

# Primarily Psychogenic Dermatoses

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In purely psychogenic dermatoses, the psychiatric disorder is the primary aspect, and somatic findings arise secondarily. These are the direct consequences of psychological or psychiatric disorders.

In dermatology, there are four main disorders with primarily psychiatric genesis.

2. Dermatoses due to delusional disorders and hallucinations, such as delusions of parasitosis
3. Somatoform disorders
4. Dermatoses due to compulsive disorders

## Disorders of Primarily Psychiatric Genesis

1. Self-inflicted dermatitis: dermatitis artefacta syndrome, dermatitis paraartefacta syndrome (disorder of impulse control), malingering

**Note:** Self-inflicted dermatitis reflects a variety of conditions that share the common finding of automutilating behavior resulting in trauma to the skin. They represent a spectrum that spans from conscious manipulation of skin and appendages all the way to a delusional psycho-

sis. The degree of severity is mostly determined by the progressive loss of awareness of the process. Although we classify these as distinct entities, the differences among them may be blurred. For example, a subject who has been repeatedly infested with mites may at some point be convinced that he or she is still infected.

## 1.1 Self-Inflicted Dermatitis: Factitious Disorders

**Definition.** Factitious disorder refers to the creation or simulation of physical or psychiatric symptoms in oneself or other reference persons. Factitious disorders (ICD-10: F68.1, L98.1) is the term used to describe self-mutilating actions (DSM-IV 300.16/ 300.19) that lead directly or indirectly to clinically relevant damage to the organism, without the direct intention of committing suicide.

The current division differentiates three groups as follows.

### Categorization of Factitious Disorders

1. Dermatitis Artefacta Syndrome: dissociated (not conscious) self-injury behavior
2. Dermatitis Paraartefacta Syndrome: disorders of impulse control, often as manipulation of an existing specific dermatosis (often semiconscious, admitted self-injury)
3. Malingering: consciously simulated injuries and diseases to obtain material gain

This categorization is helpful in understanding the different pathogenic mechanisms and the psychodynamics involved, as well as in developing various therapeutic avenues and determining prognosis.

Additionally, other special forms exist, such as the Münchhausen syndrome and Münchhausen-by-proxy syndrome (Sect. 1.1.4).

Even though factitious disorder is the most common cause for dermatitis artefacta syndrome (DAS), several psychiatric conditions can cause the syndrome (refer to the list, “Frequent Psychiatric Disorders in Self-Inflicted Dermatoses”). The skin presentation will vary depending on the genesis of the lesions or artefacts (see list of genesis of dermatitis artefacta).

Factitious disorders are caused by conscious or dissociated self-injury. The patient may be unable or unwilling to integrate the dissociated action of self injury; this functioning is often present in factitious disorder and/or

in borderline personality disorder in which several varieties of dissociative defenses are typically present. With less frequency, other psychiatric conditions may cause the syndrome.

To make the diagnosis, the clinician explores the type of benefit or gain produced by the symptom. If the gain is to be treated as a patient in the absence of suicidal symptoms, it suggests a dermatitis artefacta syndrome; if the secondary gain is economic or if the patient is avoiding work or receiving other material rewards, it indicates malingering.

**Prevalence/incidence.** The prevalence of factitious disorders is estimated at 0.05–0.4% in the population (AWMF 2003). With the exception of malingering, often observed as part of fraudulent behavior, which occurs more often in men, self-injurious behavior is observed mostly in women (5–8:1), usually beginning during puberty or early adulthood.

**Pathogenesis.** Frequently there are mechanical injuries, self-inflicted infections with impaired wound healing, and other toxic damage to the skin. Hematological symptoms may occur by occluding the extremities, creating petechiae, and by covert intake of additional pharmaceuticals or injection of anticoagulants.

### Genesis of Dermatitis Artefacta

- Mechanical
  - Pressure
  - Friction
  - Occlusion
  - Biting
  - Cutting
  - Stabbing
  - Mutilation
- Toxic damage
  - Acids
  - Alkali
  - Thermal (burns, scalding)
- Self-inflicted infections
  - Wound-healing impairments
  - Abscesses
- Medications (covert taking of pharmaceuticals)
  - Heparin injections
  - Insulin

### 1.1.1 Dermatitis Artefacta Syndrome (DAS)

**Clinical findings.** The clinical appearance of dermatitis artefacta syndrome (ICD-10: F68.1, unintentional L98.1; DSM-IV-TR 300.16 and 19) is characterized by self-manipulation. Basically, the morphology of these can imitate most cutaneous diseases (Figs. 1.1–1.9).

**! “Typical is what is atypical.”**

This means that dermatitis artefacta syndrome must be suspected in clinical patterns with atypical localization, morphology, histology, or unclear therapeutic responses. Effort should be directed to detect foreign, infectious, or toxic materials.

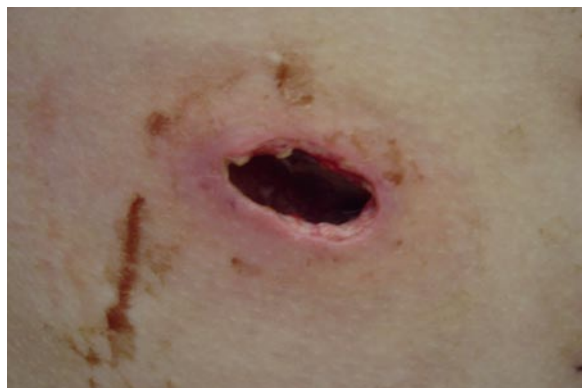
The consequences are particularly dangerous when the patient delegates the body-damaging action to the



**Fig. 1.3** Dermatitis artefacta syndrome: 58-year-old woman with skin defects on the lower calf in acute psychosis and hospital-wandering in Germany. She had had admission to four hospitals (three dermatology services) and outpatient consultation of three dermatology specialists within the previous 14 days



**Fig. 1.1** Multiple foreign-body granulomas, partly with abscessing after self-injection. Occurrence of new lesions and artefacts after surgical treatment



**Fig. 1.2** Same patient as in Fig. 1.1 with punched-out, self-induced skin defects

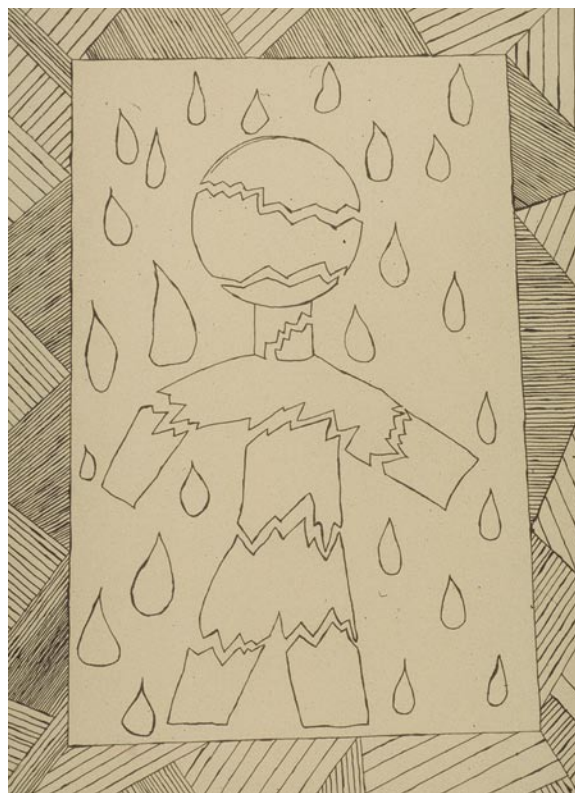


**Fig. 1.4** **a** Extensive scarred dermatitis artefacta syndrome in the face. **b** Corresponding instruments for self-manipulation





**Fig. 1.5** **a** Extensive scarred dermatitis artefacta syndrome in the face. **b** Severe artefacts are also seen in males



**Fig. 1.6** Signs of body mutilation in a patient with dermatitis artefacta syndrome

**Fig. 1.7** Unconscious artefacts: 55-year-old woman with mesh-like skin defects in the perianal area and compulsive personality disorder





**Fig. 1.8** Differential diagnosis: pyoderma gangrenosum in the face; clinical presentation of dermatitis artefacta syndrome could not be confirmed. Healing under immunosuppression



**Fig. 1.9** Artefact in a patient with immigration problems

physician or when simulated complaints result in invasive or damaging medical treatment measures such as surgical interventions (Sect. 1.1.4).

**Psychological symptoms.** DAS as dissociated self-injury may express a reactivation of injuries suffered in childhood based on a serious psychiatric disorder from earlier times, and may contain a nonverbal connotation.

The damaging behavior usually occurs covertly, often in dissociative states, without the patient's being able to remember or emotionally comprehend the event.

The so-called hollow history (van Moffaert 2003) is characteristically often found when taking the history of patients with DAS. This refers to the fact that unclear,

vague statements are made about the onset of disease, which appeared suddenly with no warning or symptoms.

Typically, the patients themselves appear astonished by the skin changes and cannot give clear statements or details about the first occurrence or appearance and course of development. The history remains unclear. The patients are conspicuously emotionally uninvolved while they relate the history of their disease, as though they were not affected themselves when details of the often disfiguring lesions are related. Pain that would be medically expected to result from the lesions is also often not reported. The family, on the other hand, is often enraged and accusatory, complaining of the physician's incompetence at reaching an appropriate diagnosis and treatment.

