Would You Have Realized?

Learning is a game. In this sense, Dermatology + Psychosomatics regularly presents the Psychodermatology Quiz. Other colleagues are welcome to submit their own contributions.

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Case Description

Mrs. N., 60 years old, is admitted to the Center for Skin Diseases for diagnostic clarification and further therapy of ulcerous excoriations in the face, some of which are deep. The symptoms have existed for about 15 years, numerous attempts by dermatologists with various disinfecting topical applications have been unsuccessful. In addition to numerous facial scars, admission examination revealed 0.5 cm deep and 1.5 × 0.5 cm fibrinous-coated ulcers with indurated surrounding tissue on both sides of the chin, which had been present for about 2 months. Overall, there had been itching skin changes in the face for 10–15 years, whereby the patient had the feeling that the changes ‘came from within’.

The examining ward physician, who requested psychosomatic consultation service, quoted other striking sentence fragments uttered by the patient, which caught his attention. ‘Strictness’, ‘Why me?’, ‘It has to be fought’. He included questions on chronic tactile hallucinosis in the differential diagnosis.

In the psychosomatic consultant contact the slender patient, who appeared burned out and exhausted, described the course of her illness. It has been intermittent for 10–15 years, or maybe longer. Somehow or other, she always dealt with it, fought it. Then it would break out again. It is very unpleasant, because people comment on it. If she remembers right, it could have appeared for the first time when her only son was born, 33 years ago.

She then quickly starts to relate how she never has any time for herself. The family has a small printshop, which can hardly hold its own against large companies. The company is actually only maintained because her son would like to take it over. While she is telling this, she displays motoric restlessness, appears hectic. When I ask her about this, she says ‘Well, when I

think of everything I could be doing while I’m here in the clinic.’

Since I assume that her manipulative behavior can be addressed consciously, I ask her directly about the course: an inflamed hair is, for example, an elicitor. ‘Whatever is in there doesn’t come out’ when she pulls the hair. ‘It’s as though it has roots. It must come out’. She then belabors the skin for 30–60 minutes with tweezers and broods on how she could solve her problems. Her comment: ‘I never have time, but I do have time for that.’ She then further describes her social situation. Her husband always had to work long hours, he has to make a go of it. She herself is not like that, but rather tends to daydreams. The reward for the work is the little house, but the price was that all social contacts got short shrift. She has begun only recently to renew old friendships. Her husband is bossy, stubborn, and impulsive. She has had to fight against that from the start. She often feels deserted. They never do anything together.

Mrs. N. is grew up with two sisters in materially deprived conditions. Her father was always dissatisfied, he could never use his creative talents as a cabinet maker. She suffered from the feeling that she wasn’t worth much, since she was a daughter.

At this point, it was possible to indicate to Mrs. N. that, these days, she is as little valued by her husband as in her childhood, that material security has always had to take first place in her life, and that she herself, like her father before her, had too little possibility to develop her artistic side. I also pointed out that she used similar words: she fights with her skin and also with her husband. Now, since the birth of her son (?), she has to give way to her son’s plans for the future, although she feels that she simply doesn’t have the strength and hasn’t had for some time.

Questions

- 1) Which initial impression, including your own thoughts and feelings, point to the importance of psychosomatic factors?
- 2) Which psychopathological diagnosis would you make?
- 3) What conflicts can be cited? What forms of defence can be assumed?
- 4) What therapy would you recommend?

Answers

1) Primarily, it is the therapy-resistant presentation of excoriations up to and including ulcerations, as well as the protracted course which are atypical for any other disease, which attracts the examiner's attention to an artificial process and thus raises the question of psychosocial stress situations. Then the question immediately arises as to the extent to which the patient herself is aware of this self-destructive behavior. The striking choice of words 'we've got to fight it' supports in fact the question of delusional symptoms. Many patients with dermatozoic delusions use a similar form of expression when they describe their desperate attempts to rid their skin of the 'little pests'. This patient, on the other hand, described more a desperate retreat. It is the only time she has for herself. She couples the skin manipulations with problem-laden topics, which she attempts to cope with cognitively.

