

KNOWLEDGE AND SELF-CARE PRACTICES AMONG A SAMPLE OF PATIENTS WITH PSORIASIS AT DERMATOLOGY AND VENEROLOGY CENTER IN BAGHDAD MEDICAL CITY

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ABSTRACT

Background: Psoriasis is a chronic skin disorder caused by immune-mediated pathways with multifactorial triggers. It has significant physical, psychological, and social burdens. The present study aimed to evaluate the level of knowledge and self-care practices among patients with psoriasis and to correlate them with sociodemographic data. **Method:** A cross-sectional study was carried out at the Center of Dermatology and Venereology, Medical City, Baghdad, from May to August 2025. Convenience sampling was used to select a sample of 250 adults with clinically confirmed psoriasis of ≥ 6 months duration. Assessment of knowledge was done with the use of a 33-item questionnaire and self-care practices with 26 items. Data were collected through direct interviews and analyzed using SPSS. **Results:** The majority ($n = 205$, 82.0%) had a diagnosis for more than a year, and ($n=111$, 44.4%) said they had a family history of psoriasis. Digital and personal sources were used less frequently than medical staff. Just ($n=1$, 0.4%) of patients had strong understanding, ($n=113$, 45.2%) had low knowledge, and ($n=136$, 54.4%) had fair knowledge. Significant associations were observed with the educational attainment as well as exposure to advanced treatment modalities. Regarding self-care practices, 55 (22.0%) classified as good, 140 (56.0%) as fair, and 55 (22.0%) as poor. **Conclusion:** Most patients demonstrated only fair knowledge of psoriasis, with persistent misconceptions regarding comorbidities and treatment risks. In self-care practice, more than half of the patients demonstrate fair practice. Future research should focus on larger multicenter studies testing culturally tailored educational programs through interventional trials is recommended to provide evidence for policy-level adoption.

KEYWORDS: Psoriasis, Knowledge Assessment, Self-Care Practice.

INTRODUCTION

Psoriasis is a polygenic, immune-mediated skin disorder that involves epidermal hyperproliferation and chronic inflammation triggered by environmental factors such as trauma (Koebner phenomenon), infections, stress, hormonal changes, smoking, alcohol, obesity, and certain medications in genetically predisposed individuals.^[1, 2] Between 1% and 2% of the U.S. population has psoriasis. It occurs less frequently in tropical regions and is also less common among North Americans, West Africans, and black persons.^[1, 2] The global prevalence is 4.4%, highest in East Asia (5.7%) and lowest in Africa

(1.7%). Urban areas and fair-skinned populations exhibit slightly higher rates, with men being more commonly affected.^[3] In Iraq (Mousel and Basra), the prevalence ranges from 0.5% to 0.7%.^[4, 5]

Patients are still ignorant about self-care and sickness management. Patient-centered concerns are understudied, especially in the Middle East, and the majority of research concentrates on clinical features. Effective sickness control in Baghdad is hampered by cultural attitudes, shame, and educational obstacles. This results in subpar results and little self-care. Raising

patient awareness can help patients take their drugs on time and experience fewer flare-ups. Even though many patients may only have a basic awareness of their disease, ongoing education significantly improves their comprehension and well-being. According to research, people with psoriasis frequently have low health literacy, which results in inadequate knowledge, poor self-management, and a lack of self-care. Increasing health literacy through reliable medical sources is essential to facilitate treatment adherence and informed decision-making.^[6-8]

Education entails taking a daily warm water bath for no more than five to fifteen minutes, using emollients, avoiding mechanical skin damage, and applying topical medications as directed under medical supervision. The modulation of disease severity is also influenced by psychosocial stressors, nutrient-rich food consumption, and environmental conditions that reduce exposure to skin irritants. As a result, the method served as a behavioral modification strategy and produced a statistically significant decrease in disability scores as well as an improvement in the patients' sense of control over their condition.^[9]

This study aims to evaluate the level of knowledge and self-care practices among patients diagnosed with psoriasis. Furthermore, it seeks to examine the

relationship between patients' knowledge and self-care behaviors and their sociodemographic characteristics.

METHOD

Study Design and Setting

A descriptive cross-sectional study design was used for assessment of knowledge and self-care behaviours among patients with psoriasis. The study was carried out at the Center of Dermatology and Venereology Medical City, Baghdad which is a large tertiary referral hospital to an extensive urban population and its surrounding peri-urban region. The information was interviewed over the three-month period between 1May and 1August of 2025, patient from dermatology out-patient department. The report is in line with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement.^[10]

Study Population and Sample Size

The study targeted patient aged 18 to 60 years with a clinically confirmed diagnosis of psoriasis for at least six months. Diagnoses were made by dermatologists based on recognized clinical criteria, including lesion morphology, distribution, and history. Using a convenient sampling method, a total of 250 adult patients were included in the study. Eligible criteria are presented in **Table 1**.

