Pakistan Journal of Positive Psychology

Print ISSN : 3078-6428 | Online ISSN : 3078-6436
Pakistan Journal of Positive Psychology

Original Article

ROLE OF RESILIENCE, FAMILY AND SUPPORT GROUPS IN SEQUENTIAL DIAGNOSIS OF SLE-A: A SELF-REPORTED CASE STUDY

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KEYWORDS
Psoriatic Arthritis, Sequential Misdiagnosis, Diagnostic Delay, Resilience, Chronic Illness, Case Study

CITE THIS ARTICLE:
Khan, S. (2025). Role of resilience, family and support groups in sequential diagnosis of SLE-A: A self-reported case study. Pakistan Journal of Positive Psychology, 3(1), 11-18.

ARTICLE DETAILS:
Received on 10 Jan, 2026
Accepted on 03 Feb, 2026
Published on 07 Mar, 2026

ABSTRACT

Systemic Lupus Erythematous (SLE) poses a significant challenge in diagnosis, particularly when the condition exhibits other rheumatological disorders and thus cannot be diagnosed succinctly due to its multisystem involvement of medical professionals and the clinical presentation of the symptoms overlapping with other autoimmune conditions, specifically rheumatological and pain-related conditions/disorders. This self-reported case study presents a case of a woman in her late twenties in Pakistan, aiming to describe her diagnostic journey, who had been having a misdiagnosis of psoriatic arthritis and fibromyalgia 12-15 months prior to being diagnosed with SLE. This case study highlights the complexity of diagnosing autoimmune diseases, the frequent occurrence of referred autoimmune overlap syndromes, and the inevitable challenges of working with female patients in resource-limited health care facilities, especially when the symptoms of the illness may overlap with psychological ones and gender-related diagnostic bias. The delay in the diagnosis was associated with substantial difficulties that she had gone through during the delay and the psychological impact/distress, systematic complications, and the process of 12-15 visits to different physicians in different areas of specialty, spent a lot of money, and reached the limits of educational and psychological health before finding the clarity of diagnosis with tenacious advocacy and complete immunological testing. Beyond the trajectories of the health care system, this case study also aims to illustrate the processes of grief and trauma associated with chronic autoimmune conditions and the processes of resilience.

I. INTRODUCTION

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease with variable clinical manifestations affecting multiple organ systems. Because symptoms may evolve gradually and overlap with other rheumatologic or pain-related conditions, the diagnostic process can be prolonged and complex (Aringer et al., 2019). Early manifestations such as fatigue, joint pain, dermatological symptoms, and nonspecific systemic complaints may resemble disorders including psoriatic arthritis or fibromyalgia, which can lead to sequential misdiagnosis and delayed treatment initiation. Systemic lupus erythematosus (SLE) is a chronic autoimmune disease with heterogeneous clinical manifestations affecting multiple organ systems (Aringer et al., 2019; Barber et al., 2021). Because early symptoms such as fatigue, arthralgia, and dermatological manifestations are often nonspecific, diagnosis may be delayed or initially misclassified as other rheumatologic or chronic pain conditions (Gergianaki & Bertsias, 2018; Kiriakidou & Ching, 2020).

Diagnostic delay in autoimmune diseases has been associated with increased disease burden, psychological distress, and financial strain due to repeated medical consultations and investigations. For many patients, uncertainty during the diagnostic process can significantly affect emotional wellbeing and functioning. Understanding these experiences through a psychosocial and positive psychology lens may provide insight into resilience processes that help individuals cope with chronic illness. The present self-reported case study describes a diagnostic trajectory from initial rheumatologic misclassification to confirmed SLE and highlights both systemic barriers and adaptive psychological responses during the illness journey.

Table1: Clinical Evolution Across Diagnostic Stages

Feature	PsA Phase	Fibromyalgia Phase	Confirmed SLE
Joint Involvement	Inflammatory small joints	Diffuse pain	Inflammatory polyarthritis
Skin Manifestation	Psoriatic plaques	Persistent plaques	Photosensitive rashes
Morning Stiffness	30–40 minutes	Minimal	>1 hour
Renal Involvement	None	None	Proteinuria

Table 1 presents the clinical evolution across three diagnostic stages experienced by the patient: psoriatic arthritis (PsA), fibromyalgia, and the final diagnosis of systemic lupus erythematosus (SLE). The table highlights key clinical features including joint involvement, skin manifestations, morning stiffness, and renal involvement. During the PsA phase, the patient showed inflammatory small joint involvement and psoriatic plaques with moderate morning stiffness. In the fibromyalgia phase, symptoms shifted toward diffuse pain and reduced morning stiffness while skin plaques persisted. After the confirmation of SLE, the patient exhibited inflammatory polyarthritis, photosensitive rashes, prolonged morning stiffness exceeding one hour, and renal involvement indicated by proteinuria. This progression demonstrates how overlapping symptoms contributed to diagnostic complexity and delay.

