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Dermatitis Artifacta in a case of Factitious and Dissociative disorder-Help seeking in a myriad of ways

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ABSTRACT

Factitious disorder is defined by the intentional production or feigning of physical or psychological symptoms with the objective of assuming the sick role. Dermatitis artifacta (DA) is a psychocutaneous condition in which skin lesions are produced or inflicted by the patient's own actions. Patients present with lesions of various forms and bizarre shapes, which are difficult to recognize. Patients often deny responsibility, so the direct confrontation will mostly lead to withdrawal and seeking help somewhere else. The self-mutilative behavior often serves as an extreme form of nonverbal communication, an appeal for help and usually occurs in patients with poor coping skills and often represents a maladaptive response to psychological stressor. DA is frustrating for physicians and family members, with a differential diagnosis that includes severely morbid medical conditions. As with all factitious disorders, patients with DA waste precious time and resources with unnecessary tests and produce high costs to the healthcare system. Increased awareness of DA can save physicians, patients, and family members many medical visits and allow for better management. In this case report, we describe a female patient with dermatitis artefacta, associated with dissociative disorder presenting with recurrent multiple genital ulcers. This case leads us to suggest that extreme help seeking need can present with a varied psychiatric manifestations, starting from dissociative episodes to dermatitis artefacta.

Keywords: Factitious disorder; Dermatitis Artifacta

Introduction

In 1951, Asher' described a psychosomatic disorder he termed Munchausen's syndrome.[1] Patients with this syndrome repeatedly seek admission into medical facilities under apparent physical or mental distress, offering plausible stories supporting the nature of their disorder[2]. Later on DSM III (1980) used the term 'factitious disorder ' for the above illness[3]. The Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision) [4]provides the following 3 diagnostic criteria for a factitious disorder: (1) intentional production or feigning of physical or psychological signs or symptoms; (2) motivation for the behavior is to assume the sick role; and (3) absence of external incentives for the behavior (as in malingering). Factitious disorder is characterized by the invention, production or falsification of physical or psychological symptoms that feign a physical or mental disease. The condition may also involve the exaggeration or false reports of symptoms of an actual underlying disease[5]. Although the purpose of assuming the role of patient is conscious and the behaviors that lead to feigning the disease are voluntary.

The true prevalence of this disorder is unknown[6]. Studies suggest these patients account for 0.2-1.0% of hospital admissions but this may be an underestimate as the disorder is often unsuspected[7]. A study from the NIH[8] found that patients with factitious fevers accounted for 9.3% of patients referred to a tertiary hospital for fever of unknown origin. Munchausen syndrome sometimes includes skin involvement, generally known by the term Dermatitis Artifacta (DA). It is a psycho cutaneous disease defined as "Deliberate and conscious production of self-inflicted skin lesions to satisfy an unconscious psychological or emotional need. These skin lesions serve as powerful, self -expressive, non-verbal messages.

Dermatitis artifacta is difficult to diagnose and is rarely recognized, but it is estimated that 0.2%-0.5% of dermatological patients suffer from this disease. There is generally considered to be a female preponderance, but estimates vary from 1:3 to 1:20 male to female ratio. Most affected patients are in their teens or early adulthood. Treatment is very difficult and with variable outcomes. There is strong association with borderline personality disorder, dissociative disorders and eating disorders. An effective therapeutic relationship requires a non-judgemental, empathic and supportive environment in order to encourage return to follow up, and eventually talk about the possible psychological basis of the disease[9].

Case history

A 30 year old married female, educated upto primary schooling, hailing from a lower middle class joint family of rural background, having no past or family history of any

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mental or physical illness was referred to us from the dermatological dept where from she had been taking treatment for genital ulcers since the last 6 months. Symptoms started when her husband, who was working in Indian Army was suddenly transferred to a distant place and patient was left to stay at her in-laws with her children. It began with complains of a burning sensation around the vulva, followed by eruptions within a day or two. The lesions were sudden in onset, and were not associated with injury, insect bite, or intake of drugs. These initially responded to topical antibiotics prescribed by a local practitioner and subsided and patient moved on to her parental home. However after 3 weeks her symptoms recurred. As this time she did not respond to the previous antibiotics she was referred to a nearby Government hospital. The patient was treated conservatively with topical and systemic antibiotics and antivirals (Acyclovir, Valacyclovir). Lesions healed within 4 – 5 days, leaving slight hypopigmentation. After few days, she would be brought in by her husband with fresh erosions over the same area. Thereafter she continued to have these symptoms and respond to antivirals irregularly sometimes she would improve over two days, while on some occasions she would continue to be symptomatic for 3-4 weeks. Every time she refused hospital admission.