Table 1: Inclusion and exclusion criteria of the study participants.

Inclusion criteria	Exclusion criteria
Adults aged 18–60 years	Significant psychiatric or cognitive impairment affecting questionnaire comprehension
Clinically confirmed diagnosis of psoriasis by a dermatologist	Illiterate individuals unable to complete the questionnaire even with assistance
Psoriasis duration ≥ 6 months	Patients diagnosed with psoriatic arthritis
Able to understand the questionnaire	Patients with severe nail involvement
Willing to participate and provided verbal informed consent	

Data Collection Tool

Sociodemographic profile, medical history and information on psoriasis) were collected by using a structured questionnaire administered by trained interviewers to all the subjects (**Supplementary file 1**). The item pool was developed based on a literature review and items were borrowed from and modified from two previously reported instruments that had been validated: the Knowledge Questionnaire for Psoriasis Patients by Wahl et al. (2013)^[11] and Self-treatment in patients with psoriasis: University hospital experience by Omar et al. (2021).^[12] Adaptation was performed by adding contextually specific elements related to Iraqi culture and clinical practice.

The final instrument used in this study consisted of four main sections. The first section, which focused on sociodemographic data, included variables such as age, sex, marital status, place of residence (urban or rural),

educational attainment, occupation, and the level of work-related physical effort.

The second part concerned clinical data on the participants and included details about time of onset of psoriasis, family history and concomitant comorbidities and treatment history (local, systemic, phototherapy or biologics) including adherence information.

The third segment was associated with the knowledge of psoriasis and consisted of 33 items including disease causation, risk factors and symptoms, complications and available treatment options.

The last 26 questions measuring the frequency of suggested practices made up the fourth portion, which concentrated on self-care behaviors. These included dietary practices, physical exercise, stress management, avoiding environmental factors known to aggravate psoriasis, personal hygiene (such as bathing and nail

care), skincare (using emollients and avoiding irritants), and stress management.

Two specialists, one in general medicine and the other in dermatology and venereology, evaluated the questionnaire. To guarantee linguistic coherence, it was translated into Arabic and then back-translated. To assess the questionnaire's viability, including its clarity, comprehensibility, completion time, and general patient acceptability, a pilot research involving 15 patients was carried out. The results showed that while some questions were redundant or had similar meanings, others were hard for patients to understand. As a result, several patients were reluctant to finish the questionnaire. It was decided to combine or remove the really comparable questions after discussing these results with the supervisor.

Data Collection Procedure

Patients who were deemed eligible were approached by the principal investigator in clinic on one of their routine visits for interview. The questionnaire was applied verbally to minimize the effect of literacy bias. The duration of each interview was about 15–20 minutes. All responses were recorded anonymously.

Knowledge Assessment

The 33 items in the knowledge component were intended to assess patients' comprehension of psoriasis, including its causes, triggers, consequences, and available treatments. Two points were given for each right answer, one point for "I do not know" answers, and zero points for wrong answers. 66 was the highest possible score. Knowledge levels were categorized as follows using the modified Bloom's cut-off: Good (≥ 53 points, $\geq 80\%$), Fair (40–52 points, 60–79%), and Poor (≤ 39 points, $<60\%$).

Practice Assessment

The 26 items in the practice component assessed adherence to recommended self-care behaviors. With a maximum score of 52. One point was given for "sometime practicing," two points for consistently practicing, and zero points for neither practicing nor being absent. The levels of self-care practice were categorized using the modified Bloom's cut-off: Good (≥ 42 points, $\geq 80\%$), Fair (32–41 points, 60–79%), and Poor (≤ 31 points, $<60\%$).

Statistical Analysis

Microsoft Excel and International Business Machines (IBM) Statistical Package for Social Sciences (SPSS) Statistics version 30 were used to enter and analyze all of the data. The individuals' baseline characteristics were summarized using descriptive statistics. Appropriate statistical tests were used to investigate relationships between knowledge and self-care habits and different sociodemographic traits. Relationships between categorical variables were examined using the Chi-square test (χ^2). To assess linear correlations between continuous variables, like age and knowledge score, the

Pearson correlation coefficient (r) was employed. Statistical significance was defined as a p-value of less than 0.05.

Ethical Considerations

The study received approval from the scientific council of Arabic board for health's specialist to the directorate of the Dermatology and Venereology Center at Medical City Teaching Hospital. Participation was voluntary, and verbal informed consent was obtained from all participants after explaining the study purpose, risks, and confidentiality safeguards.

