REVIEW OF LITERATURE

Much past work in health psychology has emphasized risk factors rather than resilience or protective factors when examining health outcomes. Numerous studies have found that negative emotions (anger, anxiety and depression) are associated with morbidity and mortality in many chronic illnesses, from cardiovascular disease (Barefoot et al., 2000) to skin disorders (Folks, 2001) to asthma (Friedman and Booth-Kewley, 1987).

Walker and Papadopoulos (2005) reported that chronic diseases contributing most heavily to death, illness, and disability have changed dramatically during the last century. Today, chronic disease such as cardiovascular disease (primarily heart disease and stroke), cancer, skin problems such as eczema and psoriasis, asthma and diabetes are among the most prevalent, costly, and preventable of all health problems. The prolonged course of illness and disability from chronic disease such as skin disorders results in extended pain and suffering and decreased quality of life for millions of people. The present study investigated the role of Personality, Health Locus of Control, State-Trait Anxiety, Self Esteem, Self Efficacy, Mental Health and its dimensions viz Being Comfortable with Self, Being Comfortable with Others and Ability to meet Life demands, dimensions of Stress viz Stress Symptoms, Perceived Stress, Daily Hassles and Uplifts, Ways of Coping, Anger Expressed and Anger Expression Styles, Perceived Parental Bonding, perception of Family Environment, Dermatology Life Index and Family Dermatology Index in adolescents with and without skin disorders.

A. CONCEPTUAL FRAMEWORK

PERSONALITY

Personality has retained its fascination for the thinkers all over the world (Mohan, 2000). ‘Personality’ refers to a general style of interacting with the world, especially with other people – whether one is withdrawn or outgoing, excitable or placid, conscientious or careless, kind or stern. A basic
assumption of the personality concept is that people do differ from one another in their style of behavior, in ways that are at least relatively consistent across time and place (Ferguson, 2000).

Definitions of Personality

Cattell (1950) stated that "Personality is that which permits prediction of what a person will do in a given situation. According to Freud, personality was "the integration of the Id, the Ego and the Super Ego". Adler’s idea of personality was “the individual style of life or characteristic manner of responding of life’s problems, including life’s goals.

Eysenck (1968) proposed a definition of personality as “more or less stable and enduring organization of person’s character and temperament, intellect and physique which determines his unique adjustment to the environment. In their personality structure, some individuals possess “core” characteristics (either inherited or develop under influence of certain situations), which make them more vulnerable than others to certain kinds of human conflict, which threaten their emotional security.

Costa and McCrae (1995) defined personality as characteristics that are pervasive and enduring and form a central part of the person’s identity.

Burger (2010) stated that “Personality can be defined as consistent behavior patterns and intrapersonal processes originating within the individual”.

Balasanov (2010) stated that “Personality is made up of the characteristic patterns of thoughts, feelings and behaviors that make a person unique”.

Eysenck’s Theory of Personality

Eysenck’s theory of personality is one of the formidable attempts in presenting a complete and explanatory theory. Eysenck’s definition of personality revolves around four behavior patterns: the cognitive, the conative, the affective and the somatic. Thus, personality, according to Eysenck, is the sum total of actual or potential behavior patterns of organism as determined by heredity and environment. Eysenck developed and
presented an exhaustive personality theory on the basis of intensive research over the years (1947, 1960, 1963, 1967, 1971, 1981). He posited four independent major dimensions of personality, viz., Extraversion/introversion (E/I), Neuroticism (N), Psychoticism (P) and Social Desirability (Mohan et al., 1987; 2000).

The Dimensional Approach

The three basic dimensions of personality by Eysenck et al. (1985) are Extraversion/Introversion, Neuroticism and Psychoticism. Later on another dimension called lie (social desirability) scale was added in the personality questionnaire of Eysenck.

Extraversion/Introversion

Eysenck and Eysenck (1968) proposed that extraversion refers to the outgoing, uninhibited, impulsive and social inclinations of person. The typical extravert is sociable, likes parties, has many friends, needs to have people to talk to and does not like reading or studying by himself. He craves for excitement, takes chances, often sticks his neck out, acts on the spur of the moment, and is generally an impulsive individual. He is fond of practical jokes, always has a ready answer, and generally likes to laugh and be merry. He prefers to keep moving and doing things, tends to be aggressive and loses his temper quickly; although his feelings are not kept under tight control. He is not always a reliable person.

A typical introvert is a quiet, retiring sort of person, introspective, fond of books rather than people; he is reserved and distant except to intimate friends. He tends to plan ahead, looks before he leaps. He does not like excitement, takes matters of everyday life with proper seriousness, and likes the well-ordered mode of life. He keeps his feelings under close control, seldom behaves in an aggressive manner and does not lose his temper easily. He is reliable, somewhat pessimistic and places great value on ethical standards (Eysenck, 1965).

Neuroticism

The second major personality dimension deduced by Eysenck (1947) was neuroticism/stability. Neuroticism refers to a general,
emotional over responsiveness, emotional lability, and liability to neurotic breakdown under stress. Neuroticism is closely related to the inherited degree of liability of the autonomic nervous system (Eysenck, 1964, 1967). According to Eysenck and Eysenck (1968), neuroticism as contrasted to emotional stability is very much similar to anxiety.

A high scoring individual on neuroticism tends to be anxious, worrying, over responsive and depressed. He reacts too strongly to all sorts of stimuli and finds it difficult to get back on an even heel after each emotionally arousing experience (Ibrahim, 1979).

Psychoticism

Eysenck and Eysenck (1975) and Howarth (1986) reported that a high scorer on Psychoticism possesses the following traits: Impulsiveness, lack of cooperation, oral pessimism, rigidity, lower super ego controls, low social sensitivity, low persistence, lack of anxiety, egocentric, impersonal, lack of feelings of inferiority, unempathic, creative, aggressive, cold, antisocial and tough minded.

A high scorer on Psychoticism is described as being solitary, crude, inhuman, insensitive, hostile and aggressive.

Lie-Scale (Social Desirability)

The lie (social desirability) scale (L) was first incorporated in the Eysenck Personality Inventory (EPI) to measure a tendency on the part of the subjects to fake good responses. A series of factorial and experimental studies have been carried out to investigate the nature of this scale in some detail (Eysenck, 1971). This scale possesses a considerable degree of factorial unity (Mohan, 2000).

It is being considered as a tendency to respond in a socially desirable way; it is variously described as a desire to conform to social norms (Edwards, 1954); nice personality (Skinner et al., 1970); ideal self and ideal responses (Choudhary, 1972).
Health Locus of Control

Locus of control is considered to be an important aspect of personality and according to Smith et al., (1997), this construct has generated enormous interest over the past 30 years.

Locus of control as defined by Rotter (1966), refers to individual differences in the extent to which people perceive events as contingent upon their own behaviour or enduring characteristics (a belief in internal control) versus the extent to which they believe that reinforcement is contingent not upon the self, but upon external factors such as chance, fate or powerful others (a belief in external control).

In short, internal locus of control refers to the perception of positive and negative events as being a consequence of one’s own actions and thereby under one’s own personal control. In contrast, external locus of control refers to the perception of positive or negative events as being unrelated to one’s own behaviour in certain situations and thereby beyond personal control.

Rotter (1966) postulated that an individual who perceives his or his illness as consequence of one’s own behaviour is said to have internal locus of control. Such a person is likely to recover soon but an external person tends to perceive his behaviour as determined by external events beyond his control; such as fate, powerful others etc. This is negative expectancy and he/she is unlikely to progress and recover from illness.

Health psychologist like Wallston et al. (1987) expanded the original scale beyond Rotter’s so called simple internal – external dimension. Wallston et al. (1987) said that one’s health status may be determined by health locus of control dimensions. Wallston et al.’s (1987) Health Locus of Control Scale measures two dimensions of health locus of control viz., Health Locus of Control – Internal i.e. the extent to which individual believes that his/her locus of control for health is internal; and Health Locus of Control – External i.e. the extent to which individual believes that external factors like luck, chance, fate are affecting his or her health. There is a large body of research which has implicated locus of control in wide range of health
behaviours and attitudes with internals engaging more in health promoting behaviors (Lau, 1982).