Appearance of symptoms would also be erratic and almost sudden all the time and surprisingly patient could always predict the timing of the lesions. Cutaneous examination revealed multiple fresh erosions on her genital area. Skin between erosions was absolutely normal. Most of the lesions were with unnatural shapes, with slight atrophy in the center and hyperpigmentation along the margins. Lesions would heal with scarring and depigmentation.

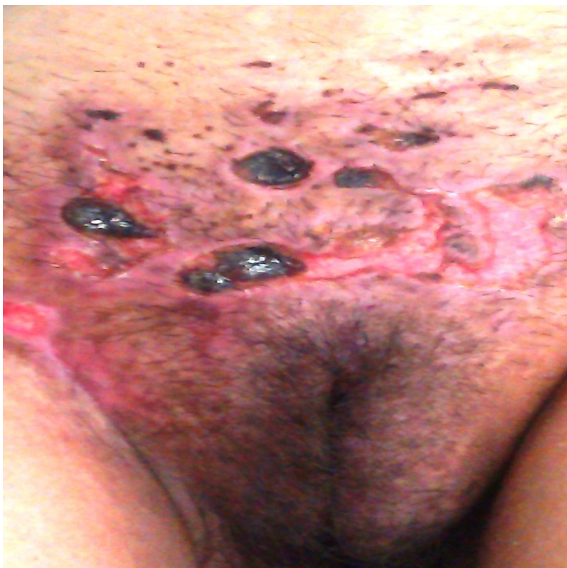

Figure 1: Genital lesions of Dermatitis Artifacta

For these complaints she visited about 3-4 hospitals and was extensively investigated. She was negative for VDRL, HSV-2, and HIV. ANA titer was within normal range. A biopsy was taken from the lesion twice at different centres, both times it revealed inflammatory cells and was non-conclusive. There were no findings under the immunoflorescense. Her blood sugar, LFT and other haematological tests were normal. Patient denied scratching, nibbing with any substance or object or self-infliction on confrontation, rather became hostile to the treating team. The ulcerations were thought to be self-inflicted. The diagnosis of DA was provisionally suspected, based on the presentation (nonconclusive linear tapering erosions, hollow history) and she was referred to our psychiatry department.

A detailed history also revealed that since the last 5 years, there has been complaints of episodes of unresponsiveness associated with blinking of eyes and clenching of teeth. This episode lasted for thirty minutes and resolved on its own. Patient would be 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. At the same time she would also complain of pain in her arm whenever she would have to do heavy work that would fluctuate throughout the day. Clinical work up and investigations at various hospitals suggested no abnormality. All these symptoms would aggravate whenever there would be any family conflict particularly after arguments with her mother-in-law.

About a year back when her husband's posting was recently announced, she had an episode of crying spell followed by complaints of dizziness and weakness. After two days she presented to the emergency with complaints of inability to pass urine. However she did not have any clinically palpable bladder. She was thoroughly evaluated. Her urodynamic studies revealed normal kidney functions. Uteroscopy revealed no obstruction. But as the complaints of anuria persisted she was referred to our psychiatry OPD. She was advised admission for observation and evaluation but she refused. This complaint however improved over a couple of weeks by itself.

A detailed psychiatric evaluation was done with a team of psychiatrist, psychologists and psychiatric social worker. Patient was indifferent to her symptoms and was not cooperative for psychiatric assistance. She was admitted after much coaxing. She was increasingly resistant to discussing this symptom and became more hostile. 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. Patient did not co-operate for any psychodiagnostic evaluation and continued to deny the self-infliction of the skin lesions even when non-punitive confrontation was applied. The lesions started to heal with local application of antivirals within 3 days of admission. However patient would insist on discharge

Reason for Admission

The patient came to the interview room complaining of depression and some unusual physical sensations. It began with complains of a burning sensation around the vulva, followed by eruptions within a day or two. She reports that during the last couple of days she has depressed feelings irritability, and hopelessness. She was admitted on an inpatient basis in order to stabilize her symptoms.

Behavior during Interview

Patient was cooperative and presented with an appropriate affect during the interview. Her speech was slightly slowed, however not excessively so. She manifested no obvious signs of motor difficulty. The patient was very open and willing to discuss her past and present situations and feelings. Her mood was somewhat depressed and constricted, but she brightened when talking of positive or humorous experiences.