II. METHOD

Participant Detail and Clinical History

A 27-year-old female pursuing her postgraduate studies in a private university in Pakistan, presented with a complicated set of symptoms, which began manifesting itself at the beginning of 2023. She did not have any known family history of autoimmune diseases and had a half-stable socioeconomic background, but limited finances had a severe impact on her access to healthcare at all points in her diagnostic process.

Table 2: Patient Demographics and Clinical Timeline

Category	Detail
Current Age	27 years
Age at Initial Presentation	25 years
Gender	Female
Educational Status	University student – Clinical Psychology (Postgraduate)
Location	Karachi, Sindh, Pakistan
Family History	No known autoimmune diseases
Socioeconomic Status	Partially stable; financial strain affected healthcare access
Initial Symptom Onset	Early 2023
First Diagnosis	Psoriatic Arthritis (mid-2023)
Second Diagnosis	Fibromyalgia (late 2023)
Final Diagnosis	Systemic Lupus Erythematosus (early 2024)
Total Diagnostic Delay	Approximately 12–15 months

Table 2 summarizes the demographic characteristics of the patient and her clinical history.

Evolution of Clinical Presentations

The symptoms of the patient started insidiously in early 2023 with polyarticular pain of the bilateral hands, wrists, cervical spine, and temporomandibular joints. She had heavy bilateral finger swelling, morning stiffness, which took 30-40 minutes, and extreme fatigue. Interestingly, she experienced widespread psoriatic skin lesions, recurrent migraines, pain on her face, jaw lock syndrome, blurred vision, vertigo, and dizziness. Mental status examination showed mild anxiety and brain fog. In mid-2023, she had been diagnosed with psoriatic arthritis based on the notable cutaneous lesions and inflammatory arthritis. NSAIDs and methotrexate treatment were started, then changed after two weeks to weekly injectable formulation 20mg, and only partially responsive to severe side effects of gastrointestinal.

The diagnosis focus changed to fibromyalgia towards the end of 2023 as symptoms continued and progressed. The patient now had extensive diffuse pain, excruciating fatigue, and little morning stiffness. New symptoms were observed such as low-grade intermittent fever, extreme loss of hair, oral ulcers, and Raynaud's phenomenon. There was a little addition to pain modulators and antidepressants. The psychological burden was worsened at this point, as the patient experienced severe levels of anxiety, depressive symptoms, suicidal thoughts with attempts, insomnia, dissociative thoughts and episodes, and a complete panic attack. The overlap of chronic pain and psychological distress caused a diagnostic confusion, where some clinicians thought the woman was having a psychiatric illness and not taking notice of the psychological manifestations as an outcome of undiagnosed organic disease. After the onset of the first symptoms, a full immunological examination about 12-15 months later was done that showed the actual diagnosis. The patient had frequent photosensitive eruptions, proteinuria suggesting renal complicity, and one episode of controlled cerebral accident because of blood clot complications. Her gynecological history was also relevant, with frequent miscarriages and stillbirths, which can be indicative of antiphospholipid syndrome.

Table 3: Clinical Presentation across Diagnostic Stages

Symptom/Sign	Psoriatic Arthritis	Fibromyalgia	SLE
Joint pain/swelling	Hands, wrists, cervical, TMJ	Diffuse pain	Hands, wrists, knees
Skin manifestations	Severe psoriatic patches	Severe psoriatic patches	Recurrent rashes, photosensitivity
Fatigue	Severe	Severe	Severe
Morning stiffness	30-40 minutes	Minimal	>1 hour
Fever	Low grade	Intermittent	Intermittent
Hair loss	Severe	Very severe	Significant
Oral ulcers	Yes	Yes	Recurrent
Raynaud's phenomenon	No	Yes	Present
Renal involvement	No	No	Proteinuria
Psychological symptoms	Mild anxiety	Severe depression, suicidal ideation, panic attacks	Ongoing severe burden

Table 3 presents the development of clinical manifestations in each of the stages of the diagnosis.