AmyKay (2002) stated that “Locus of control refers to an individual's generalized expectations concerning where control over subsequent events resides. In other words, who or what is responsible for what happens. It is analogous to, but distinct from, attributions”.

A theoretical construct designed to assess a person's perceived control over his or her own behavior. The classification internal locus indicates that the person feels in control of events; external locus indicates that others are perceived to have that control (Medical Dictionary.com, 2007).

**STATE–TRAIT ANXIETY**

At various times, anxiety has been conceptualized as a response, a stimulus a trait, a motive and a drive (Spielberger, 1972).

Anxiety is defined as a complex state that includes cognitive, emotional, behavioral and bodily reactions. Worry refers to the cognitive aspect of anxiety where as Anxiety refers to its awareness (Spielberger, 1966). Anxiety is a stage characterized by heightened autonomic system activity, specifically activation of the sympathetic nervous system i.e., increased heart rate, blood pressure, respiration and muscle tone, subjective feelings of tensions and cognitions involve apprehensions and worrying (Kazdin, 2000).

Spielberger (1966) also proposed that trait anxiety reflects anxiety proneness, that is stable i.e. there were individual differences in the tendency to respond with increased state anxiety to various levels of stress.

In short, anxiety as a process refers to a sequence of cognitive, affective, physiological and behavioral events. A-State is characterized by feelings of tension, apprehension, worry and autonomic arousal occurring in response to perceptions of either threats to personal adequacy or objective physical danger. A-Trait specifically refers to the tendency of individuals to response with A-State elevations to situations which are perceived as potentially threatening to self-esteem (Mohan et al., 2000).
American Psychiatric Association (1994) considers Anxiety as “a danger signal felt and perceived by the conscious portion of the personality. It is produced by a threat from within the personality – with or without stimulation from external situations.”

Anxiety is a feeling of being nervous or worried, often as a result of fear of a possible future event (Dictionary.Com, 2011).

An abnormal and overwhelming sense of apprehension and fear often marked by physiological signs (as sweating, tension, and increased pulse), by doubt concerning the reality and nature of the threat, and by self-doubt about one’s capacity to cope with it (Merriam-Webster Online Dictionary, 2011).

SELF ESTEEM

Self-Esteem is a term used in psychology to reflect a person’s overall evaluation or appraisal of his or her own worth. Self-Esteem encompasses beliefs and emotions. Psychologists usually regard self-esteem as an enduring personality characteristic (trait self-esteem) though normal, short term variations (state self-esteem) also occur.

Given its long and varied history, the term has three major types of definition, each of which has generated its own tradition of research, findings and practical applications.

The original definition presents self-esteem as a ratio found by dividing ones successes in areas of life of importance to a given individual by the failures in them or one’s “success/pretensions” (James, 1890).

Rosenberg (1965) and social learning theorists defined self-esteem in terms of a stable sense of personal worth or worthiness.

Branden’s (1969) description of self-esteem includes the following primary properties:

- Self-esteem as a basic human need, i.e., “it makes an essential contribution to the life process,” “is indispensable to normal and healthy self-development, and has a value for survival”.
- Self-esteem as an automatic and inevitable consequence of the sum of the individuals’ choices in using their consciousness.
• Something experienced as a part of, or background to, all of the individuals, thoughts, feelings and actions.

GENERALISED SELF-EFFICACY

Self-efficacy is defined as the ‘beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments’ (Bandura, 1977 a). It has been related to both general and diabetes-specific health behaviors (Schwarzer, 1992).

The belief that one can succeed at something that one wants to do is known as self efficacy (Bandura, 1977). One decides whether or not to carry out a healthy behavior by deciding whether it will achieve the desired effect and then whether one is capable of doing it. One may know that exercise will help one to be fit but we might not feel capable of doing it.

The concept of generalized self-efficacy developed by Jerusalem and Schwarzer (1992) reflects a global reference in one’s coping ability across a wide range of demanding situations (Schwarzer, 1992).

Margolis and McCabe (2006) stated that “Self efficacy is defined as the belief in ones capabilities to achieve a goal or an outcome”.

Ormrod, (2006) defined self efficacy as the belief that one is capable of performing in a certain manner to attain certain goals. It is believed that our personalized ideas of self-efficacy affect our social interactions in almost every way.

MENTAL HEALTH

Menninger (1945) defined mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. It is the ability to maintain temper, an alert intelligence, socially considerate behaviour and a happy disposition.

The World Health Organization (1967) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.
According to Wig (1999), it is important to recognize that physical and mental health are really not separate. Health is indivisible. Body and mind together make one unit. The separation between body and mind is only a convenient way of thinking. Medical science has repeatedly demonstrated how powerfully the mind influences the body. It is not only that a healthy body keeps a healthy mind, but a healthy mind also greatly contributes towards a healthy body.

The world Federation of Mental Health (Wig, 1999) has recently come out with a three point definition of mental health based on the following three criteria:

- A person who is mentally healthy must be comfortable within himself or herself: if you are not comfortable within yourself, if you are tense, nervous, fearful, sad, aggressive or suspicious, you are not mentally healthy, at least not for the time you are having such negative emotions (Wig, 1999).

- A person who is mentally healthy is not only comfortable within oneself but also makes others comfortable around him or her. It is a very important component of the definition. You may be very happy and comfortable within yourself but if you are making the life miserable for those around you, you are not a mentally healthy person. In fact the degree of your mental health can be judged from the faces of those who are in your company. Ultimately mental health is a kind of balance or harmony between our self interest and social responsibility (Wig, 1996).

- A mentally healthy person is constantly striving to improve further. A mentally healthy person never feels that he/she has reached perfection because he/she is always making further efforts for self improvement (Wig, 1996).

Mental health is an expression of emotions and signifies a successful adaptation to a range of demands (About.Com, 2007).

A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in

STRESS

Tracing the history of the concept of stress, its origin dates back to 1914, when Cannon used the term in medicine. Cannon (1939) also suggested the term “homeostasis” from the Greek language where “homeo”, means similar, and “stasis”, means position, for “the coordinated physiologic processes, which maintain most the steady states in the organism”.

Lazarus and Folkman (1984) defined stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being”.

There is overwhelming evidence that stress is a particularly important mediator of health-behavior relationships because it is a common and inevitable aspect of life and its broad effects can influence a range of bodily systems and behaviors. Stress appears to involve more or less simultaneous activation of psychological and biological systems, hence plays a crucial role in the etiology of chronic disorders (Cohen and Williamson, 1988).

Morrow (2011) stated that “Stress can come from any situation or thought that makes you feel frustrated, angry, nervous, or anxious”.

A state of psychological tension and physiological arousal produced by a stressor (IB Psychology, 2011).

Stress is a general term to describe tense situations and reaction to stress usually has a strong emotional content. Seyle (1950) defined stress as the nonspecific (that is, common) result of any demand upon the body, be the effect mental or somatic.

Stress is defined neither by the conditions acting on the person (the stressor), nor by the state of the person (coping resources, ego strength etc), nor by his reactions (stress responses), but rather by the interplay of the three (Korchin, 1986).
Stress is perceived to be interaction between the person and environment. Lazarus (1966) defined stress as an organizing concept that includes a number of variables and processes — relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her well-being.

According to International Encyclopedia of Psychology (1996) stress is an adaptative reaction to circumstances that are perceived as threatening. It motivates people and can enhance performance. Learning to cope with adversity is an important aspect of normal psychological development, but exposure to chronic stress can have severe negative consequences if effective coping mechanism are not learned. The stress of contemporary life could impair immunologic functioning and increase susceptibility to disease.

Larsen (2000) opined that stress is the subjective feeling that is produced by events that are perceived as overwhelming and beyond one's control. Events that typically elicit stress are called stressors. There are individual differences in response to stress. Stress really lies in the transaction between the person and the characteristics of the environment. Personality processes may moderate this transaction.

Stress is an unavoidable effect of living and is an especially complex phenomenon in modern technological society. It has been linked to coronary heart disease, psychosomatic disorders, and various other mental and physical problems. Treatment usually consists of a combination of counseling or psychotherapy and medication (Britannica.Com, 2010).

