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Review Article

Counseling in psoriasis: overcoming the concerns and challenges

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ABSTRACT

Psoriasis is a systemic, immune-mediated disorder, characterized by systemic inflammation predominantly in skin and joints with significant physical and psychosocial consequences. It is a chronic disease with an unpredictable journey consisting of flares and remissions. Psoriasis has also been linked to loss of self-esteem in patients, depression and suicidal tendencies. In addition, it also contributes to financial burden due to the long-term management. This results in negative impact on the caregivers and family of the patient. Due to these multiple factors, there has been low compliance to therapy and higher likelihood of discontinuation of treatment. Considering the emotional aspect involved in this disease, counseling of the patients becomes one of the integral pillars for the management of the disease. Hence, the clinician's role becomes significant, due to limited access to counselors, therapists and social groups, in our country. The present review describes the impact of psoriasis on the patient's life and the practical approaches that may be taken to counsel the patient of psoriasis.

Keywords: Psoriasis, Depression, Suicidal tendencies, Anxiety

INTRODUCTION

Psoriasis is a chronic, relapsing, systemic inflammatory disorder which predominantly effects the skin. Globally psoriasis affects only 1% of the total population, with men and women being equally affected.[1] The overall incidence in India ranges from 0.44% to 2.2%, with an overall prevalence of 1.02%.[1] Etiology of psoriasis is complex and remains unclear, though there is evidence of genetic, environmental, and immunological factors playing a significant role. It is considered to be an autoimmune disease mediated by T lymphocytes.[2]

The systemic nature of psoriasis involves inflammatory changes, which may manifest in various forms such as joint pains. According to literature, common comorbidities associated with psoriasis are psoriatic arthritis, cardiovascular disease, psychological disturbances, and metabolic syndrome such as diabetes mellitus type II, arterial hypertension, dyslipidemia.[3,4] This has also been made evident in the Indian population by various studies described in Table 1.[2,5]

Though in the present era, advanced treatment regimens are available that may offer a clear skin; improvement in quality of life (QoL) and adequate counseling lay the foundation of psoriasis management.[6] Patients have feelings of unacceptance and anticipate rejection, leading to poor QoL. As per the national psoriasis foundation, 75% of psoriasis patients had poor QoL.[2,7] Indian data suggests that 28% of moderate to severe psoriasis

patients face unemployment post diagnosis with approximately loss of 32 days annually from work.[8]

Despite the adverse effects on QoL, dermatologists tend to concentrate more on physical manifestations rather than the psychological effects of the disease on patient.[9]

Counseling of patients with psoriasis is vital in the management of this disease. The clinicians should be empathetic and spend adequate time with the patients to educate them about psoriasis, steps to cope with the disease, and ensure adherence to therapy.[10] However, it is challenging to do so in routine clinical practice due to time constraints, lack of systematic training of clinicians, limited knowledge of patients regarding the disease and misplaced beliefs.[11]

A recent survey conducted amongst 19,000 physicians demonstrated that the time spent with patients, in general, depended on the practices, special needs, and working environments.[12] According to the Market Scan Medicaid database, the average time spent by the psoriasis patient's first visit to the doctor's clinic and till follow-up appointment is 153 days.[13]

Table 1: Studies conducted in India on patients with psoriasis.

Author name, year	Number of patients	Results
Kumar et al, 2016	30 patients and 30 controls.	Prevalence of metabolic syndrome, elevated glucose levels, higher triglycerides level, high waist circumferences, low HDL levels are higher in cases compared to controls
Sharma et al, 2016	100 patients, 100 control	Metabolic syndrome (38%; 12%), hyper-triglyceridemia (53%; 25%) impaired glucose tolerance (38%; 16%)
Ali et al, 2014	Not mentioned	Hypertriglyceridemia (59% vs 31%), abdominal obesity (45% vs 39%), hypertension (39% vs 34%)
Sharma et al, 2013	100 patients, 100 control	The 58 and 59 patients have metabolic syndrome according to ATP III and IDF criteria
Karoli et al, 2013	96 patients, 100 control	Higher prevalence of hypertension, diabetes mellitus, and metabolic syndrome. Flow-mediated dilation was lower in patients with psoriasis than control.

*All above mentioned studies are case control studies.

Without a permanent cure, psoriasis, is perceived as a lifelong burden for patient.[14] The review aims to evaluate importance of counselling and significant aspects needed to be considered while counseling a patient of psoriasis.

