

Tips for Helping to Alleviate the Psychosocial Issues of Psoriasis

Author:

Richard G. Fried, MD, PhD



Both clinicians and patients living with psoriasis know that the chronic and capricious disease can have deleterious effects on the psyche. The literature is replete with studies that substantiate the contention that psoriasis has negative effects on the way patients feel and function. Depression, anxiety, anger and feelings of futility and helplessness are commonly reported by those afflicted with psoriasis.¹⁻³ They are often sad, mad and anxious about the way their skin looks, feels and behaves. Pruritus, burning, pain and other dysesthetic symptoms are frequently reported. The unpredictable nature of flares leaves patients feeling vulnerable and lacking in control, a combination fraught with opportunity for psychological pain. In addition, from a functional perspective, psychosocial and vocational impairment are more commonplace among psoriasis patients. New research elucidating the medical comorbidities including coronary artery disease and diabetes^{4,7} further burden those with psoriasis with a Damocles-like harbinger of future medical illness.

The utility of an article on the negative psychosocial issues associated with psoriasis is not simply to substantiate their existence. In some ways that would be akin to validating the assertion that a group of patients have debilitating pain with ambulation but offering no suggestions for intervention or amelioration. This article provides several concrete suggestions to help clinicians and patients to enhance their emotional well-being and clinical outcomes.

Therapeutic Alliance-Mutual Development Agreement

There is little doubt that a therapeutic alliance characterized by patient belief that their clinician is competent, caring, understanding and compassionate increases the likelihood of medication adherence, positive therapeutic outcome and patient satisfaction. This is quite a tall order to accomplish in the brief minutes allotted in the typical patient encounter.

A few key ingredients necessitating little elongation of the actual encounter can often be efficacious in achieving this therapeutic alliance coveted by most patients. A smile, a few seconds of eye contact and the physical touch of a handshake are crucial elements to initiate the cascade of acceptance and warmth desired by both clinician and patient. Simple and clear empathic statements such as "I know living with psoriasis can be very difficult" or "I am sure it must be very frustrating and upsetting at times to deal with the demands and intrusions of psoriasis" can be extremely effective in exhibiting to patients that you are sensitive and understanding and that you are one of those doctors who "get it."

A very brief explanation of the pathogenesis of psoriasis accomplishes several things. It substantiates for the patient that you are indeed an up-to-date psoriasis expert and also that you view them as intelligent enough to be offered an explanation of their disease. Quickly explain that it is known that psoriasis is a condition where molecules called cytokines are released in the skin causing the skin cells to turn over at a much more rapid rate than normal causing elevation, redness and flaking. The clinician might say, "These molecules with odd sounding names such as tumor necrosis factor, interleukin 17, interleukin 23 and many others specifically instruct your skin to misbehave in this fashion. We have learned so much about psoriasis, but still have to figure out why it is happening in these spots in your skin. The good news is that we have so many effective, new and emerging treatments for psoriasis that alone or in combination are better than ever."

This can help provide a better understanding of what is happening in their skin together with an optimistic outlook for their future. Mission accomplished! When well-rehearsed, this entire process takes approximately 2 to 3 minutes. To borrow an advertising slogan from a clothing retailer, "an educated consumer is our best and most satisfied customer."

Addressing Self-Talk

Cognitive behavioral psychologists and psychiatrists contend that “self-talk” is a more important determining factor of how we feel than the actual objective events in our life. Self-talk is the ongoing internal dialogue or what I call the “background noise” that is ever-present throughout our waking hours.

“Catastrophizing” self-talk such as “it would be awful,” “I can’t stand it when,” “it is horrible” and “it is the most horrible thing that could happen to me” are the cognitive perpetrators of negative feelings, negative interpretations and psychosocial impairment. These “awfulizing” and “catastrophizing” proclamations are repeated over and over internally and often become integrated as mantras leaving no room for other interpretation. Specifically, a common internal mantra of “I can’t stand it when I have psoriasis on my elbows, it is awful, it controls my every moment and ruins any chance at happiness that day” is indeed a rigid prescription and near guarantee that the occurrence of psoriasis for that individual will “ruin” their likelihood of experiencing happiness or pleasure. This can be an unrecognized self-imposed punishment.