Measures

The laboratory assessment at the diagnosis of SLE showed the presence of positive ANA at a high titer, positive anti-dsDNA antibodies, positive anti-Smith antibodies (high specificity to SLE), and positive antiphospholipid antibodies. Complement system testing revealed that C3 and C4 levels were very low with active disease. The hematological parameters showed high levels of anemia, leukopenia, moderate levels of thrombocytopenia, high levels of ESR, and high levels of CRP. Urinalysis positive proteinuria, which demonstrated lupus nephritis. These results met several categories according to EULAR/ACR criteria of 2019 of SLE (Gergianaki & Bertsias, 2018).

Table 4: Key Diagnostic Investigations

Test	Findings	Clinical Significance
ANA	Positive (high titer)	Screening test for SLE
Anti-dsDNA	Positive	Highly specific for SLE
Anti-Smith	Positive	Highly specific for SLE
Antiphospholipid Ab	Positive	Associated with thrombosis and pregnancy loss
C3/C4	Significantly low	Active immune complex disease
Hemoglobin	Significantly low	Anemia common in active SLE
WBC	Leukopenia	Autoimmune destruction
Platelets	Moderate thrombocytopenia	Autoimmune destruction
Urinalysis	Proteinuria	Lupus nephritis

Laboratory findings supporting the diagnosis are presented in Table 4.

Procedure

The treatment process of the patient was complicated and difficult. Early oral methotrexate was stopped due to extreme adverse effects. She then tested about 10-12 various immunosuppressive agents with no long-term progress. The stability was achieved by the treatment of injectable methotrexate 20mg/weekly with hydroxychloroquine. She was given corticosteroid pulses with partial response, pain modulators with partial response, and various psychiatric drugs such as antidepressants, anxiolytics, mood stabilizers, and sleeping pills. The drug treatment plan involved constant readjustments, changes in brands, and importation of supplements that were not available locally, which contributed significantly to the financial burden. During the 15 months of the diagnosis, the patient met multiple physicians; self-reported (12 –15) specialists who specialize in various areas such as general practitioners, rheumatologist, dermatologist, ENT, cardiologist, internal medicine specialist, neurosurgeon, neuropsychiatrist, gynecologist, psychiatrist, and plastic surgeon. The entire consultation process was carried out within the confines of individual facilities because of issues regarding the quality of care provided in the public sector. The economic cost was extreme, and the out-of-pocket expenses were counterbalanced by family's help to some extent. There were disparities in access to medications, as some were not available locally, and some had to be imported at a high cost.

The effect was felt in all spheres of her life. The patient had to leave her postgraduate program halfway through the semester, a radical break to her academic career. She became psychologically depressed and developed suicidal thoughts and attempts, acute insomnia, dissociation, and frequent panic attacks that required expansive psychiatric care. Physically, there was chronic pain, fatigue, and one controlled cerebral vascular incident which caused a tremendous disservice to the daily activities. She was socially isolated and cut off progressive relations. Financially, the total healthcare costs had become excessive with family savings drained. This self-reported case study does not include identifiable patient information. The author provided informed consent for publication of personal clinical experiences.

RESULTS

Table 5: Clinical Timeline

Diagnosis Stage	Details
Initial symptom onset	Early 2023 – joint pain/stiffness, chronic fatigue, brain fog, significant swelling offingers (both hands), Psoriasis Patches, Blurry Vision, Vertigo, Dizziness, Facial Pain, Chronic Migraines, Jaw Lock Syndrome, Mild Anxiety
1st Diagnosis	Psoriatic Arthritis (mid-2023)
2nd Diagnosis	Fibromyalgia (late-2023)
Final Diagnosis	Systemic Lupus Erythematosus (early-2024)
Total diagnostic delay	Approximately 12–15 months

Table 5 outlines the clinical timeline of the patient's illness and diagnostic progression. The table traces the sequence from the initial onset of symptoms in early 2023 to the final diagnosis of systemic lupus erythematosus in early 2024. Early symptoms included joint pain, fatigue, psoriasis patches, neurological complaints, and mild anxiety. The patient was first diagnosed with psoriatic arthritis in mid-2023 and later reclassified as fibromyalgia in late-2023. The final SLE diagnosis occurred approximately 12–15 months after symptom onset, demonstrating a significant diagnostic delay.