RESULTS

Baseline Characteristics

A total of 250 patients with psoriasis were included in the study. More than half were male ($n = 148$, 59.2%), and most participants were between 18–30 years ($n = 76$, 30.4%) and 31–40 years ($n = 71$, 28.4%). Most respondents were married ($n = 176$, 70.4%) and lived in urban areas ($n = 219$, 87.6%). In terms of education, a large proportion had a primary school education ($n = 101$, 40.4%). Only a small proportion reported having jobs that involve physical effort ($n = 11$, 4.4%). The majority of participants had been diagnosed with psoriasis for more than one year ($n = 205$, 82.0%). Additionally, 44.4% ($n = 111$) reported a family history of psoriasis (Table 2).

Table 1: Sociodemographic and clinical characteristics of patients with psoriasis (N = 250).

Variable	Number (n)	%
Age		
18-30	76	30.4
31-40	71	28.4
41-50	64	25.6
15-60	39	15.6
Sex		
Female	102	40.8
Male	148	59.2
Marital status		
Single	67	26.8
Married	176	70.4
Divorced	3	1.2
Widowed	4	1.6
Residence		
Urban	219	87.6
Rural	31	12.4
Educational level		
Primary	101	40.4
Secondary	61	24.4
University degree	75	30.0
Post graduate	13	5.2
Occupation		
Governmental sector	52	20.8
Non- governmental sector	86	34.4
Student	14	5.6
Unemployed	92	36.8
Retired	6	2.4
Work Involves physical effort		

Yes	11	4.4
No	239	95.6
Duration of Psoriasis		
6 months – 1 year	45	18.0
More than 1 year	205	82.0
Family history of psoriasis		
Yes	111	44.4
No	139	55.6

Among the 250 patients, 89 (35.6%) reported a past medical history, including hypertension in 43 (17.2%), diabetes mellitus in 36 (14.4%), and cardiac disease in 15 (6.0%). All patients were receiving treatment, with topical therapy being the most common, reported by 196 (78.4%), followed by injection therapy in 118 (47.2%) and oral therapy in 69 (27.6%). Among topical treatments, emollients were the most frequently used agents (133, 53.2%), followed by steroid creams (69, 27.6%). Among systemic therapies, biologic agents were used by 119 (47.6%) patients, while immunosuppressants were used by 64 (25.6%). Regarding sources of psoriasis-related information, most participants obtained their knowledge from medical staff (170, 68.0%), followed by the internet (56, 22.4%), family (45, 18.0%), and friends (6, 2.4%).

Patient's Knowledge about Psoriasis

Participants' knowledge varied across several domains. Awareness that psoriasis could progress to psoriatic arthritis was reported by 113 (45.2%) participants, while 130 (52.0%) recognized that the disease could worsen over time. Most respondents correctly identified skin scaling as the accumulation of dead skin cells (198, 79.2%), whereas 67 (26.8%) incorrectly believed that scaling indicated symptom resolution. Stress and anxiety were recognized as exacerbating factors by 211 (84.4%) participants, although awareness of other triggers was limited, with 67 (26.8%) attributing disease onset to sore throats and 154 (61.6%) to environmental pollutants. Regarding treatment, 193 (77.2%) agreed that therapy should be individualized according to disease severity and lifestyle. Corticosteroid ointments were correctly identified as short-term therapy by 130 (52.0%) participants, whereas 42 (16.8%) favored herbal remedies. Awareness of treatment-related risks was moderate, with 100 (40.0%) associating phototherapy with an increased risk of skin cancer and 56 (22.4%) believing that sunlight could reduce immunity. Only 6 (2.4%) participants considered psoriasis contagious, while 63 (25.2%) believed it to be an allergic condition; in contrast, 128 (51.2%) correctly identified psoriasis as an immune-mediated disease. Awareness of comorbidities was limited, with only 63 (25.2%) recognizing its association with obesity, diabetes, and cardiovascular disease, and 79 (31.6%) acknowledging a hereditary predisposition (Table 3 and 4).

Table 3: Distribution of psoriasis patients according to their knowledge.