Samuelson (2011) stated that stress is a “state of extreme difficulty, pressure or strain”.

**Type of Stressors**

Stressors can be grouped into two categories:

a) Life Event Stress

b) Chronic Stress or Daily Hassles
Stressful Life Events

Stress is the wear and tear of life caused by an excessive demand on the body system to cope. The stresses of daily life ranging from bodily adjustment to sudden temperature or humidity, an emotionally charged argument with one’s spouse or boss, all constitute stress.

In the recent years attention is being paid to the life events which may not be very detrimental for the growth of society but can play havoc in the life of person affected. For instance destruction of one’s house in fire, death of someone in the family, difficulties in job, marriage and various other threats or conflicts that many people face in their daily lives. Some of such events under certain conditions can act as powerful stressors that affect people’s lives directly or indirectly.

According to Encyclopedia of Stress (2000), a life event stress is a comprehensive list of external events and situations (stressors) that are hypothesized to place demands that tend to exceed the capacity of the average person to adapt. The difficulty in adaptation leads to physical and psychological changes or dysfunction, creating risk for psychological disorder or physical disease.

Solanki and Ganguli (1987) stated that life stress refers to a state of imbalance with an organism that (i) is elicited by an actual or perceived disparity between environmental demands and the organism’s capacity to cope with these demands, and (ii) is manifested through variety of psychological, emotional and behavioural response.

Daily Hassles or Chronic Stressors

These are persistent, repetitive, and almost routine stressors that are part of everyday life. Lazarus and Cohen (1977) have characterized daily hassles as stable, repetitive, low-intensity problems encountered daily as part of one’s routine. They are different from major life events and tend to have different negative behavioural outcomes (Kanner et al., 1981). These daily hassles are much less powerful than life events stressors and personal stressors i.e. individually the stressors do not generally pose severe threats, but cumulatively over time they may pose threats equally serious (Lazarus.
and Cohen, 1977). They are also chronic in nature i.e. their impacts persists over long period of time and the effects of the exposure are gradual (Cohen, 1980).

Hassles are irritants, things that annoy or bothers, which can make a person upset or angry, whereas Uplifts are events that make one feel good, joyful, glad, or satisfied. Some hassles and uplifts occur on a regular basis and others are relatively rare. Hassles and Uplifts are related to health of an individual. The influence of stress may be more apparent if it is linked in time with the health outcome investigated, and therefore the best measure for illness research is likely to be minor events (Swartz, 1991).

**COPING**

Individuals cannot remain in a continuous state of tension. Even if a deliberate and conscious strategy is not adopted to deal with stress, some strategy is surely adopted. According to Lazarus (1981) coping refers to cognitive and behavioural efforts to manage disruptive events that tax the person’s ability to adjust. Coping responses are a dynamic series of transactions between the individual and the environment, the purpose of which is to regulate internal states and/or alter person-environment relations (Lazarus and Folkman, 1984).

A given situation is appraised as stressful only when one lacks the resources to deal with it. These resources decide one’s potential in dealing with stress and the consequences of stress. Where effective coping helps to maintain equilibrium, ineffective coping leads to maladjustment and disease. Hence the ways of coping one employs has a significant role to play in combating stress (Lazarus, 1984). The term coping is viewed as a stabilizing factor that may help individuals maintain psychological adaptation during stressful periods (Billings and Moos, 1984; Folkman and Lazarus, 1985).

Coping is a survival mechanism conceptualized as a transaction between an individual and the environment in which a response is directed at minimizing the psychological, emotional and physical burdens associated with a stressful situation (Folkman and Lazarus, 1988; Synder and Dinoff, 43
Review of Literature

1999). It consists of constantly changing cognitive, behavioural and emotional efforts to manage particular external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus and Folkman, 1984).

According to Mohan (2003) coping is a continuous cognitive and behavioural process of overcoming stress and stressful consequences of external forces.

Kelly (2010) stated that “Coping refers to the thoughts and actions we use to deal with stress. In large part, feeling stressed or not depends on whether we believe we have the coping resources to deal with the challenges facing us”.

Coping Styles

Although there are many ways to classify the coping responses, most approaches distinguish between strategies that are active in nature and oriented toward confronting the problem. Carver et al., (1989) have organised the dimensions of coping included in measurement procedures into three domains:

- **Task – Focused Coping**: It involves attempts to define the meaning of a situation and includes such strategies as logical analysis and cognitive redefinition.

- **Emotion – Focused Coping**: This includes responses whose primary function is to manage the emotions aroused by stressors and thereby maintain effective equilibrium.

- **Avoidant – Focused Coping**: is coping that is directed at managing or reducing emotional distress, which includes cognitive strategies such as looking on the bright side, or behavioral strategies such as seeking emotional support.

ANGER EXPERIENCED AND ANGER EXPRESSION STYLES

Anger refers to unpleasant emotional state ranging from mild irritation or annoyance to rage and fury, usually in response to perceived mistreatment or provocation (Spielberger et al., 1988)
According to Spielberger (1988), the concept of 'Anger' refers to an emotional state that consists of feeling that varies in intensity, from mild irritation or annoyance to intense fury and rage.

Harper (2010) defined “Anger as a strong feeling of displeasure”.

When anger is expressed in some specific situations for a short while, it is referred to as State Anger and when it is a personality predisposition that is a preferred way of reacting to life situations, it is referred to as Trait Anger.

ANGER EXPRESSION STYLES

Spielberger (1988) gave three anger expression styles. Individuals may typically be classified as “Anger–Out” if they express anger towards other persons or objects in the environment. Anger – out generally involves an increase in state anger and the manifestation of aggressive behavior. Anger directed outward may be expressed in physical acts such as assaulting other persons, destroying objects and slamming doors or expressed in criticism, insults, verbal threats and the extreme use of profanity (Spielberger et al., 1988).

Persons who direct this anger inward towards ego or self or who hold in (suppress) the anger is classified as ‘Anger–In’. With psychoanalytic conception, thoughts and memories relating to anger provoking situations, and even feelings of anger themselves may be repressed or denied. But in contrast, the suppressed anger is consciously experienced as an emotional state i.e. state anger, varying in intensity and fluctuating over time as a function of the provoking circumstances (Spielberger, et al., 1988).

Since Anger Expression is distinct from experience of anger, control of anger is another facet of anger expression. Anger-Control refers to individual’s effort to control one’s temper, keep one’s cool and calm down faster.
PARENTAL BONDING

The concept of a ‘bond’ between a parent and a child is generally accepted despite the lack of a satisfactory definition of the concept. Theoretically it might be proposed that parent-child bonds could be broadly influenced by characteristics of (e.g. individual differences in attachment behaviour), characteristics of the parent or care taking system (e.g. psychological and cultural influences) and by characteristics of the reciprocal, dynamic and evolving relationship between the child and the parent (Parker et al., 1979).

In each person’s life much of the joy and sorrow revolves around attachments or affectionate relationships -- making them, breaking them, preparing for them, and adjusting to their loss by death. Among all of these bonds as a special bond -- the type a mother or father forms with his or her newborn infant. Bonding does not refer to mutual affection between a baby and an adult, but to the phenomenon whereby adults become committed by a one-way flow of concern and affection to children for whom they have cared during the first months and years of life (Klaus et al., 2011).

According to Rutter (1972), the characteristics necessary for adequate mothering is a loving relationship, leading to an unbroken attachment to one specific person in the family who provides adequate stimulation.

Bowlby (1969), while discussing mother-child interaction, emphasized the retrieval behaviour of the mother which is concerned with reducing the distance between infant and mother, so serving a protective function.

Ainsworth et al., (1975), drew attention to few dimensions of maternal behaviour which were reflected in the balance of attachment and exploratory behaviour in the children. The dimensions were labeled sensitivity-insensitivity, acceptance-rejection, cooperation-interference, and accessibility-ignoring.

Studies suggest that the parental contribution to bonding may be influenced by two principal source variables i.e. the first variable as “care” dimension and the second variable as “psychological control over the child” or “overprotection” dimension (Parker et al, 1979).
Care has been associated with affection, emotional warmth, empathy and closeness. Overprotection has been associated with control, intrusion, excessive contact, infantilization and prevention of independent behaviour (Levy, 1970, Parker et al., 1979.).