LIVING WITH PSORIASIS: PATIENT'S PERSPECTIVE

Psoriasis causes painful, debilitating, physical symptoms associated with psychological impairments. The negative self-perceptions of a patient with psoriasis are beyond the physical discomforts of the disease. If psoriasis is present on the face and hands, it becomes a cause of social stigma, anxiety, embarrassment, and low self-esteem.[15] Gupta et al found 9.7% of patients reported their wish to die, and 5.5% reported active suicidal ideation.[16] Lakshmy et al have reported that among a total of 90 patients, 78.9% had depression and 76.7% had anxiety, while 56.6% patients suffered from severe stress, suggesting a poor QoL. Concurrently, 16.6% patients reported that their QoL was "poor" to "very poor" and 35.6% of them reported "neither poor nor good."[17]

The professional life of a psoriatic patient is also hampered to quite an extent. In a survey of the national psoriasis foundation, US about 17% of total patients aged 18-54 have reported psychological effects in their workplace. Over 6% of employed people have reported that they have been discriminated professionally, and 23% reported that it affected their choice of career. Around 37% of all patients with psoriasis admitted on difficulties in going to school/college and work which consequently affects productivity and performance.[18]

Apart from the social life, the impact of psoriasis on the personal life is also inevitable, as many as 38% psoriasis patients agreed it negatively affected their sex life. About 53% of unmarried people admitted that they had difficulty in maintaining sexual relationships, whereas the same was seen in 30% of married people. Around 81% were of the psoriasis patients always worried, and 76% felt guilty that they might pass psoriasis to their progeny.[2] According to the world health organization (WHO), there were about 804,000 suicides due to psoriasis in 2012 worldwide.[19] A survey of psoriasis patients in UK revealed prevalence of depression in around 10,400 patients, anxiety in 7,100 patients, and 350 suicides attributable to psoriasis each year.

Patients also tend to resort to unhealthy practices such as alcoholism. Studies have demonstrated a higher prevalence of alcohol consumption in psoriasis patients. However, data on the direct association of the co-relation of alcohol use and severity of psoriasis is limited.[20]

The prevalence of alexithymia was reported to be 24.8% in psoriasis patients implying that these patients also simultaneously face a difficulty to identify, describe and communicate their feelings. It is predominant in females

as compared to males especially in cases where plaques extend to sensitive areas like face, hands, or genitals.[21]

TOOLS TO MEASURE QoL

Various tools and questionnaires have been developed to study the impact of the disease on the QoL of patients such as those presented in the table below (Table 2).[10]

An increase of more than 3-fold inpatient cost, 1.8-fold outpatient cost and 1.2-fold prescription cost have been reported among psoriasis patients with psychiatric disorders compared to psoriasis patients without psychiatric disorders.[22]

Table 2: Parameters to evaluate QoL.

S. no.	Parameters
1.	**Psoriasis-specific measures**
	Psoriasis disability index (PDI)
	Psoriasis area and severity index (PASI)
	Psoriasis index of QoL (PSORIQoL)
2.	**Skin-specific measures**
	Dermatology life quality index (DLQI)
	Questionnaire on experience with skin complaints
3.	**Generic QoL measures**
	Short form 36 (SF-36)
	Subjective wellbeing scale (SWLS)
	EuroQOL 5D
4	**Mixed QoL measures**
	Salford psoriasis index (SPI)
	Koo-Menter psoriasis instrument (KMPI)

PATIENT COUNSELING IN PSORIASIS

Communication between dermatologists and patients lays the very foundation of counseling. It enables the patients to open up and share their concerns. Counseling patients with psoriasis may help in improving their mental and social conditions. These sessions should be aimed at increasing personal control, overcoming negative thoughts, relieve stress, anxiety, depression associated with disease. Clinicians should encourage patients to express themselves, seek social support and avoid syllogism and maintain good feelings about themselves.[23]

Table 3: Verbatim that may help while counseling.

S. no.	Statements
1	It can happen to anyone
2	It is not you; it is the disease
3	It is not a contagious disease
4	You can live your life normally like everyone else
5	Open up more with close ones
6	Don't be shy to discuss your personal matters
7	Psoriasis isn't an infection/ or infectious,
8	Psoriasis is not curable but can be controlled like any chronic condition.

Management of day-to-day activities, socializing, and keeping themselves busy can aid in managing their long-term health conditions.[24]

Even before discussing on the various aspects of the disease, it is pertinent to be conscious about the verbatims used. Some of them have been listed in Table 3.

Once dialogue is initiated, different aspects of disease need to addressed to improve patient outcomes (Table 4).