Knowledge	Yes n (%)	No n (%)	Don't Know n (%)
Knowledge Questions			
Does psoriasis worsen or developed in different ways over time?	130 (52)	101 (40.4)	19 (7.6)
Can people with psoriasis develop psoriatic arthritis?	113 (45.2)	61 (24.4)	76 (30.4)
Does the disappearance of all psoriasis symptoms mean complete healing?	67 (26.8)	140 (56)	43 (17.2)
Does the accumulation of dead cells cause skin scaling?	198 (79.2)	26 (10.4)	26 (10.4)
Can a sore throat cause psoriasis?	67 (26.8)	97 (38.8)	86 (34.4)
Can taking antibiotics trigger psoriasis?	32 (12.8)	135 (54)	83 (33.2)
Can environmental pollution contribute to psoriasis?	58 (23.2)	156 (62.4)	36 (15.2)
Can certain medications, such as blood pressure drugs, worsen psoriasis?	18 (7.2)	56 (22.4)	176 (70.4)
Can stress or anxiety exacerbate psoriasis?	211 (84.4)	29 (11.6)	10 (4)
Does exposure to sunlight increase the severity of psoriasis?	96 (38.4)	122 (48.8)	32 (12.8)
Does diet affect the development of psoriasis?	60 (24)	158 (63.2)	32 (12.8)
Can laundry detergent and certain chemicals irritate psoriasis?	100 (40)	138 (55.2)	12 (4.8)
Does scratching the skin worsen psoriasis?	116 (46.4)	127 (50.8)	7 (2.8)
Is psoriasis treatment used based on the patient's lifestyle, the severity of psoriasis, and the location of the condition?	193 (77.2)	28 (11.2)	29 (11.6)
Can corticosteroid ointments or creams be used for only one week at a time?	130 (52)	108 (43.2)	12 (4.8)
Do herbal treatments have a positive effect on psoriasis?	42 (16.8)	151 (60.4)	57 (22.8)
Can all topical treatments for psoriasis be used on all areas of the skin (specifically the face and sensitive areas)?	91 (36.4)	141 (56.4)	18 (7.2)
Can phototherapy increase the risk of skin cancer?	100 (40)	64 (25.6)	86 (34.4)
Does sunlight reduce the skin's immune system strength?	56 (22.4)	110 (44)	84 (33.6)
Is chemotherapy used to treat psoriasis and psoriatic arthritis?	72 (28.8)	23 (9.2)	155 (62)
Do moisturizers stop the skin from producing oils?	52 (20.8)	102 (40.8)	96 (38.4)
Is there a maximum limit for the number of UV exposures for psoriasis treatment?	38 (15.2)	92 (36.8)	120 (48)

Is it harder to treat psoriasis on the nails?	61 (24.4)	72 (28.8)	117 (46.8)
Is ointment better than cream for treating psoriasis?	170 (68)	71 (28.4)	9 (3.6)
Does the effect of topical corticosteroids decrease when used daily for extended periods?	135 (54)	80 (32)	35 (14)
Is psoriasis an inflammation of the skin?	87 (34.8)	156 (62.4)	7 (2.8)
Is psoriasis a contagious disease?	6 (2.4)	243 (97.2)	1 (0.4)
Is psoriasis caused by an immune system disorder?	128 (51.2)	116 (46.4)	6 (2.4)
Is psoriasis an allergic disease?	63 (25.2)	179 (71.6)	8 (3.2)
Are women more likely to develop psoriasis than men?	49 (19.6)	159 (63.6)	42 (16.8)
Can psoriasis be passed down through generations?	79 (31.6)	87 (34.8)	84 (33.6)
Is psoriasis more common in people over 50 years old?	10 (4)	202 (80.8)	38 (15.2)
Do obesity, diabetes, stress, and cardiovascular diseases occur more frequently in people with psoriasis than in the general population?	63 (25.2)	104 (41.6)	83 (33.2)

Table 4: Distribution of psoriasis patients according to their Self-Care practice.