2) The social stress factors are clear in the extended psychosomatically oriented discussion. Neurotic excoriations (paraartefacts) ICD L98.1; impairments of impulse control ICD F 63.9.

3) The patient initially emphasizes the feeling that she has no time for herself, is always under pressure to achieve and to sacrifice herself for others. Her experience of being passively at the mercy of events can be seen in her saying that it 'breaks out'. She is in the conflict situation of wanting to be separate from her closest reference persons and lead her own life, while on the other hand wanting to stick together, pass material achievements on, and not wanting to leave the self-chosen structures. She cannot find a solution.

She holds the men responsible: her father in the past, then her achievement-oriented husband, then the son, for whom she must still work. Her own fear of doing something autonomously for herself is deflected by compulsive diligence ('what I could have done during this time') and rigid patterns of behavior. Her own need is denied. The patient cannot deal constructively with aggression. It can be assumed that the desire to rebel is accompanied by feelings of guilt and aggression and turns inward against itself in a self-destructive way.

From a behavior-therapeutic point of view, coupling of an initially indifferent behavior, in the form of a first expression of skin impurities, with tension and problem-laden situations can be assumed. The dependency-type behavior, which is mean-

while automatized has taken on a tension-reducing character and thus fulfils a relief function for a short time. The experience of being at the mercy of the disfiguration contributes to further depressive behavioral patterns.

4) A supportive local dermatological therapy is indicated as a flanking measure, but cannot supplant psychotherapeutic intervention. The first step, as described above, is to make the patient conscious of a biopsychosocial model of disease which enables her to seek professional help without feeling guilty. A conflict of goals can be expected, since her own desire for autonomy and the pressure of expressing arising aggression outwardly are not in accordance with the apparently successful behavior applied for a number of years in dealing with conflicts and the inner attitude of subjection.

Since the relationship between manipulations and cognitions, which relate to problem solving, is also apparent to the patient, and she has already initiated changes on her own at the behavioral level (resuming old social contacts) I would prefer making a behavior-therapeutic approach which, starting from analysis of problem behavior could be expanded, if appropriate, in the sense of an integrative thinking model, which re-constructs unconscious conflicts.

In behavior therapy, the following problems may arise with respect to the skin (independent of this, there are goals which are not related to the skin): Problem behavior and unfavorable coping strategies for social stress factors, alternatives for tension reduction, feelings of disfiguration with avoidance and retreat behavior and further potentiation of the depressive reaction, conflict avoidance behavior and adequate expression of anger ('Not having to fight with the skin any more'). Such a therapy can be made on an outpatient basis or begun in hospital, which would have the advantage that the patient would really be less stressed at least for a limited time.

Key Learning Points

Problem- and Behavior Analysis in Behavior Therapy

Starting from a differentiated exploration of the patient and a systematic self- or possibly also outside observation (baseline), behavioral patterns, accompanying thoughts, emotions, and physical reactions are set in relation to an eliciting stimulus, and to the resulting consequences, which maintain the process. In the total assessment, both the persistent cognitive schemata (e.g., 'I always have to take care of the family, night and day') and the Ego-structural aspects (e.g., compulsive personality) and physical disposition play a role. The degree to which behavioral patterns applied thus far were dysfunctional and what alternative modes of behavior are available is worked out on a conscious and observed level in cooperation with the patient.

Ego-structural Disorder

Ego-functions are activities of the Ego, which a person can use in dealing with his inner self and his environment. Among these are the capacity for introspection, test of reality, capacity to distinguish between inner and outer, affect tolerance and affect control, anxiety tolerance, frustration tolerance, impulse control, sublimation capacity, anticipation and judgment capacity.

In an Ego-structural disorder, parts of the Ego-function are inadequately developed and thus prevent successful coping with life and conflict.

Suggested Reading

- Gieler U, Stangier U, Brähler U (Hrsg): *Hauterkrankungen in psychologischer Sicht. Jahrbuch der Medizinischen Psychologie*, Bd 9. Göttingen, Hogrefe, 1993.
- Fruensgaard K: Psychotherapeutic strategy and neurotic excoriations. *Int J Dermatol* 1991;30:198–203.
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