Would You Have Realized?

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

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Case Description

Ms. L., a young woman in her thirties, is hospitalized in the day clinic of the dermatological department because of serious excoriations, especially in the face (acne excoriée) and the sternal region. She remembers having first symptoms at the age of 11, and is able to differentiate between normal acne papules and the efflorescences she presents with. Hospitalization was necessary because with her really demanding job she could not find time to regularly visit a dermatological practice, e.g. for therapy with ultraviolet radiation.

The ward physician describes excoriated papules and small scars in the face, but also on the upper trunk of the patient, and macular hyperpigmentations on the patient's cheeks, behind her ears, and on her neck. The patient suffers from itching and pricking paraesthesias, getting worse when she gets some peace. The pruritus stops when the patient scratches her skin until it bleeds. Somatic therapy includes PUVA and topic anti-inflammatory and preserving ointments. There were no pathological laboratory findings. Allergologic diagnostics were done without evidence of atopic diathesis.

Ms. L. asks for psychosomatic consultation because she read in the internet about excoriations and psychic connections. When she enters the room, she creates an atmosphere of somewhat cheerful activity, not waiting for any questions. She presents her considerations, and that she indeed can not find any correlation between her skin reactions and stress. It seems that on the one hand she realizes that she is responsible for the manipulations, on the other hand she is not able to describe in which situations she is scratching or pinching her skin. She summarizes: 'I am not sure what it would feel like if I had no skin disease. I live with it for such a long time now, it belongs to me. My mother had similar skin reactions, and with all her problems I can understand it could be psychosomatic, but me?'

She is asked about her life, her job, about biographic details. Ms. L. says that she was a 'difficult child'. She had been tall,

hyperactive and very vital. Her mother had always been overtaxed with her. She remembers that she had to be very independent already at the age of six. For example, she had to take the bus to her physiotherapy without assistance. She often had been anxious; but she also remembers that she wanted to be independent. During the dialogue she points out that she had a very aggressive, dominant grandfather, who had determined the familial climate – she had always felt torn between him and her mother. Asked about more details of the relationship to her mother, she can not really answer, it seems as if the connection is cut. Ms. L. has a very busy job in a profession dominated by men. She does not have a partner or family. During the weekends she works with drug addicts, emphasizing a Christian attitude.

Ms. L. is given some general explanations about the connections between anger and compulsive skin picking, about the stress reducing part of this behavior, about children who occupy themselves with their skin or their hair when they are alone ('Oh, I have done that, curling my hair, for years'), unconsciously searching the contact to a mother, she is informed about scratch control mechanisms, habit reversal, and cue-controlled relaxation. Although Ms. L. seems to be very interested she summarizes after one hour: 'There is indeed nothing I haven't already thought about, I mean, there is nothing really new for me'. At this moment anger arises in the countertransference of the psychosomatic consultant and has to be reflected not only as an objective insult after all the efforts of the consultant but also as a sort of message that might give a hint for psychodynamic considerations. The patient is told that she seems to be caught between her wish for independence and her helplessness. It might have been very important during her childhood to look after herself but that at the moment she isolates herself by not accepting help from others. Perhaps between her and persons she relates closely to some sort of entanglement develops, creating anger. Ms. L. stops talking. For the first time she is listening. And then she adds: 'Always when I meet my mother I feel weak, insufficient, without any

own opinion. I don't know how it happens, but then I'm doing things I never wanted, I buy clothes I never wear.' There is enough time left to talk about possibilities to give her relief.

Questions

- 1) Which psychopathological diagnosis would you make?
- 2) Could you formulate psychodynamic considerations?
- 3) What is your therapeutic recommendation?

