Would You Have Realized?

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

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Case Description

Mrs. A. is referred to psychosomatic consultation in order to examine if psychodynamic factors play a role in her disease and to help her cope with it. To the colleague on ward the patient seemed desperate, depressed and feeling helpless. Mrs. A. was hospitalized because of chronic recurrent psoriasis which had begun in loco typico 36 years ago, had generalized later and also affected the joints of the fingers and toes. In the past months Mrs. A. had been experiencing a lot of stress in her private life and at work and the disease had aggravated.

Mrs. A. convincingly describes her burden due to psoriasis. She suffers under the disfigurement and under the oily or malodorous ointments. This does not go together with the value she places on being attractive and neat. She greets the consultant with the words: 'Sorry, I have just put on my cream.' When asked about the beginning of her disease she tells about her family history: Her mother died of leukemia at the age of 33, when she was a girl of only 9. Her father then married a successful business woman who had never had a partner before. 'She was always more than perfect.' This woman gave up her job, but she was neither able to produce a friendly atmosphere nor a warm relationship with Mrs. A. and her 4 year older sister. The children were never 'good enough'. They would have to function perfectly or else be punished by silence (non communication) for days.

The patient was 13 years old when psoriasis first manifested – at the same time her father developed the disease from which he has been severely suffering ever since. After having finished school, she had to leave home and soon got married. When she delivered her only son (21) she developed psoriasis arthritis which improved again in the last years. However, over the past years the skin disease has worsened a lot. What has happened? Two years ago her mother-in-law had died. She had to care for her father-in-law for one year until he died, too. 'It was too much, especially because I had just started to work again – and actually only because of my husband. Our marriage had never been good, we had many ups and downs. I kept thinking I could change my husband.

I wanted him to be perfect. In the meantime this has become better. He has accepted me and my difficulties and we are closer now.' She remembers that she experienced the same feelings towards her father-in-law as towards her stepmother: She had to function but there was no affection. For several months now her stepmother has been severely ill and she suspects that it might be up to her to take over care for the old lady as well as for her father. Besides, she knows that her son will leave home, soon – 'I can't let him go'. There is yet another problem: She works for a large company where a colleague of hers will not talk to her for days when she makes a mistake – just like her stepmother! She does not mention this spontaneously but only when I ask for similarly offending situations and feelings in the present as in her biography. Concerning her son she has been afraid for 10 years, especially when he was 13, to become severely ill. 'What would happen, if he had a stepmother as cruel as I had?'

Her mood is depressed, she feels burned-out, prone to colds, and at the mercy of her skin disease and all the situations she has described.

Questions

- 1) Which psychopathological diagnosis would you make?
- 2) Which psychodynamic considerations do you develop? What seems to be the affect most difficult to bear?
- 3) What is your psychotherapeutic recommendation? Do you have an idea of some first explanations you could give to the patient?

Answers

- 1) Chronic psoriasis (ICD L 40.9), aggravated by psychosocial factors (ICD F 54.0). Psychophysical exhaustion (F 48.0).
- 2) The course of the disease seems to be influenced by experiences of separation and/or rejection or ambivalent relation-

ships. First symptoms occurred after her mother had died and in contact with a demanding and little caring stepmother. In order to win her stepmother's love the 13-year-old child tried to fulfill all her expectations: to be perfect and to be extremely efficient by ignoring her wishes for fun and relaxation. She learned to live with the disease, never wondering if her skin could symbolize her desire for closeness or her difficulty to find the correct distance in her relationships. Only when she experienced another aggravation of the disease when nursing her father-in-law, she began to suffer emotionally. It was a repetition: Once again she had to deny her wish for autonomy (remember she had just started a new job!), had to care for her father-in-law although she had no feelings of love for him and neither had he for her. She still did it though, in order to save her marriage. With her sun growing up she began to fear losing him, when he would leave home. She was also afraid that she would have to fulfill her father's and her stepmother's wishes when they fell ill. This conflict between the wish for autonomy vs. dependence brought along strong and unbearable affects of anger and disappointment. She does not know how to disassociate herself because she is afraid of losing affection. Why is she so burdened by the visibility of her psoriasis and the bad smell of the ointments? It certainly is difficult to be disfigured and to smell bad with tar ointments or the like. However, it also seems to be an attack on her small relationship to her mother whom she described as a woman who was always very cultivated. She is really threatened. Her chance now seems to be, that self-denial and overcharge have led to a burn-out syndrome which makes her call for psychosocial support. Mrs. A. is not conscious of identifying herself with the demanding and punishing manner of her stepmother: 'I wanted my husband to change!' And she is not conscious of her own complex of guilt which leads her to exhaust herself.

- 3) There are different possibilities: Mrs. A. presents her burden by the disfigurement. It would be likely to recommend a cognitive behavior therapy comprising exercises to talk about the disease, confrontation with avoided situations, support not to focus attention on the disease but on healthy parts of the body, support to gain a new perspective on her wishes, and training of her ability to carry them through. She has to learn to take into account her feelings of anger and fear and to live her life in a way allowing herself to determine closeness and distance. A psychodynamic therapy would as well focus on the emotional conflicts, the repetition, the parallels between biography and actual conflict, and one would expect that in the therapeutic relationship a situation would manifest which reflects the patient's strain to be effective, her longing for love and closeness, her disappointment and anger. The therapist's task would be to clarify these feelings and to establish an atmosphere in which the patient can stand them without being afraid of refusal. It would also be important to reveal Mrs. A.'s identification with parts of her stepmother as well as her complex of guilt. The burn-out syndrome would allow to take her off from work for some weeks and to consider an intensive therapy in a psychosomatic clinic. There she could benefit from verbal and non-verbal therapeutic strategies like psycho-

dynamic orientated creative therapy or concentrative movement therapy.

Mrs. A. will not easily give up her duties or 'burrow in the past', as she says. At the first consultation it is possible to explain the links between past and current feelings and to look for similar experiences. Indeed, Mrs. A. associated that the atmosphere at work where her colleague punishes her with silence reminds her of her childhood, when her stepmother did not talk to her for days. Mrs. A. is relieved to understand that her 'inner child' feels just as alone as in former times. By this she can develop an idea that psychotherapy is not for 'crazy people' but for hurt people who want to make new experiences in order to take care of themselves.

Key Learning Points

Psychophysical Exhaustion, Disturbance of State of Health

Symptoms of psychophysical exhaustion may vary very much. Patients complain about headaches, stomach-aches, heart problems, dizziness, problem to breathe, or pain of the skeletal and muscular system. They feel nervous, irritable or burdened. Asked directly they report to withdraw from friends and social activities, to consider to quit working, to have difficulty to concentrate, to feel depressed and full of unspecific fear, to be prone to brood, to feel weak and tired. Their complaints are followed by times of illness, reduced working capability, sick-leave and increased use of psychopharmacological drugs or drugs against pain. A disturbance of the vegetative nervous system is assumed, which depends on emotional instability, neurotic personality traits and stress. Patients are sensitive for common stress factors, which do not only concern their own personality but also have signal character for a social situation in general. Symptoms occur if stress is combined with unbearable conflicts. If there is enough social support, they may remain rather healthy until support decreases. It should be considered that our medical system is orientated primarily on the somatic aspects of a disease and its treatment. This leads to rather long intervals until patients will talk about their emotional stress. Therapy comprises counseling, individual or group psychotherapy, training of physical fitness, enough time for retirement and sleep, and sometimes change of job.

Suggested Reading

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