A heterogeneous psychopathological spectrum exists among patients with DAS. There are often serious personality disorders (mainly emotionally unstable personality disorders of the borderline type, ICD-10: F60.31; DSM-IV-TR: 301.83 borderline personality disorder) or other disorders as described below.

#### Frequent Psychiatric Disorders in Self-Inflicted Dermatitis

- Early personality disorders
- Emotionally unstable personality disorders of the borderline type
- Narcissistic personality disorders
- Histrionic personality disorders
- Antisocial personality disorders
- Dependency personality disorders
- Depressive disorders
- Anxiety disorders
- Compulsive disorders
- Posttraumatic stress disorders

In the anamnesis, two-thirds of patients report traumatizing experiences such as sexual and physical abuse and situations of deprivation.

Mild forms of self-inflicted dermatosis result from conflicts of adolescence or from alcohol, medication, or drug abuse.

In addition, DAS can occur as a comorbidity in depressive, anxiety, and compulsive disorders, as well as in posttraumatic stress disorders. Dissociative amnesias and serious depersonalization states may occur in connection with self-mutilating behavior.

The autoaggressive behavior of DAS patients manifests in other conspicuous incidents, so the connection between artefacts and suicidal behavior should be emphasized, a point that is highlighted in the literature

to the extent that dermatitis artefacta syndrome may represent a masked suicidal behavior.

Very often, the patients report being under great pressure and tension prior to self-injury and feel relieved following it, which releases tension and acts as a form of “tranquilizer” (Janus 1972; Paar and Eckhardt 1987; Eckhardt 1992).

Overt self-damaging behavior or conscious DAS may represent the desire for secondary gain from illness, or it may show blurred transitions to dermatitis paraartefacta syndrome.

**Differential diagnosis in the group of self-inflicted dermatoses.** At the time of the self-damaging acts, manifest psychotic illness or other psychiatric conditions may be present, within the framework of which the self-injury occurs. The illnesses listed in the following overview belong in this category.

The underlying co-occurring psychiatric conditions need to be enumerated as well as other medical conditions triggering or co-occurring with the skin condition or generating additional psychiatric/psychological burden.

#### Differential Diagnosis in Dermatitis Artefacta Syndrome (AWMF Guideline 2003)

- Emotionally unstable personality disorders of the borderline type
- Schizophrenias, schizotypal and delusional disorders
- Affective disorders with psychotic symptoms, juvenile autism
- Hypochondriacal delusion
- Parasitosis
- Monosymptomatic psychosis
- Acute intoxications, psychotropic substances, withdrawal syndrome
- Brain-organic psychosyndrome
- Seizures
- Cultural or religious acts
- Sexual acts
- Suicidal intent
- Comorbidity with organic diseases
  - Lesch–Nyhan syndrome
  - Cornelia de Lange syndrome
  - Rett syndrome
  - Chronic encephalitis, neurosyphilis, temporal lobe epilepsy
  - Oligophrenia
  - Dementia syndrome (F00-F04)

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### 1.1.2 Dermatitis Paraartefacta Syndrome (DPS)

In dermatitis paraartefacta syndrome (DPS), the most common underlying psychiatric condition is an impairment of impulse control (ICD-10:F63.9; DSM-IV-TR: 312.30 impulse-control disorder NOS), but other psychiatric conditions may underlie this syndrome. The patients have lost control over the manipulation of their skin. In dermatology, a minimal primary lesion is often characteristically excessively traumatized, leading to pronounced, serious clinical findings.

The patterns of disease listed in the following summary belong to DPS.

#### Dermatitis Paraartefacta Syndrome (DPS)

- Skin/mucosa
  - Skin-picking syndrome (epidermotillomania, neurotic excoriations)
  - Acne excoriée
  - Pseudoknuckle pads
  - Morsicatio buccarum
  - Cheilitis factitia
- Integument
  - Onychophagia, onychotillomania, onychotemnomania
  - Trichotillomania, trichotemnomania, trichoteiromania

The differential diagnosis should also consider DPS in the Köbner phenomenon.



■ <b>Table 1.1</b> Overview of skin-picking syndrome/neurotic excoriations		
Group	Self inflicted dermatoses	
Subgroup	Dermatitis paraartefacta/impaired impulse control	
Diagnosis	Skin-picking syndrome (usually acute course)	
Localization	Face	Acne excoriée
	Body	Skin-picking syndrome
Differential diagnosis	Compulsive disorders/lichen simplex chronicus	
	Atopic eczema/neurodermatitis circumscripta	
	Prurigo group	

**Clinical presentation.** The clinical presentation of DPS is characterized by the following specifically defined dermatoses.

### Skin-Picking Syndrome (Neurotic Excoriations)

One of the greatest confusions of terms in psychosomatic dermatology is the definition of the skin-picking syndrome, which largely corresponds to the skin lesions formerly called neurotic excoriations (ICD-10: F68.1, L98.1, F63.9; F68.1; DSM-IV-TR 312.30), partly because the terms “neurosis” and “psychosis” have mostly been abandoned in the modern classification systems and have been replaced generically by the term “disorder” (Table 1.1).

Generally this is a single nosological entity; however, a variety of synonyms have been used: skin-picking syn-

drome, emotional excoriations, nervous scratching artefact, neurotic excoriations, paraartificial excoriations, epidermotillomania, dermatotillomania, and acne excoriée or acne urticata.

The term “neurotic excoriations” corresponds to skin-picking syndrome.

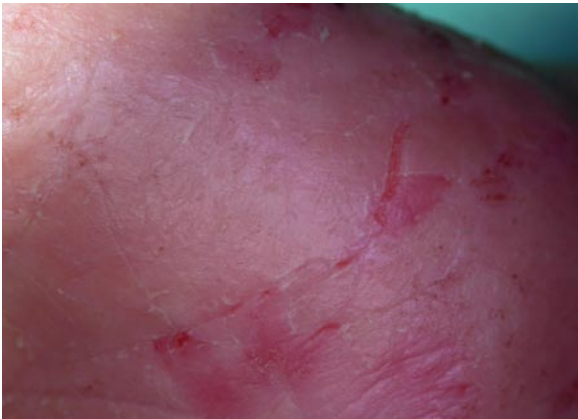
Our recommendation for the definition is as follows:

➤ **Skin-picking syndrome is a DPS most often facilitated by impaired impulse control, resulting in self-injury to the skin or mucosa and usually serving to reduce underlying emotional tension.**

**Clinical findings.** Skin-picking syndrome (neurotic excoriations; ICD-10: F63.9; DSM-IV-TR 312.30) is characterized by excoriations, erosions, and crusting in addition to atrophic and hyperpigmented scarring secondary to self-inflicted trauma (Figs. 1.10, 1.11).



■ **Fig. 1.10** Skin picking in a 62-year-old right-handed woman with impaired impulse control in combination with rage affects



■ **Fig. 1.11** Close-up of a 62-year-old, right-handed woman with typical triangular skin defects

**Table 1.2** Differential diagnosis: skin-picking syndrome and lichen simplex chronicus

	Skin-picking syndrome	Lichen simplex chronicus
Clinical presentation	Primary disorder, intensive itching, discrete papules	Chronic, lichenified, severely pruritic dermatitis
Psychiatric disorder	Disorder of impulse control, psychovegetative lability, and adjustment disorders, which in part occur in episodes under stress and are associated with loss of control	Compulsive disorders, chronic stress, or conflict problematics, whereby the subjectively unalterable compulsive act of scratching the skin predominates

Most commonly localized on arms and legs, the skin-picking syndrome may also occur in the face, where it is frequently referred to as *acne excoriée* (see the following section).

**Psychiatric symptoms.** The psychiatric disorder is characterized by an impairment of impulse control with repeated inability to resist the impulse to scratch. In some cases, there is an urgency to suppress or destroy a skin lesion perceived as disfiguring. In the skin-picking syndrome (neurotic excoriations) and *acne excoriée*, some relief of the patient's conflict-related tension is obtained through the skin in a circular process of lack of impulse control, picking, and progressive concern and guilt about the new lesion created.

At the beginning of the skin-picking behavior, there is a progressive buildup of a feeling of tension, which may or may not be accompanied by itching, followed by excoriation of the skin in the second phase, and subsequently a third phase of satisfaction or a feeling of relief after this act. The syndrome is often accompanied by comorbid depressive and anxiety disorders.

Some authors believe this behavior has a correlate of sexual satisfaction (see Chap. 5) due to the comparable staged course and possible symbolic content.

**Differential diagnosis.** The psychiatric and somatic differential diagnosis includes lichen simplex chronicus (Table 1.2), in which most compulsive disorders (Sect. 1.4) are in the foreground of the psychiatric symptoms. Clinically, there are chronically lichenified areas.

**Therapy.** Therapy for skin-picking syndrome is based on the treatment measures and guidelines for DPS and is summarized in that section.

In mild cases, therapy may be achieved by psychoeducation or supportive psychosomatic primary care. In individual cases, medication therapy with benzodiaz-

epines or selective serotonin reuptake inhibitors (SSRIs) is indicated and justified.