Self-care practice			
Practice Questions	Always n (%)	Sometimes n (%)	Never n (%)
Do you bath daily to maintain good hygiene?	146 (58.4)	87 (34.8)	17 (6.8)
Do you use warm water for bathing?	184 (73.6)	62 (24.8)	4 (1.6)
Do you avoid hot water bath?	175 (70)	63 (25.2)	12 (4.8)
Do you avoid scented soaps and irritating shampoos?	146 (58.4)	69 (27.6)	35 (14)
Do you wash your skin gently?	155 (62)	58 (23.2)	37 (14.8)
Do you dry your skin by patting rather than rubbing?	159 (63.6)	60 (24)	31 (12.4)
Do you keep your skin moist by applying a moisturizer regularly?	111 (44.4)	45 (18)	94 (37.6)
Do you avoid scratching psoriatic lesions?	150 (60)	91 (36.4)	9 (3.6)
Do you trim your nail regularly?	204 (81.6)	41 (16.4)	5 (2)
Do you exposure your skin to short periods of sunlight daily?	32 (12.8)	77 (30.8)	141 (56.4)
Do you wear cotton clothes?	196 (78.4)	50 (20)	4 (1.6)
Do you wear wool clothes?	32 (12.8)	96 (38.4)	122 (48.8)
Do you wear synthetic fiber clothes?	168 (67.2)	75 (30)	7 (2.8)
Do you manage emotional stress?	52 (20.8)	100 (40)	98 (39.2)
Do you avoid smoking?	136 (54.4)	23 (9.2)	91 (36.4)
Do you avoid exposure to cold weather?	66 (26.4)	102 (40.8)	82 (32.8)
Do you maintain a healthy weight?	115 (46)	107 (42.8)	28 (11.2)
Do you avoid exposure to sore throat (streptococcal infection)	87 (34.8)	62 (24.8)	101 (40.4)
Do you increase your fluid intake?	228 (91.2)	22 (8.8)	0
Do you consume fruits and vegetables regularly?	222 (88.8)	22 (8.8)	6 (2.4)
Do you consume foods rich in omega_3 fatty acid? (ex. Seafood, Soyabean, Nuts, Spinach...etc.)	203 (81.2)	29 (11.6)	18 (7.2)
Do you consume foods rich in zinc? (ex. Meet, Chicken, Liver. etc.)	223 (89.2)	20 (8)	7 (2.8)
Do you consume foods rich in vitamin D? (ex. Eggs, Milk, Yogurt, Oran juice, Cheese .. etc..)	224 (89.6)	13 (5.2)	13 (5.2)
Do you avoid hot spicy food?	135 (54)	69 (27.6)	46 (18.4)
Do you avoid junk foods?	106 (42.4)	81 (32.4)	63 (25.2)
Do you avoid heavy meals?	108 (43.2)	80 (32)	62 (24.8)

Among the 250 participants, the majority demonstrated a fair level of knowledge about psoriasis 136 (54.4%), while 113 (45.2%) had poor knowledge, and only 1 (0.4%) had good knowledge (**Figure 1 A**).

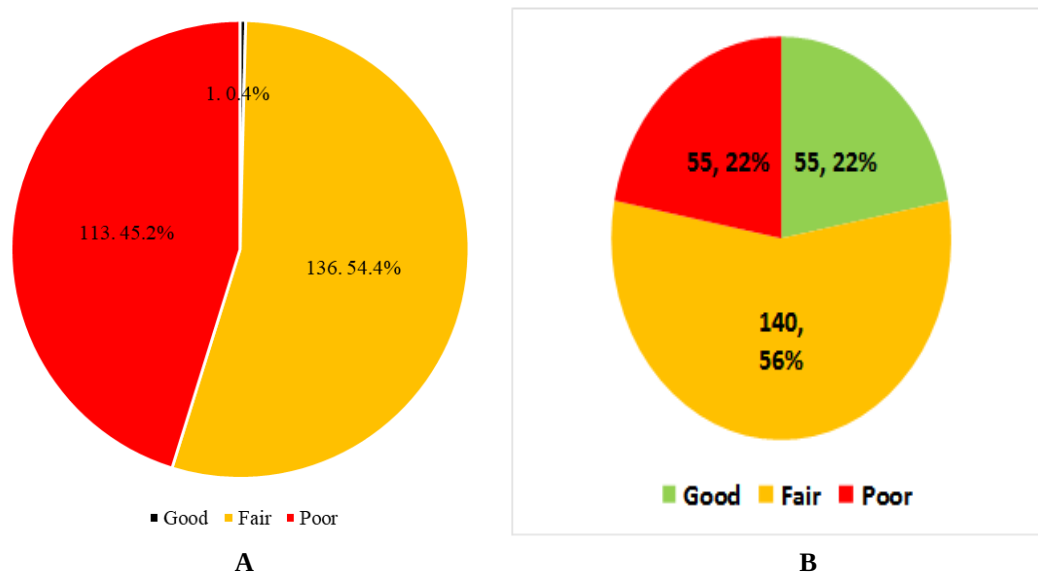


Figure 1: Distribution of psoriasis patients.

A: Distribution of psoriasis patients according to knowledge levels.

B: Distribution of psoriasis patients according to self-care practice levels.

Table 5 shows the association between patients' knowledge levels and their sociodemographic and clinical characteristics. Overall, no statistically significant associations were observed between knowledge level and age (χ^2 , $df = 6$, $p = 0.560$, Cramer's $V = 0.10$), sex ($df = 2$, $p = 0.641$, $V = 0.06$), marital status ($df = 6$, $p = 0.991$, $V = 0.04$), residence ($df = 2$, $p = 0.068$, $V = 0.15$), physical effort at work ($df = 2$, $p = 0.808$, $V = 0.04$), duration of psoriasis ($df = 2$, $p = 0.057$, $V = 0.15$), family history of psoriasis ($df = 2$, $p = 0.630$,

$V = 0.06$), or past medical history ($df = 2$, $p = 0.691$, $V = 0.05$). Education level was the only variable significantly associated with patients' knowledge ($df = 8$, $p = 0.001$), with a small-to-moderate effect size (Cramer's $V = 0.23$), indicating that participants with postgraduate education tended to demonstrate higher knowledge levels than those with lower educational attainment. Although residence and duration of psoriasis approached statistical significance ($p = 0.068$ and $p = 0.057$, respectively), their effect sizes remained small ($V \approx 0.15$).