Table 6: Clinical Presentation by Diagnosis Stage

Symptom	Psoriatic Arthritis	Fibromyalgia	SLE
Joint pain/swelling	Hands, wrists, cervical, tmj	Diffuse pain	Hands, wrists, knees
Skin manifestations	Severe	Severe	Recurrent rashes, photosensitivity,
Fatigue	Severe	Severe	Severe
Morning stiffness	< 30-40 minutes	Minimal	>1 hour
Widespread pain	Yes	Yes	Yes
Fever	Low grade	Intermittent	Intermittent
Hair loss	Severe	Very Severe	Significant
Oral ulcers	Yes	Yes	Recurrent
Raynaud's phenomenon	No	Yes	Present
Renal involvement	No	No	Proteinuria

Table 6 compares the clinical presentation of symptoms across three diagnostic stages: psoriatic arthritis, fibromyalgia, and SLE. The table shows that many symptoms such as fatigue, joint pain, and skin manifestations were present throughout the illness but varied in severity and pattern. While fibromyalgia was characterized by diffuse widespread pain and minimal morning stiffness, the SLE stage showed more systemic manifestations including photosensitive rashes, prolonged stiffness, Raynaud's phenomenon, and renal involvement (proteinuria). This comparison highlights the overlapping symptomatology that complicated early diagnosis.

Table 7: Diagnostic Investigations and Treatment History

Test	Findings	Medication	Details / Response
ANA	Positive (high titer)	NSAIDs	Partial relief
Anti-dsDNA	Positive	Methotrexate	Weekly injectable – partial control
Anti-Smith	Positive	Hydroxychloroquine	Ongoing – stabilization
Complement C3/C4	Significantly Low	Corticosteroids	Intermittent – good response
Hemoglobin	Significantly Low; Anaemia	Pain modulators	Partial benefit
WBC count	Leukopenia	Antidepressants	Anti-Depressants, Sleeping Pills, Mood Stabilizers
Platelets	Moderate thrombocytopenia		
ESR	Elevated		
CRP	Elevated		
Urinalysis	Proteinuria		

Table 7 summarizes the diagnostic investigations and treatment history of the patient. Laboratory findings revealed several markers consistent with SLE, including positive ANA, anti-dsDNA, and anti-Smith antibodies, low complement levels (C3/C4), anemia, leukopenia, thrombocytopenia, and proteinuria. The table also outlines the treatment approaches used during the disease course, including NSAIDs, methotrexate injections, hydroxychloroquine, corticosteroids, pain modulators, and psychiatric medications. These interventions provided partial symptom control, with hydroxychloroquine and methotrexate contributing to stabilization of the condition.

Table 8: Healthcare Journey Challenges

Aspect	Details
Physicians consulted	12-15
Specialists seen	General Physicians, ENT Specialists,Cardiologists, Internal Medicine Specialists, Rheumatologists , Dermatologist,Neurosurgeons/Neuropsychiatrists, Gynecologist (for recurrent history of miscarriages/still births), Psychiatrists, Plastic Surgeons
Facilities	Private clinics and hospitals
Financial Burden	High out-of-pocket costs/ financial aid from primary care providers
Medication access	Inconsistent availability

Table 8 describes the healthcare journey and systemic challenges encountered during the diagnostic process. The patient consulted approximately 12–15 physicians across multiple specialties, including general physicians, rheumatologists, dermatologists, neurologists, cardiologists, psychiatrists, and gynecologists. Care was primarily received through private clinics and hospitals, resulting in substantial out-of-pocket healthcare costs. Additionally, inconsistent availability of medications further complicated treatment continuity. The table illustrates structural and financial barriers that contributed to the prolonged diagnostic pathway.

Table 9: Impact Assessment

Life Domain	Impact	Severity
Academic performance	Had to drop PG program in the middle of the first semester, reduced productivity	Severe
Social life	Reduced participation	Moderate–Severe
Psychological health	Anxiety, depressive symptoms, sucidal ideation/attempts, Insomnia, Dissociative, Full blown panic attacks	Severe
Physical health/function	Chronic pain and fatigue, chronic anxiety attacks manifesting physical symptoms, Blood clot complications (one episode of a controlled heart stroke)	Severe
Financial status	Significant strain	Severe

Table 9 presents the multidimensional impact of the illness on the patient's life, categorized across several life domains including academic performance, social life, psychological health, physical functioning, and financial status. The illness resulted in severe academic disruption, forcing the patient to discontinue her postgraduate program. Psychological consequences included anxiety, depression, suicidal ideation, insomnia, dissociation, and panic attacks. Chronic pain, fatigue, and vascular complications affected physical functioning, while healthcare expenses created significant financial strain. Overall, the table highlights the profound biopsychosocial impact of delayed diagnosis.