Bonding is the process that a child goes through in developing lasting emotional ties with its immediate caregivers, which is seen as the first and most significant developmental task of a human being, and is central to that person's ability to relate properly to others throughout its life (Adoption.com, 2011).

Close relationships, healthy open communication, and perceived parental support are especially important during adolescence, as children experience many physical and emotional changes. Research shows teens who have positive relationships with their parents are less likely to engage in various risk behaviors, including smoking, fighting, and drinking. They are also less likely to report symptoms of depression and more likely to report high levels of perceived well-being (Aufseeser et al., 2006).

FAMILY ENVIRONMENT

Family is the oldest and the most important of all the institutions that man has devised to regulate and integrate his behaviour as he strives to satisfy his basic needs (Deepshika et al., 2011).

It has been confirmed through various studies that if family relationship has been good, not only during adolescence but also during the earlier, formative years, the adolescent will develop into a well adjusted individual (Woolf, 1963).

Family Environment dimensions

Moos and Moos (1994) postulated three distinct dimensions of family environment viz., Relationship dimension, the Personal Growth, and the System Maintenance dimension. The Relationship dimension includes measurements of cohesion, expressiveness, and conflict. Cohesion is the degree of commitment and support family members provide for one another, expressiveness is the extent to family members are encouraged to express
their feelings directly, and **conflict** is the amount of openly expressed anger and conflict among family members.

The **Personal Growth dimension** includes measurements of independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious emphasis. **Independence** assesses the extent to which family members are assertive, self-sufficient and make their own decisions. **Achievement Orientation** reflects how much activities are cast into an achievement oriented or competitive framework. **Intellectual-cultural orientation** measures the level of interest in political, intellectual, and cultural activities. **Active-recreational orientation** measures the amount of participation in social and recreational activities. **Moral-religious emphasis** assesses the emphasis on ethical and religious issues and values.

The **System Maintenance dimension** includes measurements of organization and control. This measures how much planning is put into family activities and responsibilities and how much set rules and procedures are used to run family life.

Family is a fundamental environment where all care and relationships that determine the child’s personal development and growth takes place (Tagarro, 2002).

**SATISFACTION WITH LIFE**

Life satisfaction refers to a cognitive judgmental process.

**Shin and Johnson (1978)** define life satisfaction as "a global assessment of a person's quality of life according to his chosen criteria".

According to **Diener et al., (1985)** satisfaction with life refers to cognitive judgmental process which is the hallmark of subjective well being area that centers on the person’s own judgments. Judgments of satisfaction are dependent upon a comparison of one’s circumstances with what is thought to be an appropriate standard.
Satisfaction with life refers to the fulfillment or gratification of a desire, need, or appetite. It refers to pleasure or contentment derived from such gratification (Farlex, 2009).

According to Seligman (2011) life satisfaction is the way a person perceives how his or her life has been and how they feel about where it is going in the future. It is a measure of well being as well as a cognitive, global judgement. It is having a favorable attitude of one's life as a whole. Life satisfaction has been measured in relation to economic standing, amount of education, experiences, and the people's residence as well as many other topics.

Contentment with life, particularly in regard to the fulfillment of one's needs and expectations (Education.com, 2012).

DERMATOLOGY LIFE INDEX

The Dermatology life index consists of 10 questions with simple tick-box answers scored from 0 to 3. The mean answer time is two minutes. The Dermatology life index has been described in at least 36 skin diseases in more than 130 articles and published abstracts, in 17 countries and 21 languages. Use of the Dermatology life index has allowed new insights into several aspects of clinical dermatology. It seems likely that if quality of life is severely impaired, patients become depressed or demotivated to treat themselves effectively.

The Dermatology Life index has been used to measure the effect of inpatient care on Quality of life, in a study which compared various university dermatology inpatient units. A important use of this measure is in health service research was to assess the effectiveness of outpatient consultation on quality of life of patient.

FAMILY DERMATOLOGY INDEX

According to Finlay (2006) Family quality of life is concept where the family needs are met and the family members enjoy their life together as a family and have the chance to do things that are important to them.
According Basra (2006) Family dermatology index studies the emotional impact, physical well being, relationships, people reactions’, social life, leisure activities and burden of disease and care between the parents and the patients suffering with skin problems. Family dermatology index is simple and practical measure for general clinical use. It can be used across different skin disorders. It can be used as an additional outcome measure in clinical research.

B. REVIEW OF PSYCHOSOCIAL FACTORS PLAYING A ROLE IN SKIN DISORDERS

Stress, Coping and Skin Disorders

In view of Koo and Smith (1991) among the skin diseases, acne is the most frequently encountered, and the relationship between acne and its psychosocial effects on the patients suffering with acne has been investigated for a very long time. As emotional stress can exacerbate acne, patients may experience psychological and psychiatric problems as a result of having acne. The importance attributed to the theories about the place of psychogenic factors in the pathogenesis of acne is gradually decreasing. On the other hand, the extent of the effect of acne on patient emotional wellbeing is still an investigation topic, though research results are inconsistent.

A comprehensive review by Ginsburg (1995) addressed psychologic and psychophysioologic aspects of psoriasis. Psoriasis does not have to be visible to other people for the patient to fear and anticipate their censure, and it does not need to be objectively severe to warrant significant disability and distress. A substantial proportion of patients with psoriasis live with the condition as a source of significant psycho-logic stress. In addition, the belief that such psycho-logic stress affects the course of the condition tends to have common currency in the experience of patients.

Anderson (1998), reported that acne vulgaris or common acne is a highly prevalent skin disease involving the sebaceous follicle, characterized by the formation of inflammatory and non-inflammatory lesions and is the most common skin condition treated by physicians. Embarrassment felt from
the visually apparent nature of acne, fear of scarring and the sometimes appreciable physical discomfort from infection and inflamed lesions are primary reasons why persons with acne seek treatment. Thus, quality of life is a natural outcome for evaluation in clinical trials of acne products in patient care. Key psychosocial considerations in quality of life impacts from acne include the individual’s level of social functioning, the extent of negative self perceptions such as embarrassment and lack of self confidence, their limitations in grooming and self styling and physical discomfort such as itching, pain and burning sensations. For some persons, the perceived burden from acne is sufficient to produce decrements in general emotional well being and loss of productivity at work or school.

Clinicians have debated the different ways in which one copes with problems, on one hand an individual might be coping very well while on the other hand, another individual might be finding it difficult to cope up with a certain type of a skin condition. One explanation might be that the severity of the skin condition is a good predictor of adjustment: that is to assume that patients who have more obvious or severe skin diseases are affected to a greater extent than those whose conditions are less serious. Others have suggested that the prominence of the condition may be a factor in adjustment (Williamss and Griffiths, 1991). However this observation is not well supported when subjected to scientific study (Baker, 1992). One might expect for example that darker skinned vitiligo patients would suffer more than lighter skinned patients since the condition is more conspicuous on darker skins. However, in a recent study of psychological reactions to vitiligo between different races, it was found that Afro-Caribbean respondents were not significantly more depressed than Caucasian respondents. Asian members of the sample were found to be significantly more negative about the consequences of their condition than either black or white respondents, possibly suggesting that a more culturally bound explanation for this negative self-image is more likely (Papadopoulos et al, 1998).

Patients with psoriasis often report numerous interpersonal concerns related to their condition. In a survey of the National Psoriasis Foundation, Krueger and colleagues (2001) reported that 27% of individuals cited
difficulties with sexual activities, 81% were embarrassed if psoriasis was visible, and 88% expressed concerns about the disease worsening. Gupta and Gupta reported that more than 40% of their samples of psoriasis patients were affected sexually by their condition. This group had slightly more psoriasis affecting the perineal region, greater joint pain, and higher levels of depression.