### Acne Excoriée (Special Form)

A special form of skin-picking syndrome is *acne excoriée* (ICD-10:F68.1,L70.5;F68.1;DSM-IV-TR312.30), which is characterized and defined by its localization in the face.

**! Acne excoriée is the special form of skin-picking syndrome in the face in which there is minimal acne (maximal picking with minimal acne) and significant scarring.**

In this, usually minimal lesions are extensively manipulated by squeezing and pressing, usually with the fingernails or sharp instruments. Often the patients cannot resist the impulse to perform these acts but justify the manipulations with the argument that they are removing infectious material. This results in excoriations, erosions, or even ulcerations that heal with stellate discolored scarring (Figs. 1.12, 1.13).

The therapeutic approach is similar to that for DPS, although questions of disease coping may be more urgent due to the stigmatization in the face.

### Further Reading

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**Fig. 1.12a–c** Minimal form skin-picking syndrome (acne excoriée) with minimal preexisting acne and a manipulation urge for more than 20 years. **a** Overview. **b** Close-up of patient in **a**. **c** Skin picking in a male



**Fig. 1.13** Maximal form skin-picking syndrome (acne excoriée) with manipulation urge for several years and now acute exacerbation during a life crisis

### Morsicatio Buccarum

Morsicatio buccarum (ICD-10: F68.1, K13.1; F68.1; DSM-IV-TR 312.30) are benign, sharply demarcated, usually leukodermic lesions around the tooth base and buccal mucosa. These may result from continuous, unconscious sucking and chewing on the oral mucosa. The diagnostic criteria of impaired impulse control are in the foreground of the psychiatric symptoms (Fig. 1.14).

Compulsive disorders may also be present in the underlying psychiatric condition.

Morsicatio buccarum is found more often among denture wearers without other psychiatric symptoms. Lichen planus can be ruled out by a biopsy in cases of doubt.



**Fig. 1.14** **a** Morsicatio buccarum (linea alba buccalis) with constantly changing sucking of the cheek mucosa in situations of tension. **b** Ulcer from biting in a patient with disturbance of impulse control

### Cheilitis Factitia

Cheilitis factitia (ICD-10: F68.1, K13.0; F68.1; DSM-IV-TR 312.30) is compulsive licking (lip-licker's dermatitis) and the basis of the pathogenesis. It results in an irritant contact dermatitis, leading to eczematous skin changes and a predisposition to secondary impetiginization. The licking usually affects discrete, symmetric, sharply delineated areas beyond the outline of the lips, frequently associated with traumatizing lip chewing (Fig. 1.15).

Psychopathologically, impaired impulse control is in the foreground, which often goes unnoticed. Frequently the patients are children, and following diagnosis and careful explanation of the causes to parents and patients, full healing is achieved by controlling the eliciting mechanism.

### Pseudoknuckle Pads

Pseudoknuckle pads (ICD-10: F68.1, M72.1; F68.1; DSM-IV-TR 312.30) occur due to trauma (rubbing, massaging, chewing, sucking) to the finger joints and are clinically characterized by hypertrophic, padlike, rough, slightly scaly skin lesions. Mental retardation in these patients may be common (Fig. 1.16).

Real knuckle pads are due to a form of genodermatosis without mechanical trauma and are characterized histologically by cell-rich fibrosis. Explanatory discussions of pseudoknuckle pads in the sense of psychoeducation with the worried parents, subsequent observation, and increased attention may reveal the mechanism. Healing may be promoted by suppression with supportive skin-care measures as a replacement act. Lack of response may require a subsequent referral



**Fig. 1.15** Cheilitis factitia (lip-licking dermatitis) in impaired impulse control, with secondary superinfection



**Fig. 1.16** Pseudoknuckle pads due to constant rubbing, especially under stress



**Fig. 1.17** Significant onychophagia in adolescent conflict

for psychotherapy, including behavior therapy modalities aimed at alternative coping strategies and stress reduction techniques.

### Further Reading

Meigel WN, Plewig G (1976) Kauschwielen, eine Variante der Fingerknöchelpolster. *Hautarzt* 27(8): 391–395

### Onychophagia, Onychotillomania, Onychotemnomania

#### Onychophagia

Onychophagia (ICD-10: F68.1, F98.8; DSM-IV-TR 312.30) is nail biting or nail chewing, usually with swallowing of the nail fragments. A combination with thumb sucking is also frequent. Both conditions are considered not relevant as clinical entities from a public health perspective and so are excluded from the ICD-10 and DSM-IV-TR as disorders of impulse control. Currently they are considered as symptoms or behaviors. Nevertheless, bacterial or fungal infections, inflammation, bleeding, and malformations may arise or be triggered by the repeated trauma, with shortening of the distal nail plate. Onychophagia usually occurs as part of unresolved conflicts or tension and is especially observed in adolescence (Fig. 1.17).

The frequency cited is up to 45% of adolescents, so certainly not every patient with onychophagia has a serious personality disorder or urgently requires psychotherapy.

The central causality factor is inappropriate dealing with stressful situations.

#### Onychotillomania

In onychotillomania, trauma of the paronychium or constant manipulation, picking, and removal of the cuticle and/or nail is seen as the elicitor of self-induced nail diseases. These may range from onychodystrophy to serious paronychias.

#### Onychotemnomania

Cutting nails too short leads to traumatization of the nail body or nail fold.

### Further Reading

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### Trichotillomania, Trichotemnomania, Trichoteiromania

#### Trichotillomania

Trichotillomania is the best-investigated DPS disorder. Women are thought to be especially affected, with a prevalence of up to 3.5% (Christenson et al. 1991). The disease occurs often at younger ages.





**Fig. 1.18a–c** Dermatitis paraartefacta syndrome. **a** Close-up: student with trichotillomania and adjustment disorder in a psychosocial stress situation at examination time. The three-zone arrangement is clearly recognizable. **b,c** Other views of patients with trichotillomania



**Clinical presentation and pathogenesis.** Trichotillomania (ICD-10: F63.3, F68.1; DSM-IV-TR 312.30) is based on pulling out of the hair, resulting in marked hair loss.

Clinically, there is a typical three-phase zone presentation:

- Zone 1: Long hair (unremarkable, not affected, normal hair/haircut)
- Zone 2: Missing hair (recent alopecia due to pulling)
- Zone 3: Regrowth of hair, shorter and less regular than the normal hair (older, former alopecia areas with irregular hair regrowth after intermittent pulling)

As to the cause of the three-zone presentation, healthy long hair (zone 1) can be easily grasped and then pulled (Fig. 1.18).

Around the torn hair is a hairless zone 2. Isolated hemorrhages can be found in the area of the pulled-out hair in the fresh tear area.

In addition, the older areas show regrowth (zone 3) with shorter hair that cannot be grasped and pulled yet, which explains the third zone of shorter hair. If such a three-zone presentation is found, the diagnosis of trichotillomania is confirmed.

Transient tearing of hair in early childhood can be viewed as a nonmalignant habit that will spontaneously resolve. The diagnosis of trichotillomania should be made only with pronounced findings and persistence of the disorder over a period of months. However, the symptoms, especially in adulthood, may last for decades, and anamneses show a high proportion of episodes in childhood or adolescence.



**Special psychiatric symptoms.** Trichotillomania is based psychopathologically on impairment of impulse control characterized by a buildup of tension prior to pulling, often followed by a feeling of pleasure, satisfaction, or relaxation upon the removal of the hair.

Many people twist and manipulate their hair due to increased anxiety or stress in certain situations without suffering trichotillomania. In the differential diagnosis, some authors discuss or prefer to classify trichotillomania among the compulsive disorders. In compulsive disorders, repeated acts are performed as rituals that must be rigidly followed. The further psychopathology of impaired impulse control is presented in the section on psychiatric disorders of DPS (Sect. 1.4).

Tearing out of hair as a stereotype (ICD-10: F98.4) must also be delineated, whereby this is a psychiatric illness with skin reference.

### Trichotemnomania

Trichotemnomania is a rare form of hair damage in which the hair is intentionally cut off. This form of hair damage is classified as an artefact/malingering.

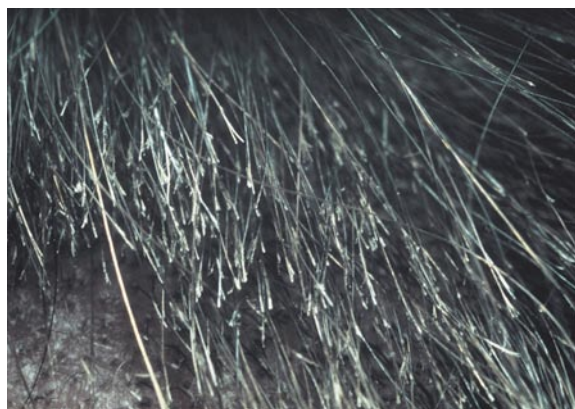
### Trichoteiromania

In this variant of self-inflicted hair loss, there is physical damage to the hair by rubbing and scratching the scalp, resulting in pseudoalopecia. In trichoteiromania (Greek *teiro*, “I scratch”), macroscopic, whitish hair tips with split ends are seen, corresponding under the light microscope to brushlike hair breaks or trichoptilosis (Fig. 1.19).