Results from the Sacks Sentence Completion Test reflect several themes consistent with the patient's interview and background. One of the most prominent themes concerns patient's views of the future and her estimations of her ability

to deal with the problems and stress of life along prominent sexual conflict. These themes can be seen in the following statements: When the odds are against me, *I collapse*. To me the future looks *tough*. My sexual life somewhat is…….? (refused to complete the sentence). I know it is silly, but I am afraid of *being alone for the rest of my life*. My greatest weakness is *I am not good and weak*. There is also a prominent theme of poor self-concept or "damaged self" that can be seen in some of the former as well as in the following statements: I would be perfectly happy if: *my skin problems would go away*. Most of my friends don't know that I am afraid of *everything*. When I was young, I was *successful on the outside, but always felt bad on the inside*.

Management- To deal with the current situation of the patient confrontational technique and cognitive behavior therapy has been planned.

Discussion

Dermatitis artefacta refers to conditions in which patient self-inflicts skin lesions. It is a form of 'focal suicide'[10]. Histological findings are not characteristic and diagnosis depends on the clinical presentation. Characteristic clinical features are 'hollow history'[9] i.e. sudden appearance of complete lesions without prodrome, lack of history of progression of lesions, strenuous denial by the patient of inflicting the lesions and patient can forecast the site and timing of lesions. Lesions are bizarre with sharp angulated, geometric borders and surface necrosis, do not correspond to any known dermatosis and confined to areas accessible to the dominant hand.Patient appears indifferent towards her disease - 'la belle indifference[9]. Genital ulcers may be due to a number of causes, with the most frequent ones being infections – including sexually transmitted diseases – as well as tumors and mechanical causes. These conditions need to be excluded before a diagnosis of dermatitis artefacta is made[11]. Successful management of genital ulcer disease depends on accurate diagnosis corroborated by appropriate laboratory tests when required[12]. Diagnosis can be confirmed when so fresh lesions appears when patient is under total surveillance 24 hours a day and when no lesions appear in an area totally protected. There is little experience on the treatment of factitious disorders. The use of confrontation in the cases of factitious disorder with physical symptoms has been greatly criticized mainly because this had been done aggressively, causing the rejection of the patient to any type of psychiatric treatment. Non-punitive confrontation may make it possible to treat the real underlying psychopathology and avoid the continuation of treating the false complaint or symptoms of the patient. In cases where skin involvement is mild and patient is relatively healthy psychologically, supportive and symptomatic therapy is adequate. Thus the visible symptoms of dermatitis artefacta serve as a non-verbal communication - a 'cry for attention and help' from a patient incapable of meaningful verbal communication.

References

1. E.K. Joe, V.W. Li, C.M. Magro, et al. Diagnostic clues to dermatitis artefacta. *Cutis*. **1999**, 63, 209-214.
2. R, Asher. Munchausen's syndrome. *Lancet* **1951**, 1, 339-341.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd text rev ed. Washington, DC: American Psychiatric Association; **2000**.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th text rev ed. Washington, DC: American Psychiatric Association; **2000**.
5. Ameratunga et al. Hypogammaglob ulinemia factitia-Munchausen syndrome masquerading as common variable immune deficiency . *Allergy, Asthma & Clinical Immunology* **2013**, 9, 36.
6. D. Bhugra. Psychiatric Munchausen's Syndrome. *Acta Psychiattrica Scandinavica* **1988**, 77, 497-503.
7. A.M. Doherty, J.D. Sheehan. Munchausen's syndrome – more common than we realize? *Ir Med J* **2010**, 103(6), 179– 181.
8. R.P. Aduan, A.S. Fauci, D.C. Dale, J.H. Herzberg, S.M, Wolff. Factitious fever and self-induced infection: a report of 32 cases and review of the literature. *Ann Intern Med* **1979**, 90(2), 230– 242.
9. J.A. Cotterill, L.G. Millard. Psychocutaneous disorders. In : Champion RH, Burton JL, Burns DA et al, eds. Textbook of Dermatology Vol 4,6th edn. **1998**, 2785-2813.
10. L. Stankler. Factitious skin lesions in a mother and two sons. *Br J Dermatol* **1977**, 97, 217.
11. J. Hernandez-Gil, M.V. Guiote, A. Vilanova, F. Mendoza, J. Linares, R. Naranjo. Genital artefact ulcers appearing simultaneously in a couple. *Actas Dermosifiliogr*. **2006**, 97(2), 122–5.
12. T.F. Mroczkowski, D.H. Martin. Genital ulcer disease. *Dermatol Clin*. **1994**, 12(4), 753–64.