Table 10: Diagnostic Criteria Met (EULAR/ACR 2019)

Criterion	Present	Details
Constitutional	Yes	Intermittent fever
Hematologic	Yes	Anemia, leukopenia
Mucocutaneous	Yes	Malar rash, ulcers, alopecia
Musculoskeletal	Yes	Inflammatory arthritis
Renal	Yes	Proteinuria
Complement proteins	Yes	Low C3/C4
SLE-specific antibodies	Yes	Anti-dsDNA, Anti-Smith, Anti-Phospholipids

Table 10 summarizes the diagnostic criteria met according to the 2019 EULAR/ACR classification criteria for systemic lupus erythematosus. The patient fulfilled multiple clinical and immunological domains including constitutional symptoms (intermittent fever), hematologic abnormalities (anemia and leukopenia), mucocutaneous manifestations (malar rash, ulcers, alopecia), musculoskeletal involvement (inflammatory arthritis), renal manifestations (proteinuria), and immunological markers such as low complement levels and SLE-specific antibodies (anti-dsDNA, anti-Smith, and antiphospholipid antibodies). These findings collectively supported the definitive diagnosis of SLE.

III. DISCUSSION

Diagnostic delays in Autoimmune conditions are frequently reported in SLE due to variable clinical presentation and evolving immunological findings (Kiriakidou & Ching, 2020).This case illustrates how overlapping clinical symptoms may complicate early recognition of systemic autoimmune diseases such as SLE. The patient's initial presentation with inflammatory joint symptoms and dermatological manifestations resulted in a provisional diagnosis of psoriatic arthritis, followed by consideration of fibromyalgia when widespread pain and fatigue became prominent. Such diagnostic transitions are not uncommon in early autoimmune disease stages where symptom expression may not yet fulfill classification criteria. According to the EULAR/ACR classification criteria, definitive diagnosis of SLE often requires accumulation of clinical and immunological findings over time (Aringer et al., 2019).

Beyond clinical complexity, the diagnostic delay was accompanied by psychosocial consequences including stress, uncertainty, and financial burden. Despite these challenges, the case also demonstrates elements of resilience and adaptive coping. Within positive psychology, the broaden-and-build theory proposes that positive emotions can expand cognitive and behavioral resources that support long-term psychological resilience (Fredrickson, 2001). Similarly, the concept of posttraumatic growth suggests that individuals facing significant adversity may develop new perspectives, personal strength, and meaning as they adapt to life challenges (Tedeschi & Calhoun, 2004). Interpreting chronic illness experiences through these frameworks highlights the potential for psychological growth alongside medical adversity. Recognizing resilience processes in patients with chronic autoimmune diseases may inform more holistic care approaches that integrate psychological wellbeing with medical management.

IV. CONCLUSION

The findings of the present study highlight the crucial roles that self-esteem and social support play in shaping students' academic performance. The strong positive correlations among these variables demonstrate that students who possess higher self-esteem not only experience greater perceived social support but also achieve better academic outcomes. Moreover, the mediating role of social support underscores its function as a significant psychological and social mechanism that bridges the impact of self-esteem on academic success. This suggests that confidence and self-worth alone are not sufficient for optimal academic achievement; rather, they must be complemented by a supportive social environment that nurtures motivation, resilience, and engagement.

In light of these results, educational institutions should prioritize developing programs and interventions that simultaneously strengthen students' self-esteem and foster supportive peer and mentor relationships. Such initiatives could include mentoring systems, counseling services, and collaborative learning environments that enhance students' sense of belonging and self-efficacy. By cultivating these internal and external resources, universities can create a more holistic learning environment conducive to both academic and personal growth. Ultimately, this study reaffirms that academic excellence is a multifaceted construct influenced not only by individual abilities but also by the quality of social connections and psychological wellbeing.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Funding
The author received no funding from any organizations.

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