Casuistic case reports of trichoteiromania state that the patients additionally complain of trichodynia with dysesthesias and pruritus.

The differences between the three paraartefacts affecting the hair are presented in Table 1.3.

**Therapy.** In pediatric cases, a session of psychoeducation with the parents is often successful. This condition



**Fig. 1.19** Trichoteiromania: clearly distended whitish terminal hair ends due to mechanical-abrasive traumatization. Dermatitis paraartefacta syndrome with impaired impulse control in a 31-year-old woman

is frequently a psychoreactive disorder, and a self-limiting course with spontaneous healing can be achieved by attentive observation of the impaired impulse control and appropriate support in the environment.

In older children or adolescents, behavior therapy in the form of habit reversal (see Chap. 13 for different techniques) and having the patient keep a “pulling” diary may be helpful. This is supplemented by relaxation training and replacement of hair pulling by other motor acts to reduce tension, such as the use of stress squeeze balls.

Over a course of several years, the acts of the paraartefacts such as hair pulling may be conditioned to a significant degree. Healing among young patients is thus often easier to achieve than among older patients. In serious cases of trichotillomania, there may be isolated serious psychiatric disorders such as borderline personality disorder, for which inpatient psychotherapy may be indicated and therapeutic success cannot be achieved without concurrent use of neuroleptics.

**Table 1.3** Trichotillomania, trichotemnomania, trichoteiromania (Reich and Trüeb 2003)

	Trichotillomania	Trichotemnomania	Trichoteiromania
Injury pattern	Pulling out the hair	Cutting off the hair	Breaking off the hair by scratching
Clinical findings	Typical three-phase configuration with long, missing, and regrowing hair	Pseudoalopecia with hair stubble that appears shaved	Pseudoalopecia with broken hair of normal thickness; hair stubble with whitish-looking ragged ends
Trichogram	Telogen rate reduced	Normal hair root pattern	Dystrophic hair root pattern; sometimes reduced telogen proportion

Fluoxetine and clomipramine have been successfully used in recalcitrant forms of trichotillomania, taking comorbidities into account (Swedo et al. 1989; Wichel et al. 1992).

Psychotherapy and guidelines for paraartefacts are presented below.

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## Summary

**Psychiatric symptoms of DPS.** In DPS, impulse control is impaired.

In the ICD-10, kleptomania, pyromania, pathological gambling, and intermittent explosive disorders also belong to the group of impaired impulse control along with the paraartefacts, whereby patients cannot resist aggressive impulses, responding with violence or destruction.

### Impairment of Impulse Control

- **The main characteristic of paraartefacts is impairment of impulse control and thus the failure to resist impul-**

**sive urges or temptations to perform a repeated act without reasonable motivation, which is damaging to the person or to others. In questioning, however, the patient can often admit the manipulation, denoting the presence of a semiconscious impairment.**

### Diagnostic Criteria of Paraartefacts (DSM IV)

- Repeated inability to resist impulses
- Increasing feeling of tension prior to the act
- Pleasure, satisfaction, or feeling of relaxation during the act
- No causal relationship to other somatic or psychiatric diseases
- The impairment is accompanied by clinically significant suffering

Often, a minimal primary lesion is excessively manipulated, which only then leads to a pronounced, serious finding. A classic example is manipulation of acne in the morning in front of the mirror, at which time the urge to manipulate cannot be resisted. Emotionally tense situations or unresolved conflicts and an ungovernable urge to self-manipulation may be present as the cause. Compulsive disorders often play a causal role.

The Köbner phenomenon can also be considered among the mild DPS; it is frequently observed in psoriasis and lichen planus.

## 1.1.3 Malingering

**Clinical findings.** Malingering (ICD-10: Z76.5) (V65.2 in DSM-IV-TR) is defined as intentional and conscious creation and elicitation of physical or psychiatric symptoms, in order to obtain benefit.

In malingering, too, mechanical injuries from pressing, rubbing, biting, cutting, stabbing, or burning, or self-inflicted infections with wound-healing impairments, abscesses, mutilations, acid burns, or other toxic damages to the skin are in the foreground. Hematological symptoms may occur because of occlusion of extremities, creation of petechiae, and additional covert taking of pharmaceuticals, as well as by heparin injections.

Malingering provides another focus in dermatology in the framework of expert opinions of occupational illnesses and disability procedures (Fig. 1.20). Additionally, there are manipulations of epicutaneous tests during evaluation procedures and simulation (malingering) of serious symptoms to obtain workman's compensation



**Fig. 1.20** Malingering: 44-year-old construction worker with skin lesions due to constant intentional immersion of the hands in liquid cement without protective gloves. Numerous periods of disability were certified by various doctors, and patient had desire for disability

certification. In intentional provocation of contact allergies, the patient is usually familiar with the causative allergen but does not admit this to the doctor.

**Psychiatric symptoms.** Malingering is conscious, intentional self-injurious behavior by the patient in order to obtain material advantage from the illness (V65.2 Malingering in DSM-IV-TR). They may also be characterized by another social advantage, such as another secondary gain by eliciting attention and care by the family, as in factitious disorder (300.10 and 300.19 DSM-IV-TR, ICD-10 F68.1), in which the physician is intentionally deceived (Fig. 1.21).

Among the psychosocial motivations for malingering are to avoid criminal prosecution, obtain narcotics, avoid military service, or obtain financial advantages. The advantage may lie in a higher disability pension and other financial compensations. Intentional and conscious malingering is hardly amenable to psychotherapeutic measures because there is no patient motivation for therapy.

## Therapy

**Therapy for self-inflicted dermatosis.** Compared with other dermatological diseases, therapy of this group is one of the greatest challenges for the dermatologist, especially when the patient comes to the specialist primarily with purely somatic concepts and expectations without insight (Table 1.4).



**Fig. 1.21** Malingering as constriction dermatitis artefacta syndrome in the left shoulder/upper left arm in order to establish contact with the doctor (secondary profit from illness)

DAS is especially therapy-resistant because these conditions either arise unconsciously and cannot be recalled by the patient or is malingering created by the patient with intentional calculation. So on the one hand, clear delineation must be drawn in malingering, whereas on the other hand, confronting the patient too soon about the dissociated artificial genesis may lead to termination of the doctor–patient relationship and even end in suicide or attempted suicide (Table 1.5).

**DAS.** Somatic or monocausal therapy alone often does not achieve healing in DAS patients and may lead to frustration and even to bilateral open aggression in treatment. The therapy of DAS is usually long term, lasting for years.

Cautious (nonaccusatory) creation of a therapeutic relationship is the foundation of the approach in the early stages of therapy. This can begin with local therapy

**Table 1.4** Psychocutaneous diseases

Disease entity			Insight 0 to ++++
Primary psychiatric diseases	Delusion of parasitosis		0
	Illusion of parasitosis (formication)		++
	Body dysmorphic disorder		0
	Factitious disorders (Dermatitis artefacta syndrome and Dermatitis paraarteacta syndrome)	Dermatitis artefacta	+
		Trichotillomania	Variable: 0 to ++
		Neurotic excoriations	+++ to ++++
Primary dermatological diseases	Eczema, psoriasis, urticaria, vitiligo, seborrheic dermatitis, etc.		++++

**Table 1.5** Therapy of artificial disorders (DAS dermatitis artefacta syndrome, DPS dermatitis paraarteacta syndrome)

Therapy	DAS	DPS	Malingering
Psychosomatic primary care (complaint diary)	+++	+++	+
Psychoeducation	+++	+++	+
Behavior therapy	+	+++	–
Deep-psychological/psycho-dynamic psychotherapy	+++	+	–
Psychopharmaceuticals	++	+	–
Confrontation	--	+/-	+++

directed at wound healing with topical medications and occlusive bandaging with zinc oxide (Unna boot).

In DAS illnesses in the narrower sense, the patient rarely can perceive or acknowledge the self-manipulations because these are often coupled with a dissociative amnesia, rendering the patient relatively unaware of the act.

**! Premature confrontation by the physician is contraindicated because it often leads to severing of the doctor–patient relationship and to renewed autoaggressive acts, up to suicidal impulses or a doctor–shopping odyssey.**

Most important is the creation of a trusting relationship that the patient experiences as helpful and not a threat to his or her self-esteem. One possible access is often

achieved through keeping a complaint diary, since the patient can slowly recognize psychosocial components in the somatic course.

Psychotherapy is usually indicated. Long-term therapy with psychodynamic approaches to stabilize the personality has proven beneficial. However, in the majority of cases, healing of the hidden DAS requires the combination of long-term psychotherapy with psychopharmaceuticals.

#### Stepwise Plan for DAS Therapy

1. Bland local therapy
2. Complaint diary
3. Psychosomatic primary care
4. Psychoeducation (no confrontation)



5. Relaxation therapy
6. Deep-psychological therapy (analysis of past conflicts) with the inclusion of behavior therapy concepts
7. Psychopharmaceuticals (low-strength neuroleptics, SSRI's)

The treatment of covert long-term consequences of early traumatization is often a nearly impossible task for the dermatologist. At the beginning, the doctor can often only initiate a prephase of problem recognition in the patient by introducing a thinking-through of the problems and checking for motivation to undergo psychotherapy.