Skin Disorders such as Acne, Eczema and Psoriasis are an overwhelming problem for many teenagers, even if others do not think that their condition is serious. Depression and behavioural problems are common in this age group and the patients often lose confidence and feel isolated. Acne is suspected to be a contributory factor in a number of suicides. So, it is particularly important to recognize the psychological effects of this condition in this vulnerable age group (Kanwar et al., 2002). Itching caused by atopic eczema is often prolonged and severe and can seriously affect sleep patterns not only of the patient but also of other members of the family. It is difficult to sleep with a spouse who is constantly scratching and children with eczema wake frequently particularly during exacerbation, rousing parents and siblings. Family studies have shown that the psychological impact on parents of coping with a child with eczema is enormous with most (80 to 90) feeling anxiety, guilt and physical and mental exhaustion. Psoriasis exhibits unsightly red, scaly areas and can be a lifelong disease. Like eczema, it affects all age groups and is often extremely itchy. Patients report that severe psoriasis affects all aspects of their lives and can lead to severe depression. Psoriatic arthropathy is a rare condition but it can be so severe that the patient is bound to a wheelchair and the disease is occasionally life-threatening (Dogra et al., 2002).

Gupta and Gupta (2003) maintained that there is a wealth of evidence to support the fact that atopic dermatitis is aggravated by stress primarily through increased itching so the stresses that are a part of adolescence may precipitate flares at a time when being different is more problematic and self-esteem more fragile—a time when youngsters strive to maintain control of their bodies, feelings, and environment. For many adult patients, the difficulties that emerge in adolescence continue into adulthood. The associated negative
feelings then intrude into every aspect of patients’ lives, creating the possibility of social and occupational inhibition, relationship difficulties, and lack of personal and sexual fulfilment.

In a study conducted by Ferhbas et al., (2004) on patients suffering from acne; the authors reported that in almost 75% of the patients, acne localization was on the face, 50% the patients’ clinical acne severity was moderate, and in almost 25% of the patients severity was severe. It was found that acne was related to shyness and social inhibition, stress, decreased self-esteem and self confidence, disruption in body perception, suicidal ideation, somatic symptoms, anxiety, and depression, and that the effective treatment of acne leads to recovery from such symptoms.

Chronic dermatological diseases, such as psoriasis and eczema, can make demands on patients who may exhaust their ability to cope and lead to significant social impairment and psychological morbidity. This is especially the case in times of exacerbation of the disease (Zachariae et al., 2004). Studies show that psychological factors play an important role in at least 30% of skin diseases. In many cases, the influence of the disease on quality of life is a stronger predictor for psychiatric morbidity than the degree of affection determined by the doctor. One, among other explanations for this may be found to be related to the individual’s ability to cope and the strategies used.

Psychological distress has been frequently reported in cases of skin disorders (Picardi et al, 2006), with one third of dermatologic disorders having significant psychiatric comorbidity. The impact of the skin disorders are important psychosocial stressors. Psychosocial factors affecting skin disorders and other medical conditions were phobia, health anxiety, stress, denial. In the factors mentioned above stress was considered to be the cause of exacerbations of skin problems. According to Picardi et al., (2006) the skin plays a key role as a sensory organ in socialization processes through the whole life cycle. It is responsive to emotional stimuli, and its appearance greatly influences body image and self-esteem. Not surprisingly, a relationship between psychological factors and skin diseases has long been hypothesized. There is a common opinion that many cases of skin disease are caused by
psychological stress, or are related to certain personality traits, or represent a complication of a psychiatric disorder.

According to Arck et al., (2006) like few other organs, the skin is continuously exposed to multiple exogenous and endogenous stressors. Superimposed on this is the impact of psychological stress on skin physiology and pathology. The "brain-skin connection," which underlies inflammatory skin disease is triggered or aggravated by stress. According to Arck et al (2006) the skin and its appendages as both a prominent target of key stress mediators (such as corticotrophin releasing hormone, ACTH, cortisol, catecholamines, prolactin, substance P, and nerve growth factor) and a potent source of these prototypic, immunomodulatory mediators of the stress responses.

According to Tanida et al., (2007) the main components of stress response systems are the hypothalamic-pituitary-adrenal system and autonomic nervous system of which the sympathetic medullary system plays a dominant role. Although activation of the stress response system improves the ability of an organism to maintain homeostasis, persistent activation of this system may lead to psychological or somatic diseases. Acne vulgaris has long been known to develop under mental stress. It is thought activation of hypothalamic-pituitary-adrenal system induces secretion of hormones such as adrenal steroid hormone which can aggravate acne. Psychological stress, anxiety, depression, and low self esteem affect skin conditions to a great extent.

Everen and Everen (2007) reported that people with disfigurements may encounter rejection in a variety of social situations. Sociologists have made a distinction between such instances of actual rejection (enacted stigma) and the anticipation of rejection (felt stigma). Felt stigma concerns expectations about others behavior, social anxiety, fear of negative evaluation and body image would appear to be relevant to understanding this. Among patients with vitiligo and psoriasis quality of life has been shown to be related to perceived stigma. Fear of negative evaluation also significantly predicted interpersonal discomfort, stress over others' reactions, and the degree to which psoriasis interfered with the patients lives. There is some evidence that
distress associated with disfigurement is partly due to attempts to conceal and avoid.

According to Yolac et al., (2008) sociodemographic, clinical risk factors and psychological symptoms such as stress, anxiety, etc have a deep impact on patients suffering with skin disorders.

According to Richard et al., (2009) the occurrence of depression in association with dermatologic disease is common. Psychiatric disturbance is reported in approximately 30% of dermatology patients. Depression can have carried presentations and is more relevant clinically in dermatology patients during critical psychosocial periods of development. Early recognition and treatment of depression associated with skin disorders can lead to improved therapeutic outcomes and may avert disastrous outcomes, including suicide.

According to Weinstein (2009), Atopic dermatitis or eczema is a chronic, relapsing skin condition that can lead to psoriasis, pruritus, and patches of dermatitis. Coping with the physical and emotional aspects of eczema can significantly impact the quality of life. It is most common in childhood, as many patients seem to outgrow the condition by adulthood. There is increasing interest in exploring the feasibility and efficacy of using non-drug alternatives and various coping strategies such as counselling and therapy in the management of skin problems such as acne, eczema and psoriasis. Lifestyle modifications have emerged to be a better tool in the management of skin problems.

Evers et al., (2009) reported that chronic itch is the main symptom of skin disorders such as acne and psoriases. As an adjunct to standard dermatological care, multidisciplinary itch-coping programmes have been developed. These programmes usually make use of a broad scope of cognitive-behavioural methods for the reduction of itch and scratching behaviour, including self monitoring, guidance in skin care and coping skills to manage itch triggering factors, stress management methods with relaxation techniques.

According to Gupta and Gupta (2010) studies highlight the fact that people are not always well prepared to cope with the emotional and
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psychological challenges that can be brought on by a skin problem, and that a variety of complex factors can influence the extent to which a person is affected by their condition. Adolescents suffering with skin problems usually find it difficult to cope with the new changes that the skin brings about and this makes it very tough for them to cope up with, which in turn gives rise to an impaired quality of life.

Heller et al., (2011) reported that stress has been indicated as a trigger in many dermatologic conditions, including atopic dermatitis, acne vulgaris, and chronic urticaria. With each of these conditions, one encounters both patients who experience a close chronologic association between stress and exacerbation of their skin disease, and patients for whom their emotional states seem to be unrelated to the natural course of their cutaneous disorder.

American Dermatology Society, (2011) reported that a person’s physical appearance is the first thing seen by others in social situations. The skin is one of the most important components of an individual’s physical appearance. It is likely that the majority of people with chronic non-contagious dermatological disorders, cosmetically disfiguring skin disorders experience considerable psychosocial rejection, which is mainly determined by feelings of stigma due to their skin lesions that can often have severe social impacts on a patient.

Mental Health and Skin Disorders

According to Sarwa et al., (1996) the self-image may be favourable and give rise to favourable emotions. If self image is unfavourable, it can rise to anxiety, fear and various symptoms of misadaptation. Thus, self-image, by affecting mental health, indirectly influences also our quality of life. Self-assurance, sense of one’s own worth and self-acceptance constitute a source of our confidence in our vitality and of our conviction about our self-reliance. If a person starts to think that due to illness he/she became worthless and worse than other people, he/she will develop a negative self-image. On the other hand, the sense of inferiority releases adverse emotions (such as e.g. anger and depression) and, as already stated, mental condition is a major factor in the assessment of the quality of life. It is worth stressing here that
self-image may be of paramount importance in the diseases that evidently change patient's looks. Dermal diseases evidently fall into that category and may affect patient's mental health.

