

chodynamic theoretical approach in a focus group setting involving psoriatic patients, focusing on the effects of the participation on their caregivers. The study had an exploratory nature, given the limited period of the intervention (6 Focus Group meetings) and the limited number of participants (52 patients, 41 caregivers). Indeed, the effects of the intervention were not evident on the patients themselves. The experimental group was characterized by initial higher anxiety than the control, which did not further worsen over time, possibly thanks to the participation in the group, but any conclusion on this should be taken carefully. Possibly, anxiety, depression and quality of life of our patients is grounded in very deep and long-standing causes that cannot be modified with only 6 meetings. More important to the scope of the present study is the indirect effect of a psychological intervention for caregivers, on which we can draw some preliminary considerations.

The caregivers of the patients who agreed to participate in the meetings presented an initial quality of life more compromised than the caregivers of the group of patients who did not agree to participate in the Focus Group. Possibly, patients (and their corresponding caregivers) who accepted to be involved in the focus groups were more in contact with their suffering linked to the pathology. These results are also in line both with the systemic approach - according to which there is an interconnection between people belonging to the same affective network (Haley & Hoffman, 1967) - and with studies focusing on the impact between psoriatic pathology and their impact on their family members' QoL (Eghlilib *et al.*, 2007; Kross, 2015). Furthermore, the results of our study show that the caregivers of the patients participating in the Focus Group Meetings reported a better quality of life after the meetings ($M=2.59$; $SD=2.61$) than before ($M=3.82$; $SD=3.33$), which also further improved at the follow up ($M=2.23$; $SD=2.64$). This improvement over time was independent from the seriousness of the pathology of their relatives. This is in line with some literature (Richards *et al.*, 2002; Eghlilib *et al.*, 2007), but not with others (Tadros *et al.*, 2011). Further studies (possibly meta-analytic) are needed to explore the relationship between caregivers' burden and patients' disease severity. We assume that the participation of patients in the Focus groups affected their caregivers in a direct (rather than mediated) way. Specifically, the intervention may have benefited the caregivers because it alleviated them from their responsibility towards the patients. Knowing that their cared ones were regularly meeting a psychologist may have alleviated caregivers' preoccupation associated with their role in the pathology. Arguably, the group represents a third party between patient and caregiver (Anzieu, 1993), which takes off the 'weight' of the pathology, eventually acting as a containment barrier of the consequences of the patient's pathology on the caregivers. This is in line with the results reported in their meta-analysis by Del-Pino-Casado and colleagues (2018), according to which the perceived social

support is even more important than the actual social support for caregivers' burden.

These results seem to go in the direction of what Basra *et al.* (2008) and Eghlilib *et al.* (2007) postulated with the concept of 'The Greater Patient' to describe 'the immediate social grouping of family and partner who are also affected by an individual having skin disease' (Eghlilib *et al.*, 2007, p. 1250). The authors emphasize the importance of considering the patient not only according to their individual characteristics, but also in relation to the people who take care of them.

The study presents some key limitations that should be taken into account. First of all, the intervention is limited in duration. Six Focus Group meetings is a short intervention for a psychodynamic approach, and this may explain why we could not observe any clear effect on patients' wellbeing. A second important limit is represented by the sample size, involving only 52 patients, 41 caregivers. Future studies are therefore needed to replicate the present findings. A third important element is represented by the enrolling procedure. Patients were assigned to either the control or experimental group and then respectively offered to participate in either: i) the focus groups and the questionnaires' completion; or ii) in the questionnaires' completion only. This may be related to the initial difference between the two groups in terms of psychological distress. The experimental participants have voluntarily accepted the offer to participate in a highly demanding and time-consuming focus group, whereas control participants accepted a less demanding procedure, namely filling in some questionnaire. It is possible that experimental patients were on average more motivated by higher awareness of their psychological distress. Future studies should include interventions with psoriatic patients and specific focus groups with their caregivers in order to investigate the specific factors related to the mutual relationship between emotional characteristics and FDLQI of caregivers, patients' well-being and psychological support.

Conclusions

The present study shows encouraging results about the relationship between caregivers' well-being (FDLQI) and supportive interventions for psoriatic patients. Since the intervention failed to exert any observable effect on patients in the considered timeframe, and given the absence of relation between patients' and caregivers' well-being, we cannot draw solid conclusions about the eventual indirect effect of psychological support to patients on caregivers. However, the pattern supports the hypothesis that caregivers benefit in a direct way from the psychological interventions provided to patients, shedding light on the importance of alleviating caregivers from the responsibility of the psychological well-being of the patients.

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