DERMATITIS ARTEFACTA APPEARING DURING INPATIENT PSYCHOTHERAPY PROGRAMME FOR DISSOCIATIVE DISORDER - A CASE REPORT

C.T. SUDHIR KUMAR & K.E. SADANANDAN UNNI

ABSTRACT

Appearance of dermatitis artefacta in an adolescent female patient while she underwent treatment for dissociative disorder is described. The possibility of shift of presenting symptom of episodic unresponsiveness to spurious skin lesion during psychotherapy programme was considered to be the method of its causation.

Key words : spurious dermatitis, dermatitis artefacta, dissociative disorder

Dermatitis artefacta is a self inflicted skin lesion. Some patients deny self infliction. Others have amnesia for the act. Patients with mental subnormality, psychopathy, schizoid personality, depression, and organic brain syndrome can present with spurious skin lesions. Only those lesions produced consciously or unconsciously to satisfy a deep seated intrapsychic need can be termed dermatitis artefacta (Koblenzer, 1992; Unni et al., 1994).

CASE REPORT

A thirteen year old girl, seventh standard student, hailing from a lower middle class joint family of rural background, having no past or family history of any mental or physical illness was admitted to the in-patient psychiatric services of JIPMER hospital with complaints of episodes of unresponsiveness associated with blinking of eyes and clenching of teeth of one year duration. The first episode occurred one year ago while being tutored by her uncle at her residence to complete her homework assignment. This episode lasted for thirty minutes and subsided after an intramuscular injection of B complex vitamins by a general practitioner. One month later she developed another episode while attending classes at school. Thereafter within a span of one year she had eight other similar episodes. All the episodes occurred in the same environment of learning/teaching and were of similar duration and managed in a similar manner. The patient said she was aware of these episodes and of what was happening around her during each of these episodes. There were no other symptoms to suggest a seizure disorder. A detailed clinical history, psychosexual history, physical and mental state examination and careful inpatient observation did not reveal any abnormality. The diagnosis at admission was dissociative disorder.

Routine laboratory tests of urine and blood and an electroencephalogram were within normal limits. Psychodiagnostic evaluation revealed normal intelligence and no evidence of any incipient psychotic process. A nonpharmacological management was planned after detailed evaluation of the case.

The initial psychotherapeutic sessions focused on establishing a rapport. After the first five session it was felt that the therapeutic relationship was adequate since the patient started discussing some of her problems spontaneously. She revealed that she had a very grueling schedule at school. She also felt that the situation outside the school hours was equally taxing. Her average day would include waking up at 5.30 AM and getting ready to attend tuition classes from 6.00 to 8.30 AM. Her school timings were from 10.30 AM to 4.30 PM. This was followed by another session of tuition from 5.30 to 6.30 PM. She would spend her time after returning home in completing her homework assignments. After this there
C.T. SUDHIR KUMAR & K.E. SADANANDAN UNNI

would be just enough time to have supper before going to bed. Despite intensive coaching sessions, it was found that she had poor grades in school in English and Mathematics. She often used to compare her marks with those of other girls in school and used to feel disappointed. Due to this she never felt like spending time or playing with other classmates. It was also incidentally found that two other girls in the same school had similar symptoms.

During and after each psychotherapeutic session, the patient was found to be a little more anxious than before. The observations of the ward staff also confirmed this. On the sixth day of admission she complained of reddish skin lesions over the biceps region of both arms which were apparently geometrical, non itching, non confluent and without any discomfort. The lesions appeared bilaterally symmetrically and simultaneously. No skin lesions were observed on any other part of the body. She had not been on any medication prior to the appearance of the lesions. There was no evidence of insect bite or any drug or food allergy in the past. Patient denied scratching, rubbing with any substance or object or self infliction on confrontation. A provisional diagnosis of dermatitis artefacta was made and she was referred to the dermatologist who confirmed the same. During the subsequent sessions an effort was made to discuss the issue of these skin lesions. It was noted that she repeatedly denied any self infliction. Further it was observed that she was increasingly resistant to discussing this symptom and became more anxious. At this time it was decided to conduct an interview under intravenous pentothal. One session of abreaction was attempted, which failed to reveal any areas of conflict. Following this she was interviewed more frequently over the next two days. No further psychodynamics could be unearthed and the patient continued to deny the self infliction of the skin lesions, which healed with local application of calamine lotion. However during the next seven days the patient remained asymptomatic. During this period the psychotherapeutic sessions were more supportive and focussed on problem solving skills. The therapist helped the patient to revise her study schedule and also advised her to incorporate some recreational activities in her daily routine. Her parents were also counselled in three sessions regarding the difficulties faced by the patient. They appeared to understand the need to reduce their daughter's stress and to readjust their expectations. She was discharged and advised to rejoin school and attend follow up sessions every week. Over a six month follow up period none of the symptoms were seen and it was observed that she was doing better in school than before. Her mood state was more cheerful and she was interacting better with her schoolmates.