While I recognize that the dermatologic clinician is not a cognitive behavioral psychotherapist in the usual structured and organized fashion, I do believe that we do have the power to modify the severity of this “self-defeating self-talk.” Most of us recognize that actions can speak louder than words. For example, gently touching or stroking a psoriatic plaque while examining the patient is a huge psychocutaneous intervention. Simultaneously, explaining that the vitamin D analog or topical corticosteroid that we are prescribing will slow their skin cells down and reduce inflammation conveys a powerful message of acceptance and can help diminish the patients’ feelings that they are ugly or even repugnant to others. Providing samples or a prescription for higher potency corticosteroid for “angry skin days” can enhance feelings of control and decrease anxiety. Telling patients that they have the opportunity to schedule an “emergency visit” for intralesional triamcinolone injection provides additional feelings of control and hope that can be used to internally refute the pessimistic and doomsday self-talk.

Encouraging dialogue and sensory exchange through “skin talk” can be an interesting idea for the patient and therapeutically useful. Application of topical medications is often distasteful for patients. It is a time intrusion, sometimes cosmetically messy and most of all forces patients to face their psoriasis plaques. “Out of sight out of mind” is often a preferable strategy (albeit ineffective unless receiving ultraviolet (UV) light or systemic therapy). Skin talk during topical application involves asking patients to silently repeat a new mantra consisting of 3 words: allow, restore and refresh. Using an analogy of rebooting the computer when it is misbehaving, the gentle strokes and effective ingredients within their topical preparation can allow the skin cells within a given plaque to restore and refresh their proliferative activity to a more normal rate. I have often asked patients to be a bit less judgmental and be a bit nicer to their skin. The few seconds of gentle touch during application do in fact allow for some degree of therapeutic touch and self-acceptance.

Concrete, reality-based self-talk regarding emerging therapies and improved efficacy of existing treatments can further diminish negative self-talk, negative emotional reactions and decrease inflammatory physiologic stress reactions.

Explanatory euphemisms for psoriasis also can be helpful for both the patient as well as others who are unfamiliar with the disease. “Fast skin, runaway skin, excited skin, happy skin, too comfortable to flake off skin and snowflake skin” are a few of the explanatory euphemisms I have heard patients use to alleviate the anxiety of others. I used to believe these were only helpful for children, but am now convinced they can be helpful for adults as well.

When suggesting these euphemistic descriptors to patients, I make it clear to them that I am not minimizing nor diminishing the seriousness of their skin problem. It does both directly and subliminally reinforce that psoriasis is not a premalignant, malignant, infectious skin disease and they are entitled and need human touch (their own and ideally others).

Modulation of Dysesthesias

Troubling, subjective dysesthetic symptoms accompany the clinically objective lesions of psoriasis in some patients. These dysesthesias are intrusive in their own right, but also represent a source of anxiety for some patients; they are fearful or interpret them as signs of infection, infestation or malignancy.

Asking patients about the presence, type and severity of dysesthesias is important. Assuring them that they are common and not harbingers of illness can sometimes diminish the severity and intrusiveness of the symptoms by simply allowing them to become less preoccupied and defocus their attention from the sensation.

Further, providing topical or oral agents to ameliorate this instance such as topical corticosteroids, topical calcineurin inhibitors, lidocaine cream, topical doxepin, topical amitriptyline, oral antihistamines, oral doxepin, oral amitriptyline, selective serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors and antiseizure medications can be important and helpful.

Stress-Inflammation Modulation

Stress management techniques and interventions have been shown to benefit psoriasis patients. Improvements in clinical outcomes and quality of life have been consistently demonstrated. Specifically, they are believed to diminish the inflammatory response via both central and peripheral effects. These interventions can be conceptualized as “steroid sparing” and “UV sparing” modalities because studies have demonstrated decreased steroid use and reduced total UV exposure when modalities, such as mindfulness meditation, progressive muscle relaxation, cognitive behavioral psychotherapy, yoga, tai chi and biofeedback have been used as concomitant complementary therapy.⁸⁻¹⁰

In previous decades, these interventions were believed by many simply to be “feel good interventions” making patients feel better and thus, have the focus, energy and sufficient degree of optimism to adhere to their medical regimens. However, their usefulness and efficacy is now better understood to be a combination of self-regulation, insight, cognitive restructuring and physiologic training, together with the direct modulation of the inflammatory cascade.