Table 4: Questions that needs to be addressed during patient counseling pertaining to the disease and patient's life.

Variables	Questionnaire
Disease-related	What is psoriasis?
	Are there different types of psoriasis?
	What causes it? Is it hereditary/genetic?
	Why this happened to me?
	Can psoriasis affect any part of my body? Can it spread to other parts of my body?
	Are there any lifestyle changes that I should make to improve my psoriasis
	Symptoms?
	What is the difference between psoriasis and eczema? Is it possible to have both at the same time
	Will climate affect/exaggerate condition?
Social life	Is it contagious? Am I untouchable?
	Will I be socially accepted?
	I feel humiliated in gatherings. What do I do?
	Do I have to live with it all my life?
	How should I deal with people who do not want to sit beside me?
Personal life	Will it affect my relationships?
	Will I be able to get married?
	What are the chances of disease getting transferred to my kids?
	Will intimacy affect my partner?
	How do I explain it to my family?
Profess-ional life	Can I Continue to work?
	Do I need to tell my employer?
	Do I need to avoid going to conferences, meetings, and offices?
	Am I prone to other diseases if I go out?
	Can I frequently travel as I am in marketing?
	Will I lose my job if the disease will come back again?
Economic impact	What would be the monthly/annual cost to manage my disease?
	Do I have to take the treatment regularly?
	How long do I need to take treatment?
	Will it require hospitalization if the disease severity increases?

In addition to above questions, it is extremely important to have discussion on lifestyle modifications (Table 5).

Table 5: Discussion on lifestyle changes and modifications to be addressed.

Variables	Lifestyle changes
Exercise	Type of exercised
	Duration of exercises
	Outdoor vs indoor workouts
	Encourage meditation and Yoga
	Weight loss and impact on response to therapy
Diet	Need for balanced diet
	Healing spices
	Avoid acidic food
Alcohol and smoking	Is alcohol consumption associated with increased severity of disease?
	How much alcohol can I drink on a daily basis?
	Is there any other precaution I have to take with alcohol?
	Does alcohol interact with medicine for psoriasis?
	Does smoking exaggerate psoriasis condition?
	If I quit smoking, does it change my condition?

TREATMENT CONSIDERATIONS

Since psoriasis can be controlled and not permanently cured, it is important to have in-depth discussion on the treatment aspects with the patients. Treatment should be based on a collective decision between the dermatologist and the patient. Although, from a dermatologist's perspective, treatment is based on the location and the severity of the disease, it is important to understand what the patients wants and expects from the treatment.[25]

Table 6: General discussions on treatment options.

S. no.	Common topics
1	How severe is my psoriasis as compared to others?
2	Can you tell me why you have decided to offer me this particular type of treatment?
3	What are other treatment options available?
4	What are the risks and benefits of this treatment?
5	How fast will the treatment act?
6	Is there any other treatment that I should not use while using this treatment?
7	What should I do if there is no improvement?
8	Will dose of my current treatment be changed over time? Do I need to do any lab tests frequently?
9	Do I need to stop therapy if I am planning to get pregnant?
10	Is it safe to use during pregnancy/ breast feeding?
11	Is there some other information (like a leaflet, CD/ a website I can go to) about treatment I can have?

The primary goal of psoriasis treatment is to achieve skin clearance. According to NICE, there are a number of general questions raised by patients based on different treatment options (Table 6).[26]

The following are the treatment specific questions described in (Table 7) raised by patients based on different treatment options such as topical, phototherapy, and systematic therapy.

Table 7: Frequently asked questions related to different treatment.

Variables	Frequently asked questions
Topical treatments	How do I apply the topical treatment you have prescribed?
	How many days will I have to apply the treatment? How will it affect my plaques and surrounding skin?
	Should I wash my hands after applying the treatment? What should I do if my hands are being treated?
	When should the treatment be reviewed?
	Should my child take treatment to school to use after games or swimming lessons?
Phototherapy	How often and for how long will I need phototherapy treatment?
	How many courses of phototherapy can I have?
	Can I sunbathe on holiday if I have just had a course of phototherapy?
	Should I use topical treatments at the same time as receiving phototherapy treatment?
Systemic therapy (conventional drugs/ biologics)	What are the possible side effects of this treatment?
	Google says these drugs are immunosuppressants. Does that mean I can get other diseases?
	Why the pre-screening tests?
	What if a dose is missed?
	Will it interact with my other medicines?
	How long can I use it?