Table 5: Association between patients' knowledge levels and sociodemographic/clinical variables.

Variable		Good n. (%) n=1	Fair n. (%) n= 136	Poor n. (%) n= 113	Total n. (%) n= 250	p-value
Age	18–30	0	39 (51.3)	37 (48.7)	76 (30.4)	0.56
	31–40	0	36 (50.7)	35 (49.3)	71 (28.4)	
	41–50	1 (1.6)	37 (57.8)	26 (40.6)	64 (25.6)	
	51–60	0	24 (61.5)	15 (38.5)	39 (15.6)	
Sex	Female	0	54 (52.9)	48 (47.1)	102 (40.8)	0.641
	Male	1 (0.7)	82 (55.4)	65 (43.9)	148 (59.2)	
Marital Status	Divorced	0	2 (66.6)	1 (33.3)	3 (1.2)	0.991
	Married	1 (0.5)	97 (55.1)	78 (44.3)	176 (70.4)	
	Single	0	35 (52.2)	32 (47.7)	67 (26.8)	
	Widow	0	2 (50.0)	2 (50.0)	4 (1.6)	
Residence	Rural	0	11 (33.3)	22 (66.6)	33 (13.2)	0.068
	Urban	1 (0.4)	125 (57.6)	91 (41.9)	217 (86.8)	
Education Level	Primary	0	42 (41.6)	59 (58.4)	101 (40.4)	0.001
	Secondary	0	42 (68.9)	19 (31.1)	61 (24.4)	
	University	0	44 (58.7)	31 (41.3)	75 (30.0)	
	Above(Postgraduate)	1 (7.7)	8 (61.5)	4 (30.8)	13 (5.2)	
Occupation	Governmental	1 (1.9)	32 (61.5)	19 (36.5)	52 (20.8)	
	Non-Governmental	0	50 (58.1)	36 (41.9)	86 (34.4)	
	Unemployed	0	44 (47.8)	48 (52.2)	92 (36.8)	
	Retired	0	3 (50.0)	3 (50.0)	6 (2.4)	
	Student	0	7 (50.0)	7 (50.0)	14 (5.6)	

Physical Effort at Work	Yes	0	7 (63.6)	4 (36.4)	11 (4.4)	0.808
	No	1 (0.4)	129 (53.1)	109 (45.6)	239 (95.6)	
Duration of Psoriasis	6months-1year	0	14 (31.1)	29 (64.4)	45 (18.0)	0.057
	More than 1year	1 (0.48)	122 (59.5)	82 (40.0)	205 (82.0)	
Family History of Psoriasis	Yes	0	62 (55.8)	49 (44.1)	111 (44.4)	0.63
	No	1 (0.71)	74 (53.2)	64 (46.0)	139 (55.6)	
Past Medical History	Yes	0	47 (52.8)	42 (47.2)	89 (35.6)	0.691
	No	1 (0.6)	89 (55.3)	71 (44.1)	161 (64.4)	

Analysis of treatment modalities showed that knowledge levels were significantly associated with patients receiving injection therapy ($p = 0.008$), phototherapy ($p = 0.017$), other topical agents ($p < 0.001$), and biologic systemic therapy ($p = 0.009$). In contrast, no significant associations were observed with topical, oral, emollient, steroid cream, oral steroid, or immunosuppressant therapies (all $p > 0.05$).

Patient's Self-Care Practices

Most participants reported adherence to recommended hygiene and lifestyle practices. Daily bathing was reported by 146 (58.4%) participants, while 184 (73.6%) used warm water, 155 (62.0%) practiced gentle washing, and 159 (63.6%) dried their skin by patting rather than rubbing. Avoidance of scratching lesions was reported by 150 (60.0%) participants, and 204 (81.6%) took good care of their nails; however, regular moisturization was less common, reported by only 111 (44.4%). Behavioral and environmental practices were less consistent. Only 32 (12.8%) participants reported daily sun exposure, whereas 196 (78.4%) preferred wearing cotton clothing. Regular stress management was reported by 52 (20.8%) participants, while 136 (54.4%) avoided smoking. Dietary adherence was generally high, with more than

80% of participants consuming fruits, vegetables, and nutrient-rich foods such as zinc-, vitamin D-, and omega-3-rich foods, and 228 (91.2%) reported increasing their fluid intake. Nevertheless, adherence to avoiding unhealthy dietary habits was moderate, with 106 (42.4%) avoiding junk food, 135 (54.0%) avoiding spicy foods, and 108 (43.2%) avoiding large meals.