Answers

- 1) Neurotic excoriations, Acne excoriée F 69.0
- 2) Already at the first moment of the meeting Ms. L. demonstrates her extraordinary need to be independent by presenting her own considerations and rejecting questions and answers of her interlocutor. She seems to conceal that she is rattled. She does not expect anybody to help her. She tries to develop her own opinion – but only by negotiating 'the news' – at the same time she feels unhappy not to be able to find her own hypothesis, own observations. She creates a situation in which other doctors probably would have been overtaxed with 'the difficult child' she says to have been for her mother. By rendering useless the explanations and the recommendations of the psychosomatic consultant she is unconsciously identifying with her dominating grandfather. The main affects – anger and helplessness – are felt at the end of the talk: The skin seems to serve as an 'object', through which it is possible to express anger and wishes of delimitation: she hurts herself instead of acting out the conflict with the ambivalently loved mother. This 'solution' decreases her inner tension. The overtaxed mother often had not been able to reduce this diffuse tension in her child, she could not find appeasing words, a soothing action. She had been unable to react empathically, to achieve affect attunement. When growing older the child's tension is reduced by psychosomatic reactions or, as in this case, by tension reducing behavior. Regarding attachment theory Ms. L. has developed an avoidant attachment behavior, distrusting the effectiveness of social support but instead creating a positive view of herself by emphasizing her independence. Avoidance of intimacy is associated with underlying insecurity (remember Ms. L. has no partner).
- 3) There are different possibilities. After the patient had not only 'understood' what the consultant tried to explain, but had 'felt' the connection between her feelings of anger and helplessness, her efforts for independence and her relationship to her mother, she was easily motivated for a psychodynamic psychotherapy. Only after this was offered she was interested in keeping a diary (self monitoring) to observe her scratching behavior, her concomitant cognitions and emotions and to try scratch controlling techniques. A multicomponent program of therapeutic strategies makes sense; but there are no controlled trials of behavioral or psychodynamic treatment.

Key Learning Points

Attachment Theory

Attachment theory describes close protective relationships and their variations. Closeness is a fundamental need. Attachment behavior can be understood as a set of strategies that has been learned to achieve optimal closeness. It is supposed that a secure attachment pattern is associated with an internalized sense of being worthy of care, of being effective in eliciting care when requesting it and of personal efficacy in dealing with most stressors independently. Insecure attachment can result in angry, ambivalent, dismissing/avoidant, or fearful behavior. It seems that childhood attachment insecurity and a higher prevalence of psychosomatic disease are connected. Insecure attachment behavior may be associated with disturbances in stress regulation, use of external regulators of affect, like drugs, and nonuse of protecting behaviors. Attachment insecurity contributes to psychic or psychosomatic diseases by adding a risk to a preexisting vulnerability, which provides disease specificity.

Countertransference

Countertransference describes all affects, emotions, and action impulses that a patient evokes in the therapeutic relationship. It comprises reactions to the mechanism of projective identification, to the transference of the patient, adequate reactions of the therapist to objective events in the patient's life, and reactions of the therapist resulting from his own character and history. It is necessary to realize those feelings of countertransference because otherwise the therapist is hindered in finding a correct diagnosis and intervening properly. It is essential to analyze when, how, and with which intention the reactions are provoked. There are several intervention techniques: clarification, confrontation, interpretation. Usually the analysis of transference and countertransference is concerned with the analytical process and the relation between therapist and client, with the relationships the patient has within his social context and with the patient's biographic development. It is necessary to check disturbing countertransference reactions as well as missing reactions which normally occur, such as absent feelings of anger. It is the therapist's duty not to repeat old reaction patterns but to create a new experience for the patient with the aim of stabilizing a secure attachment behavior, supporting flexible coping strategies and correcting of neurotic and other behavior patterns.

Suggested Reading

- König K: Gegenübertragungsanalyse. Vandenhoeck und Ruprecht, Göttingen, 1993.
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- Niemeier V, Kupfer J, Gieler U: Acne is not a trivial disease! Psychosomatic aspects in routine therapy. *Dermatol Psychosom* 2002;3:61–70.