The patient should not be confronted with the need of psychiatric or psychotherapeutic approaches until a stable, trusting relationship has been established between the doctor and the patient.

The treating physician should support the patient in therapy until he or she can be motivated to accept a specific therapy, such as treatment in a psychosomatic clinic or even psychotropic medication.

Patience is often important here because the motivation phase may extend over a long period of time. In dermatological practice, regular appointments, such as every 14 days, have proven beneficial in this phase.

**DPS.** The prognosis in DPS is generally better because the disorder is “semiconscious.” Behavior therapy measures for impulse control are particularly indicated and successful in this condition, including methods to improve self-management with promotion of self-observation, cognitive restructuring, and relaxation techniques.

#### Stepwise Plan for Paraartefacts

1. Psychosomatic primary care (creating awareness)
2. Psychoeducation (taking the environment into account)
3. Relaxation therapy
4. Tension reduction (object displacement)
5. Behavioral therapy for impulse control (manipulation diary)
6. Inclusion of psychodynamic concepts
7. Psychopharmaceuticals (SSRIs)

An explanatory consultation (psychoeducation) with the patient (or parents in the case of children) may be the first step toward making the offending mechanism

apparent, laying the foundation for regaining impulse control. Subsequent self-observation or outsider observations and control of the action can often achieve healing. If this is not sufficient, keeping a pulling diary (trichotillomania) or manipulation diary (skin picking) may enable better analysis and control. In addition to the date, time of day, and duration of the manipulation, the place and emotions associated with the situation, as well as any special features, should be recorded.

Moreover, psychoeducation that takes the environment (family) into account is helpful from the perspective of psychosomatic primary care. For example, in pediatric trichotillomania, clarification of the biopsychosocial aspects of the disease (the patient is not alone) may bring relief and contribute to the analysis to enable impulse control of the semiconscious disorder.

Measures to divert tension by replacing pulling of the hair or skin picking with other motor acts, such as clutching and squeezing stress balls, may be successfully used in the next step and are well accepted by patients, as are relaxation measures (Fig. 1.22).

In longer courses, introduction of a behavioral therapy is important. The habit-reversal technique has proven valuable as a behavioral therapeutic measure (see Chap. 13).

The basis begins with the conscious recognition of the impulse to self-injury, followed by interruption of the acts with internal warning signals, and finally achieving and remaining in a relaxation phase.

In courses lasting several years, high-grade conditioning of the actions, or additional serious personality disorders, in-hospital psychotherapy may be indicated along with the use of neuroleptics. Initiation of psychotherapy is determined by the comorbidities.

**Malingering.** Due to a lack of motivation for therapy, malingering is difficult or impossible to treat psychotherapeutically. Structuring of the doctor–patient relationship is primary, with clear, often purely somatic reports and confrontation, also in cooperation with health insurance. Special attention should, however, also be paid to depressive or suicidal tendencies, which may be in the foreground in emotionally conspicuous patients with malingering and thus easily overlooked if the clinical presentation changes.

**Psychopharmacotherapy.** Psychopharmaceuticals have proven valuable in stabilizing the usually massive affects and must be applied with appropriate expert knowledge. Symptomatic therapy with low-strength neuroleptics to relieve states of tension or antidepressants to relieve con-



**Fig. 1.22a,b** Patient with self-manipulation under stress. **a** Ball, **b** Magnet stones (magnetites) to reduce tension

current psychopathological symptoms, such as depressive disorders, may be helpful.

**! In DPS conditions such as trichotillomania, therapy with SSRIs may be indicated under the aspect of impaired impulse control. For dissociative artefacts, low-strength neuroleptics are usually more effective and are preferred.**

In DPS, a combination therapy with drugs and behavioral therapy has been found beneficial.

**Prognosis.** The prognosis for patients with self-injuries depends on the severity of the symptoms. It is good for mild forms, but even with appropriate treatment it is moderate to poor in serious forms, and patients with Münchhausen syndrome particularly have a bad prognosis.

If there is acute danger to the patient – or to others – and at the same time a lack of treatment motivation, a legal intervention may be necessary for admission to a psychiatric hospital in cooperation with a psychiatrist.

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### 1.1.4 Special Forms

#### Gardner–Diamond Syndrome

**Definition.** Gardner–Diamond syndrome (ICD-10: F68.1; F68.1) is characterized by periodically occurring painful infiltrated blue patches, multiple physical complaints, and characteristic psychiatric symptoms.

Synonyms are painful ecchymoses syndrome, psychogenic purpura, and painful bruising syndrome.

**Occurrence.** Gardner–Diamond syndrome mostly occurs in young women.

**Pathogenesis.** Initially, the first descriptions supported the assumption of an autoimmune process after injection of autologous blood, in the sense of an autoerythrocytic



**Fig. 1.23** **a** Gardner–Diamond syndrome in a 29-year-old woman. **b** Severe Gardner–Diamond syndrome

sensitization syndrome. Currently, an artificial genesis is accepted as most likely.

**Clinical findings.** As prodrome, there is initially itching, a feeling of tension, or burning pain, usually in the extremities and most often the legs. Then edematous erythematous plaques develop with ecchymoses, which heal within 1–2 weeks (Fig. 1.23). Characteristically, the course is of periodic episodes and healing without scarring.

Systemic symptoms include episodes of abdominal pain, nausea, vomiting, diarrhea, weight loss, headache, blurred vision, paresthesias, and other neurological symptoms, as well as hematuria, hematemesis, metrorrhagias, and amenorrhea.

**Psychiatric symptoms.** The personality structure of the patients presents classical features of dissociative disorders, including conversion disorders, masochism, depressiveness, anxiety, and inhibition in emotional expression of feelings (aggression inhibition).

**Differential diagnosis.** The differential diagnosis includes the spectrum of artefact diseases.

**Therapy, course, and prognosis.** To date, successful family therapy has been reported in isolated cases.

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## Münchhausen's Syndrome

**Definition.** The Münchhausen syndrome (ICD10: F68.1; DSM-IV-TR 300.16 and 19) is characterized by the triad of hospital wandering, pathological lying, and self-injury (Oostendorp and Rakoski 1993).

In 1951 Richard Asher reported the first cases and features of three female patients with self-induced disease, coining the term Münchhausen syndrome (Asher 1951) in reference to Baron Karl Friedrich Hieronymus von Münchhausen (1720–1797). This disease denotes malingering/simulation of acute diseases with demonstrative dramatic description of complaints and false information in the anamnesis. It includes numerous hospitalizations and surgical procedures, sometimes with visible multiple scars. Frequently it is based on a borderline disorder.

Characteristically, patients often display splitting of the environment into good and bad in the same fashion as seen in subjects with borderline personality disorder.

A pathological doctor–patient relationship is frequently present, making these subjects the most difficult problem patients to treat in medicine.

## Münchhausen-by-Proxy Syndrome

In the Münchhausen-by-proxy syndrome (ICD-10: F74.8; DSM-IV-TR 300.16 and 19), it is usually children who are injured by their primary caretakers in order to establish contact with medical caregivers. Thus, the Münchhausen-by-proxy syndrome is a special form of child abuse.

Two cases of Münchhausen-by-proxy syndrome were published for the first time in 1977 by an English pediatrician (Meadow 1977). The term was coined because the mothers systematically deceived the doctors with fictitious stories about the disease, but instead of their own bodies, they were abusing their children's (by proxy). This observation was followed by numerous publications of case reports.

In most cases, a "detectivesque" elucidation is necessary. In 98% of cases, women are the perpetrators, and of these, 90% are the biological mother, with the rest being stepmothers or daycare providers.

Bleeding, seizures, clouding of consciousness up to and including respiratory arrest, diarrhea, vomiting, fever, and skin changes with scratching, acid burns, or occlusions may be caused (Fig. 1.24).

Based on individual case reports, from the psychodynamic point of view there appears to be a bizarre split in the mothers in relation to their children. On the one hand, the child is experienced as a threat, with the mother thinking the child will take from her everything she herself needs to live (Plassmann 1995).

By injury or abuse, the child is placed in a completely dependent situation in which the mother devotes herself to the illusion of being a perfect, caring, ideal mother. Characteristically, the mothers appear to the nursing personnel as particularly zealous and engaged.

Breaking through the vicious cycle of violence is primary in the psychotherapeutic process, since the violence will be repeated until it can be made conscious, worked through, verbalized, and thus integrated in the therapeutic process.

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**Fig. 1.24** Münchhausen-by-proxy syndrome

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## 1.2 Dermatoses as a Result of Delusional Illnesses and Hallucinations

Patients with delusions appear in the dermatological practice with clear somatic complaints and denial of psychopathological issues. Characteristically, the dermatologist is confronted mostly with patients presenting with monosymptomatic delusions. This is usually an encapsulated idea, while the rest of the character structure and personality appears unchanged.

Often, the symptoms are characterized by the development of a single or several related delusional ideas, without presenting the degree of or a definite relationship to schizophrenia. This is a heterogeneous series of clinical disorder presentations.



**Definition.** The most conspicuous clinical characteristic of the group of persistent delusional disorders in dermatology (ICD-10: F22.0; DSM-IV-TR 297.1 somatic type) is the impossibility of the delusion.