Over 40% of total patients do not adhere to the prescribed treatment due to multiple reasons. The most critical factors that contribute to patient's non-compliance include treatment burden and failure to achieve skin clearance. Medicines used for the treatment of psoriasis are quite expensive, may have to be used lifelong, and are not financed by universal health coverage schemes. Treatments for psoriasis are either unavailable or not reimbursed in many countries, even on those who are listed among the WHO model list of essential medicines. The recent advancement in the treatment of psoriasis has expanded the options for the patients and physicians both,

but it has also led to a higher cost than traditional systemic medications and phototherapy.

Another significant reason for the patient's non-adherence is the recurrence of the disease or the adverse effects due to medications, which may be disheartening for the patients.[27]

In order to improve compliance, patients should be evaluated for an appropriate treatment response at dedicated intervals. Further, the patients should be encouraged to contact dermatologists if they are experiencing any untoward effects.[27,28]

It is important to encourage patients to live their life to full potential. Dermatologists should encourage their patients to join support groups or patient advocacy so that they could share their feelings with other patients. This can help patients associate with others who have a similar disease and also motivate them to live a better life. In India, these groups can play key role by working in areas like effective communication and collaboration with patient and their families, supporting healthcare research, collaboration with government agencies and sensitize the media for mass awareness.[29] Moreover, the clinician should discuss and counsel the patient's family regarding the non-contagious nature of psoriasis in order to reduce the negative impact on the QoL.[30]

Limitations

The government needs to take the proper steps to combat the stigma of psoriasis and myths related via campaigns on local mass media. This as well as the inclusion of the treatments in universal health coverage schemes and insurance would help ensure affordable treatments.[31,32] There is a need of high psychiatry referrals for psoriasis condition in India.[33] The psychological counselling should ideally be a separate topic in itself in the dermatology postgraduate education, to sensitize and train budding dermatologists. Psycho-dermatology which is an emerging aspect in the India and can probably be taken up in the clinical practice by the dermatology fraternity with more enthusiasm; liaison between dermatology and psychiatry specialists will be a step in this direction and they will ultimately help in the bettering patient outcomes.

CONCLUSION

The future of psoriasis management is a multi-disciplinary approach with dermatologists, in collaboration with other specialties such as rheumatologists, psychologists etc., depending upon the comorbidity involved. Psoriasis, requires high psychiatry referrals even in India and hence, the role of counselling cannot be overemphasized. It plays a paramount role in setting up the focused individualized discussions around the disease as well as the treatment.

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REFERENCES

1. Dogra S, Yadav S. Psoriasis in India: Prevalence and pattern. Indian J Dermatol Venereol Leprol. 2010;76(6):595.
2. WHO. Global report on psoriasis. 2016.
3. Reich K. The concept of psoriasis as a systemic inflammation: implications for disease management. J Eur Academy Dermatol Venereol. 2012;26:3-11.
4. Larsen MH. Educational and self-management interventions for patients with psoriasis in the context of climate/heliotherapy. 2015;73-9.
5. Dogra S, Mahajan R. Psoriasis: Epidemiology, clinical features, comorbidities, and clinical scoring. Indian dermatol online j. 2016;7(6):471.
6. Belge K, Brück J, Ghoreschi K. Advances in treating psoriasis. F1000Prime Rep. 2014;6:4.
7. De Korte J, Mombers FM, Bos JD, Sprangers MA, editors. Quality of life in patients with psoriasis: a systematic literature review. J Investig Dermatol Symp Proc. 2004;9(2):140-7.
8. Murlidhar R, Chatterjee M, Abhishek D, Dogra S, Ganguly S, Kar BR et al. ACTNOW: Therapeutic Inertia in management of psoriasis and its impact on patients. Maui Derm Conference. 2021;12(5):674-82.
9. Kubota K, Kamijima Y, Sato T, Ooba N, Koide D, Iizuka H et al. Epidemiology of psoriasis and palmoplantar pustulosis: a nationwide study using the Japanese national claims database. BMJ open. 2015;5:1.
10. Sarkar R, Chugh S, Bansal S. General measures and quality of life issues in psoriasis. Indian dermatol online j. 2016;7(6):481.
11. Bhosle MJ, Kulkarni A, Feldman SR, Balkrishnan R. Quality of life in patients with psoriasis. Health quality life outcomes. 2006;4(1):35.
12. Debra Wood R. Average Time Doctors Spend With Patients: What's the Number for Your Physician Specialty? Medscape's 2017 Physician Compensation Report. 2017.
13. CORPORATION C. Why People with Plaque Psoriasis Should See Their Doctors Frequently. Responsibility Psoriasis. 2018.
14. Hägg D, Sundström A, Eriksson M, Schmitt-Egenolf M. Severity of psoriasis differs between men and women: a study of the clinical outcome measure psoriasis area and severity index (PASI) in