In view of Zip (2000) measuring the impact of acne on quality of life allows one to understand the disease from the patient's point of view. In clinical research, new medications are increasingly being evaluated according to their impact on QOL which is in addition to the traditional approach of assessing only treatment safety and efficacy. In clinical practice, understanding how a patient's life is impacted by acne can help in selecting the most appropriate treatment for that patient and may enhance compliance.

Renzi et al., (2002) opined that many studies point out complex, mutual relationships between psyche and skin. There is extensive literature on the relationship between emotional stress and skin diseases (Picardi and Abeni, 2001). Furthermore, dermatologists commonly think that psychiatric disorders are frequent in their patients (Gieler et al., 2001), and several studies confirm this opinion (Picardi et al., 2001). In addition to any causal mechanism linking psychiatric morbidity and dermatological diseases, it is important to consider the consequences of the interrelation between these two conditions. For example, psychiatric morbidity is associated with increased subjective perception of pruritus, is higher among patients whose skin condition does not improve with treatment, and may affect treatment adherence.

According to De Korte et al., (2002) most authors agree that chronic skin diseases bring many changes to patients' everyday life, causing a considerable mental discomfort. However, in the accessible literature, the researchers could not locate any data indicating directly that self-image could play a significant (or an insignificant) role, for example in assessing quality of life or in the assessment of mental health. De Korte et al., (2002) reported that a considerable number of patients are characterised by low self-acceptance, low self-esteem, negative body image or low sense of self-efficacy suffering with dermatological problems. Visible dermal changes are known to adversely affect human mental condition and result in depression, anxiety and pessimistic attitudes.
According to Beattie et al., (2006) chronic diseases such as eczema and psoriases can have physical and psychological effects which affect social functioning. These effects can be better understood from the perspective of parent and child by the use of health-related quality of life (HRQL) measures. Various health related quality measure, measures are now available, of which generic health measures have been the most widely used. These permit comparison between different diseases and also the normal population.

In a survey by the National Psoriasis Foundation almost 75% of patients believed that psoriasis had moderate to large negative impact on their quality of life, with alterations in their daily activities. Furthermore, physical and emotional affects of psoriasis were found to have a significant negative impact at patients’ workplace. Salaffi et al., (2009) identified that pathological worry and anxiety occur in at least a third of patients with psoriasis and that psychological interpersonal difficulties impinge on all aspects of the patient’s daily life. Other studies reported that between 5 and 20 percent of psoriasis patients had contemplated suicide (Fortune et al., 2005). When compared with patients with other diseases, such as cancer, arthritis, hypertension, heart disease, diabetes, and depression, patients with psoriasis reported a similar reduction in health related quality of life.

Personality and Skin Disorders

It may appear that relationship between skin diseases and psychological or neurotic influences has also been established for many years (Whitlock, 1976). However the apparent leap between skin and psyche in works by early writers (Hunter et al., 1963) who described nervous influences on skin functions.

Cash and Pruzinsky (1990) reported that self-esteem is closely associated with body image. Dissatisfaction with a particular aspect of one’s self has been found to cause an overall reduction in self-esteem. The failure to live up to an ideal image in an area which is considered important to someone’s self-definition can be significantly damaging to a person’s self-image. The relevance of self-esteem to dermatology is that it is associated with body image, which is disturbed first with the onset of a disfiguring
condition. Self-esteem is also relevant in how patients cope with their condition. It has been found that people who have positive self-esteem are better able to cope with both the reactions of others to their appearance and their own feelings about their altered appearance.

Richardson (1997) reported that young children are not usually self-conscious about their appearance, but self-consciousness tends to increase as the child grows up and most adolescents are acutely self-conscious. As a child gets older they have to leave the safe confines of the family home and manage the transition first to nursery or playgroup, then to primary school and then to secondary school. These transitions can be extremely difficult for a child with a skin condition who has to cope with other people’s reaction to their skin including considerable amounts of curiosity and intrusive comments. Most young people or adults who have grown up with a skin condition can recall extremely unpleasant and traumatic episodes of being teased or excluded as a consequence of their skin condition.

According to Kellet and Gawkrodger (1999) when acne localizes primarily on the face, it has a greater effect on psychological functioning. When it is on the back or the chest, because it can be covered with clothing, it causes less distress. It was reported that after recovery, patients that had acne localized on the face experienced significant positive changes in depression and anxiety, whereas patients with acne localized on the body experienced less of a degree of change.

According to Picardi et al., (2001) whole fields of research into hysteria, personality types in dermatoses and psychoanalysis in individuals with skin disease dominated the literature until critical evaluation stressing the need for stringent appraisal led to a decline in interest in psychosomatic dermatology. Dermatology had moved from a highly skilled, descriptive, clinical specialty with unsubstantiatable theories of aetiology to an era of scientific questioning, skin pathology and biochemistry. The recent studies show that skin conditions tend to change the personality make up of an individual.
Predisposing developmental factors are clearly linked to the development of several personality characteristics that are emerging as having predictive power in explaining some of the variability in adjustment. Disrupted attachments in childhood have been discussed as having the potential to lead to stable attachment styles in adulthood, few studies have actually explored the role of attachment, and those that have, were unable to relate this directly back to early experiences. Picardi et al., (2003) found higher levels of insecure and avoidant attachment styles in a small sample of people with newly diagnosed or recently exacerbated vitiligo and alopecia areata. Interestingly, their participants also had poorer levels of social support and it was hypothesized that this might result from difficulties in accessing social support as a result of the underlying attachment style.

According to Rogers et al., (2003) it is hard for a child to grow up with a skin condition and for this not to have some impact on their self-esteem. However, the variation in the impact on self-esteem cannot be entirely attributed to the severity of the child’s condition, because it is very dependent on psychological factors and the child’s beliefs about their condition. It is possible for a child with much damaged skin to report high levels of self-esteem and vice versa; for a young person with very trivial skin blemishes to report a considerable impact on self-esteem.

Sarkar et al., (2004) assessed psychopathology and behavioural problems in 22 children with atopic dermatitis and 22 healthy controls, matched for age and gender. Participants’ mothers completed the personality trait inventory and the childhood psychopathology measurement schedule. The personality trait inventory was used to assess the mothers’ personality characteristics and mental health problems, while the childhood psychopathology measurement schedule evaluated the children’s behavioural problems. Children with atopic dermatitis were almost three times as likely as controls to experience symptoms of anxiety and depression. The researchers concluded that their study confirmed the association between dermatitis and psychological disorders.

According to Walker and Papadopoulos (2005) in the case of skin disease, the effects on quality of life may not be immediately obvious. Since
most skin conditions tend not to be physically handicapping in any way, quality of life tends to be affected through the ‘psychological handicap’ that accompanies skin disease. The way that a condition affects a person’s quality of life is mediated by a range of factors, both internal (self-esteem; body image) and external (social support; social stigma).

In view of Heading et al., (2006) respondents with acne reported permanent effects on their personalities and behaviour. They also reported prominent avoidant behaviour. A relationship between skin disease and avoidance behaviour has been found for acne, psoriasis and eczema. The researchers reported that qualitative studies of skin problems have suggested a complex array of constructs such as shame, embarrassment, diminished self image and self confidence, self consciousness, annoyance, confusion, social anxiety, phobia, somatisation, stigmatization and depression.

According to Ozel-Kizil et al., (2006) the appearance of acne during adolescence/puberty, a time when social and physical changes occur at the maximum level, and identity formation is at stake, brings this disease to the focus of concerns; therefore, it effects intrapersonal relationship, self-evaluation, and daily performance of patients suffering from skin disorders. In fact, the effect of lesions on visible parts of the body, the effect of deformations and involuntary movements on the body image and the level of social anxiety are not only critically important to adolescents, they are also important to adults and were also reported in patients with Parkinson’s disease, muscle dysfunctions, polio sequelae, disabilities as result of accidents, psoriasis, and hemi facial spasm.