- ❗ **A delusion is generally characterized by**
- The patient's great subjective certainty
  - Unshakeability of the patient's belief
  - Clear evidence to the contrary

**Categorization.** Delusions involving the skin appear commonly in the form of perceived parasitosis, body dysmorphic delusions, and other body-related delusional disorders such as bromhidrosis and chromhidrosis, as well as olfactory and tactile hallucinations. Although these diseases have a psychiatric etiology, they are still dermatological conditions.

#### Presentations of Delusional Disease in Dermatology

- Parasitosis F22.8 DSM-IV-TR 297.1 somatic type (coenesthetic delusion, body hallucinations, delusion of infestation)
- Body odor delusion F22.8; DSM-IV-TR 297.1 somatic type (olfactory hallucinations): bromhidrosis [(usually with presumed chromhidrosis (sweat discoloration)]
- Hypochondriacal delusions F22.0; DSM-IV-TR 297.1 somatic type (syphilis delusion, AIDS delusion)
- Body dysmorphic delusion F22.8; DSM-IV-TR 297.1 somatic type (delusional dysmorphophobia)

**Frequency.** Delusional disorders are generally very rare and are estimated at a prevalence of less than 0.05% in the general population.

**Differential diagnosis.** Serious organically caused, schizophrenic, or affective disorders need to be ruled out. Schizophrenia is the most common and important differential diagnosis of the monosymptomatic delusional disorders. Differentiation is often difficult to make clinically, especially in the early stages of the disorder.

#### Differential Diagnosis: Main Symptoms of Schizophrenia

- Delusions (so-called contentual thought disorder):
  - Delusional ideas
  - Delusional moods
  - Delusional perceptions
  - Systematized delusions
- Hallucinations:
  - Acoustic
  - Optical
  - Olfactory
  - Taste
  - Tactile
  - Body hallucinations (coenesthesias)
- Alogia
- Affect flattening
- Anhedonia
- Asociality
- Ego disorders
- Formal thought disorders
- Affective disorders
- Catatonia
- Impaired drive and social behavior

**Pathogenesis.** The onset of delusional disorders is determined by multicausal factors, and its development is promoted by an interaction of various biological and psychosocial factors.

One possible model for explanation is the vulnerability–stress model, according to which a subclinical, congenital, or acquired multifactorially mediated disposition to illness (susceptibility) is present, and the disorder crosses the manifestation threshold when additional factors (stress/conflicts or biological stressors) are present.

Other hypotheses include a polygenic hereditary disposition with incomplete penetrance, and the dopamine hypothesis, which assumes that hyperactivity of certain messenger systems in certain regions of the brain, especially in the limbic system, is essential to the onset of psychotic symptoms. This is also an important foundation of modern psychopharmacological treatment.

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## Delusion of Parasitosis

Delusion of parasitosis is the most frequent delusional disorder with which the dermatologist is confronted.

**Definition.** In delusion of parasitosis (ICD-10: F22.8 delusional; DSM-IV-TR 297.1 delusional vs. somatic type, or F06.0 in organic hallucinosis), there is a skin-related delusional assumption of parasitic invasion.

Although they are now considered antiquated, we mention here the terms coenesthesia (body hallucinosis) and tactile hallucinosis, which are sometimes used.

**Occurrence.** These are rare cases among the overall patient population in dermatology. Elderly, socially isolated women are typically the ones affected by a delusional fixation.

**Pathogenesis.** An elicitor is reported in the history of some patients. Thus, when the complaints begin, there may be an actually experienced parasitic infestation or observation in the environment (such as pediculosis in a granddaughter) so that the delusional disorder occurs for the first time according to the vulnerability–stress model.

**Clinical findings.** Symptomatically, the patient complains of itching, tingling, pain, or formication, coupled with the subjective certainty that the symptoms are being caused by insects, mites, worms, or other parasites.

Manipulations of the skin in the sense of self-damage are intended to remove the assumed parasites, whereby dermatitis artefacta may be created. Many times, the patient brings the removed assumed pathogen to the health provider in jars and boxes, requesting further diagnostic procedures. Microscopically and macroscopically, these are usually skin scales, fibers, or foreign matter without pathogens (Figs. 1.25, 1.26).

The clinical presentation of self-induced damage occurs to various degrees and depends on the type of manipulation or the applied substances. Clinically, there are usually excoriations, erosions, cuts, or burns on the upper arms, legs, and easily reached areas of the trunk.

Self-therapy can thus lead to pronounced irritation of the skin, for example, by numerous courses of antiparasitic substances such as lindane. Often during self-therapy, aggressive chemical substances, sometimes from veterinary medicine, are applied to the skin in order to destroy the perceived parasites. The skin of the afflicted person is often significantly damaged by frequent brushing, cleansing procedures, and the application of caustic substances.

**Psychiatric symptoms.** Delusion of parasitosis is characterized by the delusional ideation of skin infestation with insects, mites, worms, or other organisms, which is uncorrectable and presents with high subjective certainty as well as symptoms that are objectively absent.

The delusional assumption leads to great suffering and massive limitations in quality of life. The constant preoccupation with the delusion leads to detriment in various social areas and numerous visits to health providers.

The body-related delusional disorder occurs mainly within paranoid (20%) and depressive disorders (50%) and is often isolated monosymptomatically, as well as under the effects of delirium and after noxae (Hornstein et al. 1989).

Three forms are differentiated in the literature (Mulsalek 1991):

1. Hypochondriacal parasitosis as a monosymptomatic hypochondriacal psychosis
2. Infestation delusion with paranoid symptoms
3. Mixed patterns of 1 and 2

This differentiation is important when deciding upon the appropriate pharmacological intervention (antidepressants vs. neuroleptics).

Five to 15% of those individuals close to patients with delusional parasitosis develop an associated delusion (refer to the below section on folie à deux; Trabert 1999). Recently, a considerable number of patients have complained of the appearance of eroded mucocutaneous lesions with the extrusion of multicolored fibers and filaments. The skin manifestations are associated with complaints of formication, fibromyalgia-like symptoms, arthralgias, altered cognitive function, and extreme fatigue. These symptoms have been termed Morgellons disease, and although its etiology remains unclear and is currently being studied by the Centers for Disease Control, many of these patients have symptoms similar to those with delusions of parasitosis. (Fig. 1.26). This disease has gained notoriety in the media as well as on the Internet, and some have referred to it as “folie à Internet.”

**Differential diagnosis.** Differentiation must be made from other purely psychiatric diseases as well as brain-organic diseases, particularly schizophrenia, brain-organic psychosyndromes, and cerebral arteriosclerosis. The delusion must be further differentiated from pure anxiety and compulsive disorders (Sect. 1.4).

Differential diagnosis must include somatoform disorders including sensory complaints with burning and itching, dermatitis artefacta and neurotic excoriations,

as well as pruritic diseases, since these at times may also take on delusional features. The differential diagnosis is important in order to select the appropriate therapeutic approach, including the target symptomatics of psychopharmaceuticals.

**Therapy.** Delusion of parasitosis has become more amenable to treatment with the advent of the atypical antipsychotics.

Bland local therapy with wound-healing dermatological treatments can usually be attempted. Detailed medical discussions about a psychiatric genesis of the



**Fig. 1.25** **a** Delusion of parasitosis in a 71-year-old woman: containers in which the presumed parasites were collected. **b** Magnification of presumed parasites, which consisted of skin particles. **c** A

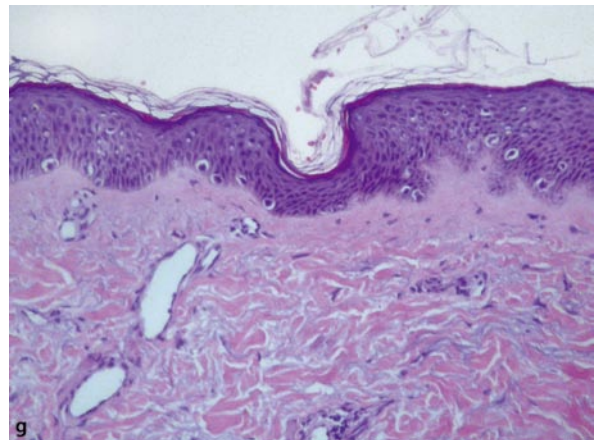
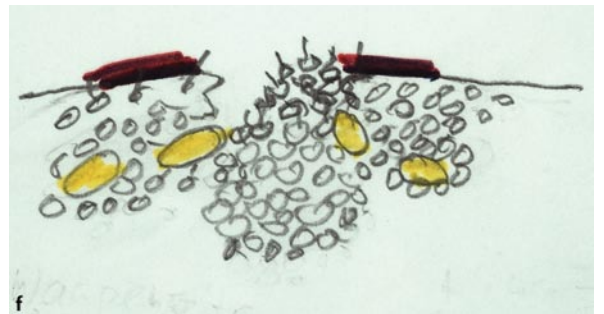
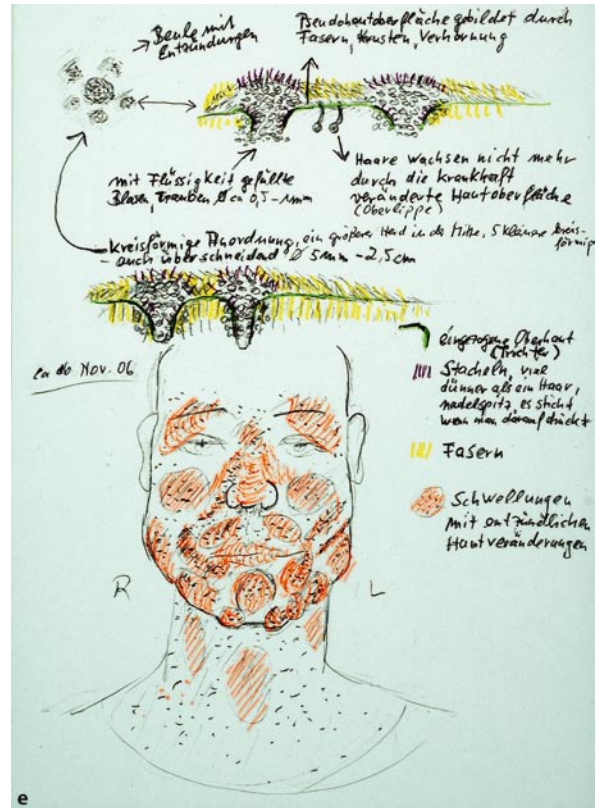
52-year-old man with delusion of parasitosis presented crumbs as presumed parasites in the dermatological office