5438 Swedish register patients. Am J Clin Dermatol. 2017;18(4):583-90.
15. Kurd SK, Troxel AB, Crits-Christoph P, Gelfand JM. The risk of depression, anxiety, and suicidality in patients with psoriasis: a population-based cohort study. Arch dermatol. 2010;146(8):891-5.
16. Gupta MA, Schork NJ, Gupta AK, Kirkby S, Ellis CN. Suicidal ideation in psoriasis. Int j dermatol. 1993;32(3):188-90.
17. Lakshmy S, Balasundaram S, Sarkar S, Audhya M, Subramaniam E. A Cross-sectional Study of Prevalence and Implications of Depression and Anxiety in Psoriasis. Indian J Psychol Med. 2015;37(4):434-40.
18. Wu Y, Mills D. Bala M. Impact of Psoriasis on Patients' Work and Productivity. AM J Clin Dermatol. 2009;10:407-10.
19. Rodriguez-Bolanos F, Gooderham M, Papp K. A Closer Look at the Data Regarding Suicidal Ideation and Behavior in Psoriasis Patients: The Case of Brodalumab. Skin Therapy Lett. 2019;24:1-4.
20. Svanström C, Lonne-Rahm S-B, Nordlind K. Psoriasis and alcohol. Psoriasis (Auckl). 2019;9:75-9.
21. Panasiti MS, Ponsi G, Violani C. Emotions, Alexithymia, and Emotion Regulation in Patients With Psoriasis. Frontiers Psychol. 2020;11:836.
22. Cai Q, Teeple A, Wu B, Muser E. Prevalence and economic burden of comorbid anxiety and depression among patients with moderate-to-severe psoriasis. J Med Economics. 2019;22(12):1290-7.
23. Uttjek M, Nygren L, Stenberg B, Dufåker M. Marked by visibility of psoriasis in everyday life. Qualitative health res. 2007;17(3):364-72.
24. Day DD. 10 Questions Your Dermatologist Wants You to Ask About Psoriasis. 2020.
25. Boehncke WH, Anliker MD, Conrad C, Dudler J, Hasler F, Hasler P et al. The dermatologists' role in managing psoriatic arthritis: results of a Swiss Delphi exercise intended to improve collaboration with rheumatologists. Dermatology (Basel, Switzerland). 2015;230(1):75-81.
26. Psoriasis?" AAoDWi, National Psoriasis Foundation: "Itch Relief YDaPMOW-B," "Sunlight and Other Psoriasis Treatments," "Time to Kick the Habit? Thinking Twice About Alcohol and Cigarettes.". Questions to Ask Your Doctor About Psoriasis Treatments WebMD Medical Reference. Available at: https://www.webmd.com/skin-problems-and-treatments/psoriasis/questions;. Accessed on June 20, 2019.
27. Truong B, Rich-Garg N, Ehst B, Deodhar AA, Ku J, Vakil-Gilani K et al. Demographics, clinical disease characteristics, and quality of life in a large cohort of psoriasis patients with and without psoriatic arthritis. Clin cosmetic investigational dermatol. 2015;8:563.
28. Nazeer M, Ravindran S, Gangadharan G, Criton S. A survey of treatment practices in management of psoriasis patients among dermatologists of Kerala. Indian Dermatol Online J. 2019;10:437-40.
29. Shah K and Garg S. Patient advocacy groups: Need and opportunity in India. Perspect Clin Res. 2011;2(1):4-7.
30. Feldman SR, Burudpakdee C, Gala S, Nanavaty M, Mallya UG. The economic burden of psoriasis: a systematic literature review. Expert review of pharmacoeconomics outcomes res. 2014;14(5):685-705.
31. National health portal. Psoriasis. Government of India. Available at: https://www.nhp.gov.in/ disease/skin/psoriasis. Accessed on: December 23, 2020.
32. Lakuta P, Marcinkiewicz K, Bergler-Czop B, Brzezińska-Wcisło L. How does stigma affect people with psoriasis? Adv Dermatol Allergol/Postępy Dermatol Alergol. 2017;34(1):36.
33. Hafi B, Abdul Latheef EN, Uvais N. Awareness of psychodermatology in Indian dermatologists: A South Indian perspective. Dermatologic Therapy. 2020;33:e14024.

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