The main objective of the study conducted by Smith et al., (2006) was to investigate the psychological sequelae of acne vulgaris. For this purpose qualitative study using a grounded theory approach was used. According to Smith et al., (2006) attenuation of negative psychological sequelae comes from an internal locus of control or enhanced self-efficacy afforded by subjects’ own health practices, such as dietary manipulation, face washing, and exposure to salt water and sun. The researcher reported that patients’ suffering from a skin problem had a low score on the internal locus of control which thereby has a negative impact on them. Training in coping skills has
been found to increase self-efficacy and decrease anxiety in college students concerned about their examinations. The value of such training with a focus on self-efficacy for patients with acne and its psychological sequelae might be an appropriate subject for further research.

According to Patiyil et al., (2006) acne has a demonstrable association with depression and anxiety; it effects personality, emotions, self-image and esteem, feelings of social isolation and the ability to form relationships. Its substantial influence is likely related to its typical appearance on the face and would help explain the increased unemployment rate of adults with acne.

Kuhl et al., (2007) believed that prevention programmes should take personality variables into consideration because there is little information about the causes of the blatantly reduced quality of life or the higher level of depression and addiction in patients with chronic skin diseases, especially psoriasis. Motivational counselling is said to help patients to overcome state-orientation, learned helplessness, depression and non-adaptive ways of coping.

Recent studies have established a relationship between personality variables and skin conditions i.e. they report personality as a risk factor for developing a skin disease. A study conducted by Brufae et al., (2010) on 60 patients suffering with eczema, indicated that certain personality styles such as externally focused and anxiety in patients with eczema aggravated their skin condition.

According to Dalgard et al., (2012) the influence of psychological stressors on health through the immune system has been described for some chronic diseases like eczema and psoriasis in earlier studies. When uncontrollable stressful events are encountered, greater self-efficacy helps to protect the individual from depression, and perhaps other somatic symptoms as well. In adolescence in particular, coping style is part of the maturation process and helps the adolescent to face life challenges.

According to Robert et al., (2012) perceived self-efficacy is a new concept to dermatologists and is relevant for clinicians. Poor self-efficacy
aggravates skin problems like eczema or psoriasis among adolescents and the same precipitates even more under stress.

Anger and Skin Disorders

Rapp et al., (2004) reported that relationship between dermatological problems and emotions has been established for a long time. He also reported that personality is an important variable, because it may affect symptom severity in acne, quality of life, adherence to treatment. Clinical observations have long been made of an association between personality traits such as anxiety, nervousness and obsessiveness and acne, but few empirical studies have been reported. Lim and Tan (1991) found no association between personality and acne severity among 101 college students, but they did find a significant association with disability, suggesting that personality may have a greater impact on functioning than on symptom severity. One personality feature that has received considerable attention in relation to non-dermatological disease is trait anger (TA), the tendency to experience angry mood easily across time and situations. Negative emotions such as anger can disturb the regulation of immune and endocrine function and can slow wound healing (Glaser et al., 2002). In one study patients with severe acne had higher TA scores than patients with less severe acne (Wu et al., 1988), suggesting that anger may affect disease severity. Anger severity has been found to be significantly related with acne severity (Rapp et al., 2004).

According to Brook (2006) acne is an inflammation of skin glands forming sebum blackheads and whiteheads. It may also cause visible disfigurement of the face. Researchers admit the fact that acne can cause emotional and psychological disturbances. Acne is associated with anger, embarrassment, frustration and depression.

It has been suggested that psychological factors such as repressing anger and altruistic interpersonal behaviour may play a role in the aetiology of chronic itching in psoriasis. The main aim of the study conducted by Schneider et al., (2006) was to investigate psychosomatic problem areas and psychiatric comorbidity in patients with psoriasis. 91 patients with psoriasis
were administered the Hospital Anxiety and Depression Scale and State-Trait Anger Expression Inventory. Results indicated that patients with psoriasis scored higher on ‘anger out ’ and ‘ state anger’ in comparison to healthy controls.

According to Gieser et al., (2008) there is evidence that chronic idiopathic urticaria, psoriasis, acne and eczema are associated with personality based difficulties in emotional regulation particularly with regard to the feeling of anger. This deficit in emotional awareness could lead to the phenomenon that emotions are rather experienced in bodily symptoms such as itching, acne etc.

According to Law et al., (2008) recent evidence has shown that skin conditions result in psychological problems such as stigmatization from peers, lower self esteem, interpersonal difficulties, anger, anxiety, depression and higher unemployment rates. Severe psychological consequences such as depression, eating disorders and body dysmorphic disorders are common among people with skin problems.

Earlier studies have investigated the possible role of personality and emotional factors in acne patients. In a study conducted by Wu et al., (2008) acne patients self-rated the severity of their conditions as mild, moderate, or severe and were compared to a control group on several personality variables. These self-ratings were compared to the objective ratings made by their dermatologists. Acne patients who self-rated their conditions as severe were found to experience significantly higher levels of trait anxiety than patients with mild and moderate conditions and control subjects; patients with severe and moderate conditions showed a higher state of anxiety than control subjects. Acne patients rated as severe by dermatologists showed higher states of anxiety, “anger-in,” and “anger-out” than the others. The results indicated that anxiety and anger are significant factors for severe acne patients.

According to Woods (2010) medical and psychological research has shown that no matter how much one exercises or eats correctly, one is putting oneself at risk if one does not manage one’s anger. Anger causes a
widespread negative effect on the body. In people with chronic anger, it can also cause peptic ulcers, constipation, diarrhoea, intestinal cramping, hiccups, chronic indigestion, heart attacks, strokes, kidney problems, obesity, and frequent colds. Medical experts have found the heart muscle is affected by anger, and anger can actually reduce the heart's ability to properly pump blood. Prolonged anger can harm the body's largest organ, the skin. People who hold in their anger often have skin diseases such as rashes, hives, warts, eczema and acne. Researchers have studied the relationship of anger and skin disorders and discovered that when a person resolves his anger, skin disorders dramatically improve (Woods, 2010).

According to Victorian Minister for Health (2012) anger triggers the body's 'fight or flight' response. Other emotions that trigger this response include fear, excitement and anxiety. The adrenal glands flood the body with stress hormones, such as adrenaline and cortisol. The brain shunts blood away from the gut and towards the muscles, in preparation for physical exertion. Heart rate, blood pressure and respiration increase, the body temperature rises and the skin perspires. The constant flood of stress chemicals and associated metabolic changes that accompany recurrent unmanaged anger can eventually cause harm to many different systems of the body. Anger, however, is not just a state-of-mind. Due to these physical effects long-term anger can be detrimental to health and wellbeing. Some of the short and long-term health problems that have been linked to unmanaged anger include: headache, digestion problems, such as abdominal pain, increased anxiety, depression, such as eczema, psoriasis, acne etc.

In a study Brufau et al., (2012) investigated the extent to which itching is caused and mediated by psychological disorders such as depression or stress. Depression and anxiety are commonly associated with itching, which worsens in response to negative emotions, while negative emotions associated with depression and anger can provoke itching. Researchers suggest that these kinds of psychological disorders act as vulnerability factors, i.e. factors that have an impact on skin disease.
Family Environment, Parental Bonding and Skin Disorders

In a study conducted by Su et al., (1997) families of children with moderate or severe atopic eczema have a significantly higher impact on family score tool named Family Dermatology Index than families of diabetic children. Childhood atopic eczema has a profound impact on the social, personal, emotional, and financial perspectives of families.

Laughter et al., (2000) opined that atopic dermatitis (AD) is a common paediatric disease, affecting 17% of American children with dramatic effects on the quality of life of afflicted children and their parents. Atopic dermatitis not only produces physical symptoms for the child such as pruritus, skin discomfort, and sleep disruption, but also causes emotional abnormalities and social dysfunction such as frustration, fussiness, isolation, negative self-esteem, and poor self-image. Parents of affected children may not only experience sleep disturbances, they also report social effects and emotional feelings of guilt, blame, worry, and frustration as a consequence of their child's skin disorder.