**Fig. 1.26** **a–g** Morgellons disease.

A 53-year old woman **(a)** complained of eroded mucocutaneous lesions **(a, b)** with the extrusion by tweezers **(c)** of multicolored fibers and filaments **(d)**. The patient's drawings of the assumed mechanism **(e)** included histological pictures **(f)**. **(g)** skin biopsy of patient with regular histological findings





■ Fig. 1.26 (continued)



symptoms, as well as discussion addressing the negative results and findings of the histological or microbiological diagnostic tests, rarely result in relief or abating of the complaints and symptoms.

Initiation of a psychopharmacological therapy with neuroleptics in cooperation with the psychiatrist is of critical importance. The pathological character of the misinterpretation is usually not accepted by the patient, and a referral to a psychiatrist is often refused.

Treatment of delusion of parasitosis as part of the liaison service within the dermatology clinic, including the dermatologist, psychiatrist, and patient, has been found beneficial. But because of organizational aspects, this is usually possible only in tertiary medical centers.

If a liaison consultation cannot be held, the dermatologist often has to initiate the treatment with psychopharmaceuticals. For this, it is necessary that he or she acquire appropriate experience and postgraduate training in their use.

Treatment with neuroleptics has been successful (see below); however, very few studies with significant numbers of patients are available.

It is important to gain the patient's confidence to be able to treat the disease adequately. Initially, slow establishing of a trusting doctor-patient relationship over several consultations is necessary. Experience has shown that patients are more likely to accept this therapy if the explanation given is the necessity to "calm the skin's superficial nervous system" and decrease the distress suffered by the patient. Psychotherapy is additionally useful.

**Psychopharmaceuticals.** In addition to haloperidol, the spectrum of psychopharmaceuticals has undergone marked expansion in recent years on the basis of new research results. Therapy with modern psychopharmaceuticals has achieved a decisive improvement in the prognosis of patients with delusion of parasitosis. Delusional disorders can usually be approached with lower doses of neuroleptics than are usually prescribed for patients with other psychiatric illnesses.

The choice of psychopharmaceutical depends on the underlying psychiatric disorder and the target symptoms to be treated. If a depressive disorder is in the foreground, an antidepressant may be used. In the case of paranoid symptoms, neuroleptics are the drugs of first choice (Musalek 1991).

Currently, the following medications are primarily used in delusional disorders in dermatology (see Chap. 15): risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify), and pimozide (Orap).

The most experience is with pimozide, reported in case reports in the United States. Although still widely used, it has a significant broad spectrum of untoward effects and is losing adepts since the advent of atypical neuroleptics, which have considerably fewer side effects.

In our experience, a combination therapy of a neuroleptic with an SSRI or an anxiolytic is often necessary when monotherapy does not bring decisive improvement in the complaints, or if psychiatric mixed symptoms are present.

It is noteworthy that no significant skin-specific studies have been performed using modern neuroleptics and that initiation of therapy must usually be preceded by a precise psychiatric diagnosis.

Suffering can often be relieved under psychopharmacological therapy, the self-injurious behavior can be considerably improved, and psychosocial integration of the patient can be restored. However, complete eradication of the disease cannot be achieved in most cases, even with long-term therapy. The delusional disorder usually becomes "silent," which can be considered a good therapeutic result.

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## Body Odor Delusion (Bromhidrosis)

Many publications address the disease complex of body odor delusion (ICD-10: F22.8, DSM-IV-TR-297.1 delu-



**Fig. 1.27** Eczema due to continuous washing in body odor delusion

sional disorder, somatic type), but in everyday practice, it is a rare disease entity (Fig. 1.27).

Bromhidrosis is the subjective unpleasant odor resulting from physiological sweat, and chromhidrosis is the secretion of subjectively colored sweat.

In a delusional disorder, an attempt can first be made to educate the patient in the sense of psychoeducational measures about the physiological variation of his or her “disease.” By these means, any delusional components that may be present can be exposed.

In stubborn cases, the use of a low-strength neuroleptic (Chap. 15) may be indicated.

### Hypochondriacal Delusions

In hypochondriacal delusions (ICD-10: F22.0; DSM-IV-TR 297.1 somatic type), there is persistent, uncorrectable delusional preoccupation with the fear or conviction of suffering from a serious physical disease (Fig. 1.28).

The delusional contents must be viewed in light of the patient’s social background with regard to biopsychosocial aspects and are influenced by his or her degree of knowledge as well as by social and cultural factors. Hypochondriacal delusion has undergone repeated changes in recent years. Whereas syphilis was in the foreground of venereology in the past, this has been replaced more frequently by a delusion of having contracted AIDS.

Delusional themes and delusional contents (Sect. 1.3.2) refer these days mainly to infections or neoplasias (cancerophobia, melanoma phobia).

**Differential diagnosis.** Differentiation must be made from psychoses with hypochondriacal content or hypochondriacal comorbidity. An important differentiation of delusional disorder from anxiety disorder must be made (Sect. 3.3.2).

**Therapy.** Characteristically, delusional diseases are almost exclusively disorders that cannot be corrected by discussions with the physician.

In delusional cutaneous hypochondriasis, atypical neuroleptics are the therapy of first choice (for example, risperidone and olanzapine or aripiprazole). Treatment with SSRIs may be successful in the blurred transition to somatoform disorders. Psychotherapy can have significant adjunct results.

### Body Dysmorphic Delusions

Body dysmorphic delusions (ICD10: F22.; DSM-IV-TR 297.1 somatic type) consist of an excessive preoccupation with an uncorrectable, imagined deficiency or disfigurement in the outward appearance, which takes on delusional proportions. The excessive preoccupation causes massive detriment to social, professional, or other important functional areas.

In this disorder, there is often a blurred transition between phases of insight and the delusional fixation on the conviction of being disfigured. The difference between dysmorphophobic disorder and body dysmorphic delusions is also important with respect to the necessity of indicating psychopharmaceuticals in the latter diagnosis, even if it is not easy to distinguish between the two in individual cases. The differentiation may involve considerable difficulties. Often there are blurred transitions between body dysmorphic delusions (delusional dysmorphophobia) and somatoform disorders, including body dysmorphic disorder, whereby the delusional



Tag	früh	mittags	abends
12.12.	36,7	36,9	37,7
13.12.	36,9	36,8	38,2
14.12.	36,8	36,9	38,1
15.12.	36,4	36,8	38,0
16.12.	36,2	36,9	37,5
17.12.	36,8	37,7	36,8
18.12.	37,0	36,9	38,0
19.12.	36,3	36,7	37,4
20.12.	36,0		

Entwicklung der Temperatur (C°)				
Christa Jabskowski				
Tag	früh	mittags	abends	spät abends
7.11.05		38,6	38,7	
8.11		37,9	37,4	
9.11	38,1	38,2	38,0	37,3
10.11	36,0	37,1		37,2
11.11	37,3	37,7	37,3	36,7
12.11	37,2	37,2	37,6	37,2
13.11	37,0	37,3	37,1	37,2
14.11	37,3	37,1	36,7	37,1
15.11	37,1	36,6	37,1	37,3
16.11	37,0	37,0	37,3	37,2
17.11	36,5	36,7	36,8	36,9
18.11	36,9	37,0	37,2	37,7
19.11	37,0	37,4	37,6	37,0
20.11.	36,7	36,9	37,4	37,4
21.11	36,9		37,2	37,4
22.11.	36,9	37,1	37,9	37,1
23.11.	37,0	37,3	37,3	37,3
24.11.	36,7	37,2	37,1	37,2

**Fig. 1.28 a** Hypochondriacal delusion in patient with pronounced nevus teleangiectaticus (Klippel-Trenaunay syndrome). Patient displays weight loss due to the delusional misinterpretation

form is characterized by the uncorrectability of the disorder. Schizophrenia must also be ruled out in the case of bizarre delusions.

