked and psychological distress, our findings suggest that in this group from South India, visible and severe cases cause more social anxiety and make daily life harder. This could be because of cultural or social factors that make people more worried about how they look or feel stigmatized because of their skin condition.

Our study adds important information about how psoriasis affects mental health. It shows that doctors should pay attention to psychological impact of disease among psoriasis patients. This includes regular mental health screening and providing assurance. There is a need of combined effort between dermatologists, psychologists and social workers in treating psoriasis patients to improve treatment compliance and overall well-being. Future

research should look at how the disease and mental health influence each other over time and ways to improve both skin symptoms and mental well-being.

Limitations of the study: At the same time, the study has certain limitations. Because it was cross-sectional, it can only show associations and not cause-and-effect relationships between disease severity, anxiety, and quality of life. The purposive sampling method may have introduced some selection bias and reduced the generalizability of results to the wider population. Another limitation is the absence of a control group, which makes it difficult to directly compare anxiety and quality of life with people who do not have psoriasis. Despite these limitations, the study provides useful and context-specific evidence on the psychological impact of psoriasis and highlights the importance of including mental health evaluation in dermatology practice.

CONCLUSION

The present study showed that psoriasis imposes a substantial psychosocial burden, with high levels of social anxiety and moderate impairment in quality of life among affected individuals. Patients with visible lesions, longer disease duration, and greater clinical severity exhibited significantly higher anxiety scores, while increased social anxiety was strongly associated with poorer quality of life across all domains. Although no major gender differences were noted in overall quality of life, males showed higher levels of very severe anxiety compared to females. These findings highlight the bidirectional relationship between psychological distress and disease severity, emphasizing the need for holistic psoriasis management that integrates dermatological treatment with mental health assessment and counselling.

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