According to Dogra et al., (2002) the Dermatology Life Index (DLI) in adults has shown that skin disease can cause problems in interpersonal relations particularly as a result of fatigue, depression and frustration. Patients often feel that the family members are not supportive or lack understanding. In a family study on eczema and its effects, the problem of looking after a child with chronic eczema was thought to have contributed to the breakup of marriages. Severe light allergy or skin cancer can limit holiday choices and messy treatments or blood left on sheds after scratching may prevent people from staying in hotels or with friends.

Housman (2002) found strong association between increased disease severity and higher family impact of eczema. Of special note is the significant association between family impact and disease severity, holding, even after an episode of care by a physician specialist. It was found out that family environment of an adolescent suffering with eczema was greatly affected. The relationships and personal growth in the family was neglected and the patient and family felt burdened all the time.
According to Walker et al., (2003) the relationship between the child and the parent may have implications for the way in which the child makes sense of and copes with his or her health. Research suggests that one of the most significant factors in the development of behavioural problems of children with disfiguring skin conditions is the reaction of the parents to the illness or deformity. Over-protective parents who shield their child from social problems, such as teasing, may prevent the development of childhood friendships and social skills, which are vital for later life (Papadouplous and Walker, 2003). Normal reactions of parents, which tend to occur with the birth of a child with a skin condition, are detailed below. Parents of children with skin disease should be aware of these.

In view of Titman (2003) in order to understand the impact of skin disease on children it is essential to consider both the child's developmental stage and the context in which they live. The impact of a skin condition will vary considerably depending on the age and level of independence of the child. Young children are entirely dependent on their parents for their healthcare and a young child’s response to a skin condition is therefore likely to both be influenced by, and have a strong influence on, the response of their parents. However, as the child grows up, they will be more strongly influenced by their peer group and become less dependent on their parents. As a consequence of this, the implications for a child with, for example, severe eczema at the age of 2 years is very different from the implications for an adolescent of age 14. For the 2-year-old child, their relationship with their parent and the parent’s skills in managing the condition may be very important factors, for the adolescent, the important issues are more likely to be related to their self-esteem, their sense of belonging to their peer group and their own ability to care for their skin.

According to Chuh et al., (2003) early studies in the field of family environment and skin disorders focused on measuring levels of psychological distress, or the presence or absence of psychological difficulties in the child or parent. However, whilst the presence or absence of psychological distress or disorder is one important outcome measure, it is quite a narrow way of defining psychological adjustment. Hence there has been increased interest in
other types of outcome measure, such as quality of life, to attempt to encompass other important areas of experience, such as social and educational factors. The researchers have found out that skin problems and its impact on the family environment directly effects the condition of the child suffering with a skin problem.

Rumsey et al., (2003) reported that the role of social support has been widely acknowledged as a buffer of the consequences of stress. Unfortunately, the social avoidance and withdrawal that are common reactions to disfigurement of skin can result in a smaller network of support for those affected. Personal accounts testify to feeling at ease with familiar others, who are perceived as seeing through superficial appearances to the "real" person beneath. Partners and families are likely to be the main provider of support, yet they themselves may be trying to deal with their own reactions and distress surrounding the disfigurement. Baker (1992) found positive social support improved rehabilitation outcomes for head and neck cancer patients 6 months after treatment. The benefits of support from family, friends and peers for those affected by burns have also been reported.

According to Jafferany (2007) more than just a cosmetic disfigurement, dermatologic disorders are associated with a variety of psychopathologic problems that can affect the patient, his or her family, and society together. Psychodermatology addresses the interaction between mind and skin. Psychiatry is more focused on the internal nonvisible disease, and dermatology is focused on the external visible disease. Dermatologists have stressed the need for psychiatric consultation in general, and psychological factors may be of particular concern in chronic intractable dermatologic conditions, such as eczema and psoriasis. Lack of positive nurturing during childhood may lead in adulthood to disorders of self image, distortion of body image, and behavioral problems. The emotional problems due to skin disease include shame, poor self-image and low self-esteem. The psychosocial impact depends upon a number of factors, including the natural history of the disease in question the patient's demographic characteristics, personality traits, and life situation, and the meaning of the disease in the patient's family and culture. Hostile personality characteristics, dysthymic states, and neurotic
symptoms have been frequently observed in common skin conditions like psoriases, urticaria, and alopecia (Ginsburg, 1996).

According to Egyetem et al., (2007) atopic dermatitis is a chronic inflammatory skin disease affecting mostly children, but the atopic trait continues, not only for later respiratory allergies, but also for skin symptoms in adulthood. In this form dry skin, flexural lichenification, head and neck dermatitis, hand dermatitis are typical. The exact etiology of atopic dermatitis is unknown, in the background interactions of genetical predisposition, skin barrier defects and immunological and environmental factors can be verified. In the complex approach of atopic dermatitis, a pivotal role is ascribed to the evaluation and possibly the elimination of provoking factors, like psychosocial stress, migration, infections, and unstable personal home environment.

Farnik et al., (2010) maintained that childhood chronic disease may affect patients’ and their family’s functioning. Particularly parents, who play an important role in cooperation between patient and health care professionals, reported impaired health related quality of life (HRQOL). An increasing interest of the impact of disease on every-day functioning led to the development and implementation of health-related quality of life (HRQOL) measures in many studies.

Perceived Health Status, Quality of Life and Skin Disorders

According to Lawton (2002) skin conditions are, by their very nature, visible. As a result, those with a skin condition receive the same reaction from society as anyone who looks ‘different’. They can be subjected to stares, whispered comments, antagonism, insult or exclusion from normal social activity. Those with a skin condition have the needs of all other patients, but in addition, the impact upon their lives of a skin condition, its treatment and the ways in which others perceive them, makes their situation unique. It may be argued that such feelings may be experienced by all patients, whatever their condition, but what makes dermatology patients different is that these feelings have been developed, compounded and reinforced by their experiences over a number of years. In addition, the stark reality is that for many dermatological conditions there is no cure. Life is characterised by periods of remission and
exacerbation. Many healthcare professionals will see patients during different stages of the disease process, often when things are at their worst and with their needs changing. Further, because a dermatological condition may be life-long, needs change with age. Dermatology patients need acceptance, support and to be treated as equal, valued, complete human beings.

According to Bhosle et al., (2006) patients with skin problems often experience difficulties like maladaptive coping responses, problems in body image, self esteem, self concept and also have feelings of stigma, shame and embarrassment regarding their appearance. Skin problems have a negative impact on the patients’ quality of life. Skin problems like psoriasis have been linked to depression and suicidal tendencies in the patients. Individuals suffering with skin conditions suffer from poor health in general and also have a negative attitude towards life.

In view of Steptoe et al., (2009) evidence linking positive affect with health behaviours has been mixed. At the biological level, cortisol output has been consistently shown to be lower among individuals reporting positive affect, and favourable associations with heart rate, blood pressure, chronic illnesses such as asthma, diabetes, eczema, psoriasis etc. Importantly these relationships are independent of negative affect and depressed mood, suggesting that positive affect may have distinctive biological correlates that can benefit health. There is growing evidence that positive psychological well being is associated with reduced risk of physical illness and prolonged survival.

According to Barreto et al., (2009) earlier longitudinal studies have supported the predictive ability of self-perceived health status on ensuing mortality in adults and functional decline in elderly populations. Answers in a Likert type scale to questions about one’s own health status compared to same-age individuals are better predictors of mortality than objective health assessments, reflecting that people have an integrated perception of their own health, including biological, psychological, and social dimensions. The magnitude of association between self-perceived health status and chronic diseases such as coronary heart disease, asthma, skin problems such as eczema etc limit daily activities due to health conditions and health behaviours
seems to vary according to gender. A study conducted by Barreto et al., (2009) investigated the association between self-perceived health status and chronic diseases showed that social and psychosocial determinants have a stronger impact on women’s health while behavioral determinants play a major role on men's health. While men are less likely to report health conditions than women, they more often perceive their health as poor.

Brufau et al., (2012) opined that skin problems can reduce the quality of life in dermatology patients. Psychological factors have often been associated with the triggering, development and persistence of skin disease. Recent evidence, for example, has indicated that psychological stress is associated with the exacerbation of different skin conditions. It has also been shown that psychopathological disorders are more acute in dermatology patients suffering from eczema and psoriasis.