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### Special Form: Folie à Deux

In folie à deux (ICD10: F24.0), a delusional disorder is shared by two or more people who are in close relationship. Usually, it is an induced delusional disorder whereby the partner or family members take on the delusions (folie partagee, shared delusion), which disappear upon separation from the patient.

The authors have observed this induced delusion especially in the delusional forms of the ecosyndrome (for example, mycophobia). This disorder is rare, and there are few individual case reports in the dermatological literature.

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**Fig. 1.28 b** Hypochondriacal delusion; 54-year-old patient measuring temperature three times a day in fear of a fungus infection. **c** Melanoma phobia

### 1.3 Somatoform Disorders

In dermatological practice, it is not only clearly defined dermatoses that are diagnosed in the patients, but there are also patients in whom categorization to a dermatological entity is not successful, in whom no objectifiable symptoms can be found, or who complain of a number of symptoms that cannot be explained. The dermatological symptoms usually consist of pruritus (itching), pain, dysesthesias, formication, feeling of disfiguration, or nonobjectifiable hair loss.

Dermatology has recently been confronted with patients who think they have acquired skin changes due to environmental toxins or detergents or who suffer from nondetectable *Candida* infections or undetectable “covert” food allergies. This group of dermatological patients is often classified with diagnoses like “nihilo-dermia,” “clinical ecosyndrome” (Ring et al. 1999), or, as Cotterill (1996) termed it, “dermatological nondisease,” sometimes exacerbated by a physician’s temptation to diagnose a very rare syndrome or entity.

Somatoform disorders are disorders that are common in everyday dermatological practice and which confront the treating physician with serious problems, but they have received very scarce attention thus far, considering the frequency of their occurrence.

**Definition.** The characteristic of somatoform disorders (ICD-10: F45; DSM-IV-TR: 300.82) is repeated presentation of physical symptoms not caused intentionally, suggesting a medical condition coupled with the stubborn demand for medical examination, despite repeated negative findings and assurance by the health provider that the symptoms cannot be explained physically.

**Classification of somatoform disorders in dermatology.** Somatoform disorders in dermatology comprise a heterogeneous presentation of completely different clinical entities, with an underlying comparable psychiatric disorder.

The essential somatoform disorders are somatization disorders; hypochondriacal disorders, including body dysmorphic disorders; autonomic somatoform function disorders; somatoform pain syndromes of the skin; somatoform itching; and skin-related somatoform burning (Table 1.6).

**Occurrence.** In studies in Marburg, Germany, 18.5% of skin patients at the routine outpatient clinic of the university presented with somatoform disorders (Stangier and Gieler 1997). These were especially often body dysmorphic disorders and psychogenic pruritus

(see Part I, Prevalence of Somatic and Emotional Disorders).

#### 1.3.1 Somatization Disorders

Somatization disorders include the occurrence of a pattern of recurrent, multiple, clinically significant somatic complaints that usually lead to medical treatment. Often there is a combination of pain, as well as various gastrointestinal, sexual, and pseudoneurological symptoms.

In dermatology, environmental physical complaints, the so-called ecosyndrome, is in the foreground of the somatization disorders, whereby multiple fluctuating complaints are attributed to various intolerances.

#### Environmentally Related Physical Complaints

For many years, an increasing number of patients have sought medical help for nonspecific hypersensitivities to environmental toxins. Totally different complaints are reported, often affecting several organ systems, and they are objectively very difficult to characterize. Many patients have made an odyssey to various specialty physicians and alternative healers without finding lasting help. The problem is popular in the media (“Allergic to everything?”). The patients are classified under various terms and diagnoses (see below).

**Definition.** In environment-related physical complaints (ICD-10: F45.0), the patients report specific and nonspecific multiple physical complaints, of which the presumed cause is exposure to environmental toxins, with no proof of a direct causal relationship between exposure and extent of complaints. Numerous doctors are often consulted.

Environment-related physical complaints can be seen as a subgroup of somatoform disorders in which there is hypersensitivity to environmental substances.

**Categorization.** The following is an overview of the patterns of complaints.

#### Categorization of Environment-Related Physical Complaints and Related Terms

- General:
  - Ecosyndrome
  - “Ecological illness”



- Multiple chemical sensitivity syndrome (MCS)
- Chemical hypersensitivity syndrome
- “Total allergy syndrome” or 20th-century syndrome
- Allergic toxemia
- “Cerebral allergy”
- Idiopathic environmental intolerance
- Multiorgan dysesthesia
- Special forms:
  - Sick-building syndrome
  - Gulf War syndrome
- Special forms:
  - Electrical hypersensitivity
  - Light allergy
  - Amalgam-related complaint syndrome
  - Detergent allergy
  - Food intolerances
- Differential diagnosis:
  - Chronic fatigue syndrome
  - Fibromyalgia syndrome
  - Hypochondriasis: infection phobia (mycophobia, AIDS phobia)

**Pathogenesis.** The concepts of environment-related physical complaints, including multiple chemical intolerances (MCS syndrome) have not been generally proven in a generally acceptable way and are controversial. Biological/physiological explanatory models, stress models with trigger factors, conditioning models, and purely emotional/psychiatric phenomena, even including sociocultural illness behavior, have been discussed. Scientific acceptance and consensus of the concept of illness does not exist at the present time.

In general, this is a heterogeneous patient group with heterogeneous pathogenesis. Thus, in some patients, objectifiable somatic hypersensitivities or even clear IgE-mediated allergies may be found in addition to psychosomatic factors.

Somatic models assume a possibly conditioned loss of tolerance to chemical exposure with gradually increasing sensitivity and generalization to the entire organism. Procedures of laboratory chemical diagnostics and the contested setting of limits cause particular difficulties here.

Moreover, sociocultural factors play a decisive role in this biopsychosocial phenomenon. The discussion of “environmental toxins,” which is often reported broadly in the media, always leads to an increase in individual syndromes, such as the amalgam-related complaint syndrome, a presumed “detergent allergy,” or atypical systemic *Candida* infection.

The role of environmental toxins remains unclear, but it must be emphasized that the diagnostic possibilities are still very limited in this area. Some authors assume an elevated sensitivity to odors, and others propose neurophysiologic changes in the transmission of stimuli. In many cases it is possible, by means of proper allergological diagnostics, to prove real hypersensitivity reactions that improve after appropriate stimulus withdrawal.

Extensive studies on larger groups of patients have shown that this is not a uniform presentation of disease. Numerous different causes appear to exist. In many patients, psychosomatic factors (often in the depressive category) play a role; in others, however, objectively recordable hypersensitivity or other diseases that had not been diagnosed earlier (such as chronic infections) can be demonstrated.

**Clinical findings.** Environment-related physical complaints are characterized clinically by recurrent and nonspecific complaints in various organ systems, which may occur as a reaction to environmental exposure to many different chemical substances unrelated to one another or to exposure to nonmaterials (such as radiation).

The complaints may be monosymptomatic or occur in combination and may be coupled with an endless variability of other symptoms.

The patients report various physical complaints, as seen in the following overview.

#### Guiding Symptoms of Environment-Related Physical Complaints

- Headache, burning eyes, rhynorrhea
- Fatigue, listlessness
- Concentration impairment, forgetfulness
- Pain in the movement apparatus
- Unspecific dizziness/tachycardia
- Dyspnea

Somatic and psychiatric differential diagnostics are of central importance in causality and in the prognosis and treatment.

#### Ecosyndrome, “Ecological Illness,” “Total Allergy Syndrome”

Different terms and diagnoses are sometimes used in this group of disorders and are synonymous with envi-

**Table 1.6** Overview of somatoform disorders in dermatology

ICD nr.	Somatoform disorder	Dermatoses	
F 45.0	Somatization disorder	Environment syndrome	Ecosyndrome, multiple chemical sensitivity syndrome, sick-building syndrome
		Special forms	Food allergies, sperm allergy, detergent allergy, light allergy electrosmog, amalgam-related complaint syndrome
F 45.2	Hypochondriacal disorder	Hypochondriacal disorder in the actual sense	Infections (bacteria, fungi, viruses, parasites)
			Neoplasia
			Other nosophobias (environment syndrome; see above)
		Body dysmorphic disorder	Whole body: Dorian Gray syndrome
			Regional: head, breast, genitals
		Special form	Botulinophilia
F 45.3	Somatoform autonomic function disorder	Erythrophobia	
		Goose bumps	
		Hyperhidrosis	
		Special form	Undifferentiated somatoform idiopathic anaphylaxia
F 45.4	Persistent somatoform pain disorder	Cutaneous dysesthesias	Glossodynia – orofacial pain syndrome
			Trichodynia
			Vulvodynia, phalldynia, anodynia
F 45.8	Other somatoform disorders	Sensory complaints	Itching
			A. Localized somatoform itching
			B. Generalized somatoform itching (pruritus sine materia)
			Paresthesias
			Burning
			Stabbing

ronment-related physical complaints, depending on the clinical description.

In the ecosyndrome, patients have different subjective presentations of disease in various organ systems, coupled with the conviction of being sick because of environmental toxins.

In the “total allergy syndrome,” numerous “allergies” are held responsible for the complaints (“allergic to everything”).

Clinical Management in Psychodermatology

Harth, W.; Gieler, U.; Kusnir, D.; Tausk, F.A.

2009, XIII, 297 p., Hardcover

ISBN: 978-3-540-34718-7