DISCUSSION

Dermatitis artefacta is a rare entity with female to male ratio of 3:1 to 8:1, with maximal incidence in adolescents (Fabisch, 1981). The underlying diagnosis may be anxiety or adjustment disorder. Precipitating psychosocial stress can be commonly elicited (Koblenzer, 1987). Certain personality traits are also observed (Fabisch, 1980). The adolescents may require parental education and family therapy (Simmons, 1987). Characteristic feature of dissociative disorder is a partial or complete loss of normal integration between memories of the past, awareness of identity, and immediate sensations and control of bodily movements (I.C.D - 10; W.H.O., 1992). This patient clearly is a case of dissociative disorder as per the history, the diagnostic criteria and the normal investigation results. The geometrical nature of the skin lesions, sharp outline, superficial nature and presence only in the regions readily accessible to the hands clearly prove that the skin lesions she developed during the hospital stay was dermatitis artefacta (Savin & Cotterill, 1992). It was interesting to note that the patient developed the lesions during her in-patient psychotherapy programme. Enhancement of anxiety and symptom shift are generally agreed to and often reported in patients with dissociative disorder (John YM Koo, 1995). But dissociative symptom shift to dermatitis artefacta is not reported in the literature as far as the authors know. On confrontation, patient had categorically denied self infliction of the skin lesions. Considering the primary diagnosis of dissociative disorder the authors are of the opinion that the denial of self infliction of skin lesions was consequent to amnesia of the act. So long as it is considered in this manner, the phenomena of dermatitis artefacta in
the present patient is a shift of symptoms from the original presenting ones. Patient's life situation showed academic pressure and scholastic difficulty on a background of parental pressure as illustrated by the daily schedule they have persuaded her to comply with. When one considers this, the deep seated intrapsychic need to temporarily escape from the stressful situation from the part of the patient becomes clear.

Dermatitis artefacta is considered rare in children unlike other age groups. Present patient was just thirteen years old. The patient reported by Unni et al. (1994). was eighteen years old. It is possible that one is seeing only the tip of the iceberg during the clinical practice. Many adolescents in the community may have similar dermatological or other stress related disorders which are under reported.

REFERENCES

Fabisch, W. (1980) Psychiatric aspects of dermatitis artefacta. British Journal of Dermatology, 102, 29-34.

Fabisch, W. (1981) What is dermatitis artefacta? International Journal of Dermatology, 20, 427-428.

John, Y.M. Koo (1995) Skin Disorders. In: Comprehensive Textbook of Psychiatry, 6th edn. (Eds) Harold, J., Kaplan, H.I. & Saddock, B.J., Baltimore: Williams & Wilkins.

Koblenzer, C.S. (1992) Psychologic aspects of skin disease. In: Dermatology in General Medicine, 3rd edn., (Eds) Fitzpatrick, Eisen, Wolff, Freedberg, Austen. NewYork : Mc Grav Hill.

Koblenzer, C.S. (1992) Psychocutaneous Disease. In: Dermatology, 3rd edn., (Eds) Moschella, S. L., Hurley H.J., London: WB Saunders Company.

Savin, J.A & Cotterrell, J.A. (1992) Psychocutaneous disorders. In: Text Book of Dermatology, 5th edn., (Eds) Champion. Burton. Ebling. London: Blackwell Scientific Public Publication.

Simmons, D.A. (1987) Hospital management of the patient with factitial dermatitis. General Hospital Psychiatry, 9, 147.

Unni, K.E.S.; Venugopal; Padmavathy & Mani, A.J. (1994) Review of spurious dermatitis and case study of dermatitis artefacta. The Antiseptic, 91, 381-383.

World Health Organization (1992) I.C.D-10 Classification of mental and behavioural disorders: clinical description and diagnostic guidelines. Geneva: W.H.O.