Exploring the Landscape

Many patients are confused, overwhelmed and cynical regarding their short- and long-term prognosis. They are frequently fearful of treatments and tired of the emotional roller coaster of elevated hope and expectation followed by clinical disappointment or recurrence. Leaving the therapeutic encounter with 2 prescriptions can be daunting. Suppose they are minimally effective or even make the psoriasis worse? Is the patient then left with the assumption that this was the last hope and they are now doomed to a lifetime of worsening and crippling psoriasis?

This scenario can be easily avoided with a simple brushstroke painting the landscape of therapeutic opportunities. Assure them that this landscape is replete with effective, gentle and new treatments that can be used to help them reach their satisfaction threshold of clinical control. For some, that threshold is a Psoriasis Area and Severity Index 75. For others, it is control of pruritus or minimization of visible lesions on the dorsum of the hands. This assurance of options and adequate control of disease is a significant gift for many patients. The heartfelt belief and reassurance that we will be there to hold and guide their hands through the plethora of therapeutic choices is a powerful intervention in its own right.

Conclusion

The negative psychological sequelae of psoriasis are well-recognized and appreciated. The reciprocal interaction of skin and psyche is better understood and support the incorporation of psychocutaneous techniques into clinical practice. It can be argued that all clinician–patient interactions have psychocutaneous components and repercussions. Using simple behaviors, targeted comments and specific treatment recommendations can improve subjective symptoms, clinical expression of psoriasis and quality of life.

Dr. Fried, who is a psychologist and dermatologist, is clinical director at Yardley Dermatology Associates in Yardley, PA.

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Sidebar:

Doctor–Patient Relationship Impacts Psoriasis Outcome

Sabrina Skiles, 30, of Houston, TX, talked to *The Dermatologist* about her psoriasis journey. “I was diagnosed with psoriasis in 2001 when I was a junior in high school. I knew a little about the disease because my mom had it. She was diagnosed at the same age I was,” she recalls.

When psoriasis first appeared on her elbows, Sabrina researched dermatologists who specialized in psoriasis in Houston and then went for her appointment. “It was great to have the dermatologist sit down with me and explain the disease and how it was affecting my immune system. She explained the current treatments that were available at the time,” she says.

Soon after seeing the dermatologist, the psoriasis spread to about 90% of Sabrina’s body. On her doctor’s recommendation, Sabrina began using tar baths for her entire body. “Although it was messy, it was very helpful and it worked. It cleared my entire body and it is very rare to find something that works this well,” she says.

Remission lasted for several years, with periodic flare-ups brought on by the stress of college. “My dermatologist then suggested biologics. I educated myself and I wasn’t too crazy about the side effects. I tried it for about 5 months and it pretty much cleared me. Then I stopped using them because of a change of insurance,” she explains.

While Sabrina experienced a period of remission, she moved to Maui, HI, in 2009 with her husband. “I had known that the environment has a lot to do with psoriasis, and so I was encouraged to know that the sun and environment would hopefully be helpful and it was. I didn’t see any flare-ups or triggers in Maui,” she says noting that she did not use many treatments while on the island.

In 2012, the couple moved to Seattle, WA. “Within 2 months of living in Seattle, I had a flare-up. I was stressed. I didn’t have a job. It was cold and rainy and I started making notes that environment was a big effect for me,” she says.

Sabrina located a Seattle dermatologist who specialized in psoriasis and she suggested light therapy for her severe scalp psoriasis. “Within a few weeks of the light therapy, I was almost 90% clear of the scalp psoriasis. I was a completely different person and it was just great to talk to her,” she says.

Sabrina now lives in Houston and her most recent dermatologist has suggested she restart light therapy. “I am excited to try that again,” she says.

Overall, Sabrina explains that it was key that the dermatologist took the time to ask what treatments she had been on before, how happy she was with the treatments and what she wasn’t happy with. The dermatologist asked about quality of life. “I realized it is important to be really open with my doctor — what kind of stress I am under, any big event in my life and quality of life,” she says.

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