Self-care practice showed 55 (22.0%) classified as good, 140 (56.0%) as fair, and 55 (22.0%) as poor (**Figure 1**). Significant associations were observed between practice level and sex ($df = 2$, $p = 0.021$), marital status ($df = 6$, $p = 0.014$), educational level ($df = 8$, $p = 0.002$), occupation ($df = 8$, $p = 0.020$), work involving physical effort ($df = 2$, $p = 0.026$), and duration of psoriasis ($df = 2$, $p = 0.024$). In contrast, no significant associations were found with age ($df = 6$, $p = 0.176$), residence ($df = 2$, $p = 0.220$), family history of psoriasis ($df = 2$, $p = 0.363$), or past medical history ($df = 2$, $p = 0.131$). These findings suggest that patients' practice levels are influenced primarily by educational attainment, occupational status, and selected demographic and clinical characteristics, whereas age, residence, family history, and comorbid medical conditions showed no statistically significant relationship (**Table 6**).

Table 6: Association Between Demographic, Clinical, and Treatment Variables and Practice Level in Psoriasis Patients.

Variable		Good n. (%) n = 55	Fair n. (%) n = 140	Poor n. (%) n = 55	Total n. (%) n = 250	p-value
Age	18–30	13 (17.1)	40 (52.6)	23 (30.3)	76 (30.4)	0.176
	31–40	18 (25.4)	37 (52.1)	16 (22.5)	71 (28.4)	
	41–50	18 (28.1)	36 (56.3)	10 (15.6)	64 (25.6)	
	51–60	6 (15.4)	27 (69.2)	6 (15.4)	39 (15.6)	
Sex	Female	22 (21.6)	66 (64.7)	14 (13.7)	102 (40.8)	0.021
	Male	33 (22.3)	74 (50.0)	41 (27.7)	148 (59.2)	
Marital Status	Divorced	1 (33.3)	2 (66.7)	0	3 (1.2)	0.014
	Married	38 (21.4)	100 (56.8)	38 (21.6)	176 (70.4)	
	Single	12 (17.9)	38 (56.7)	17 (25.4)	67 (26.8)	
	Widow	4 (100.0)	0	0	4 (1.6)	
Residence	Rural	4 (12.9)	17 (54.8)	10 (32.3)	31 (12.4)	0.220
	Urban	51 (23.3)	123 (56.2)	45 (20.5)	219 (87.6)	
Educational Level	Primary	15 (14.9)	57 (56.4)	29 (28.7)	101 (40.4)	0.002
	Secondary	8 (13.1)	38 (62.3)	15 (24.6)	61 (24.4)	
	University	26 (34.7)	38 (50.7)	11 (14.7)	75 (30.0)	
	Above(Postgraduate)	6 (46.2)	7 (53.8)	0	13 (5.2)	
Occupation	Governmental	14 (26.9)	31 (59.6)	7 (13.4)	52 (20.8)	0.020
	Non-Governmental	22 (25.5)	37 (43.0)	27 (31.3)	86 (34.4)	
	Unemployed/ Not	14 (15.2)	60 (65.2)	18 (19.5)	92 (36.8)	

	working					
	Retired	3 (50.0)	2 (33.3)	1 (16.6)	6 (2.4)	
	Student	2 (14.2)	9 (64.3)	3 (21.4)	14 (5.6)	
Work involves physical effort?	Yes	2 (18.1)	3 (27.2)	6 (54.5)	11 (4.4)	0.026
	No	53 (22.2)	137 (57.3)	49 (20.5)	239 (95.6)	
Duration of Psoriasis	6 months – 1 year	15 (33.3)	26 (57.8)	4 (8.9)	45 (18.0)	0.024
	More than 1 year	40 (19.5)	114 (55.6)	51 (24.8)	205 (82.0)	
Family History of Psoriasis?	Yes	20 (18.0)	64 (57.7)	27 (24.3)	111 (44.4)	0.363
	No	35 (25.2)	76 (54.7)	28 (20.1)	139 (55.6)	
Past medical History	Yes	24 (26.9)	51 (57.3)	14 (15.7)	89 (35.6)	0.131
	No	31 (19.3)	89 (55.3)	41 (25.5)	161 (64.4)	

Analysis of self-care practice in relation to treatment type showed significant associations with oral therapy ($p = 0.004$), injection therapy ($p = 0.021$), biologic therapy ($p = 0.013$), and immunosuppressants ($p = 0.002$).

DISCUSSION

According to our research, people's self-care practices were generally better even when they knew very little about psoriasis. Moisturization, sun exposure, and stress management remained weak points even if dietary habits and hygiene procedures were better accepted. In the areas of comorbidities, triggers, and treatment risks, knowledge gaps were particularly apparent. While practice was influenced by sociodemographic and clinical factors such as sex, marital status, occupation, and duration of disease, educational attainment was found to be a major predictor of knowledge. Patients who were exposed to innovative therapeutic approaches also shown improved awareness and compliance.

Current findings of limited knowledge but good self-care practice resonate with those of Ganapathy D and Chandrasekhar H.^[13], who showed that although 90% of the general population in India had heard of psoriasis, awareness of diagnosis, treatment, and prevention was superficial, with only a minority recognizing preventive measures or accurate diagnostic methods. In similar fashion, patients in a recent study showed a fair awareness of the fundamental characteristics of the illness, but they lacked a deeper comprehension of comorbidities, triggers, and long-term care. More than a quarter of Norwegian psoriasis patients had severe health literacy limits, which were linked to lower knowledge and worse self-management, according to Larsen MH. et al.^[14], further highlighting the impact of health literacy in influencing outcomes.

Many participants thought that a complete recovery was indicated by the absence of clinical symptoms. Similarly, they were unaware of the common triggers. These restrictions may have a detrimental effect on the management of the illness and complicate the early detection of flare triggers. These results are consistent with those of Cingöz K. et al.^[15], who discovered a connection between a lack of knowledge and widespread beliefs. The study also underlined how crucial it is that the primary source of patient data be healthcare professionals.

Tian J et al. (2024)^[16] showed that education and medication use were important positive factors of knowledge and practice, which is consistent with our findings that higher education and advanced treatment approaches greatly increase knowledge. In a comparable manner, Nabawy M et al. (2021)^[17] discovered that Egyptian patients' lack of understanding and self-care was explained by their low educational attainment. The current investigation did not find a significant correlation between knowledge and the duration of the condition.

This study discovered that self-care practices among psoriasis patients were significantly better than knowledge levels, despite the fact that there are still significant gaps. The common habit of bathing every day, using warm water, avoiding scented soaps, gently washing skin, and drying by patting rather than rubbing revealed good adherence to fundamental hygiene recommendations. These findings contrast with those of Nabawy M. et al. in Egypt, where almost 73.3% of patients stated that their overall self-care practices were insufficient.^[17]

Even though the two groups' adherence levels varied, they both discovered deficiencies in crucial skin care procedures. Significant flaws were identified. In line with studies from Egypt, where moisturization was not often utilized, as less than half of patients used frequent moisturization.^[17] This is problematic because emollients have a well-established role in maintaining barrier integrity and reducing scaling.

Only a small percentage of participants in this trial engaged in brief daily exposure to sunlight, another acknowledged therapeutic adjunct. Less than 25% of patients regularly used stress-reduction techniques, making stress management another weak area. Özer I. et al.^[18] support the psychosocial aspect of this problem by demonstrating that prejudiced attitudes and misconceptions about psoriasis are still prevalent in the community, with over one-third of respondents refusing to shake hands with patients and 22.9% of respondents thinking the condition is contagious. Regardless of the severity of the illness, such stigmatization will increase stress and anxiety and promote social isolation. Mixed adherence to avoiding dietary irritants, such as junk food, spicy foods, and large meals, suggests a partial comprehension of their function in aggravating psoriasis.

Self-care practices were found to be highly influenced by a number of clinical, treatment-related, and demographic characteristics. Higher education, women, and marital figures all showed improved adherence, probably as a result of increased social support and health awareness. Other important characteristics included occupation and physical labor. Longer disease duration was linked to higher adherence because of collected experience, and patients with less physically demanding employment tended to maintain better self-care.

Limitations

The study limitations include relying on a patient sample from a single medical center in Baghdad limited the generalizability of the findings to the wider Iraqi population. Additionally, some patients were psychologically unprepared to complete a detailed medical survey during their hospital visits.

CONCLUSION

According to the study, the majority of participants had a fair understanding of psoriasis, with the majority of misunderstandings being to comorbidities, triggers, and treatment risks. In general, self-care behaviors were reasonable. Sociodemographic and clinical characteristics, such as sex, marital status, occupation, physical exertion, and length of illness, had an impact on practice levels. Our results demonstrate the necessity of organized teaching programs in outpatient settings to enhance patients' comprehension and compliance with self-care. Future multicenter studies are advised to further investigate educational and behavioral drivers of self-care adherence in psoriasis, while doctors and national health organizations should focus patient education through clinic-based and media-supported programs.

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