

CME

Factitious disorders in dermatology

Wolfgang Harth¹, Klaus-Michael Taube², Uwe Gieler³

(1) Department of Dermatology and Allergology, Vivantes Clinic Berlin Spandau, Germany

(2) Department of Dermatology, University of Halle, Germany

(3) Department of Psychosomatic Medicine and Psychotherapy, Justus Liebig University, Gießen, Germany

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- factitious disorders
- self-inflicted lesions
- trichotillomania
- impairment of impulse control
- malingering
- Münchhausen syndrome
- Psychodermatology

Summary

Factitious Disorders are self inflicted skin lesions and includes the creation of physical or psychiatric symptoms in oneself or other reference persons. In dermatology frequently, there are mechanical injuries by pressures, friction, occlusion, biting, cutting, stabbing, thermal burns or self-inflicted infections with wound-healing impairment, abscesses, mutilations or damages by acids and other toxic to the skin. The current classification differentiates between four groups: 1. Dermatitis artefacta syndrome in the narrower sense as unconscious/dissociated self-injury, 2. Dermatitis paraartefacta syndrome: Disorders of impulse control, often as manipulation of an existing specific dermatosis (often semi-conscious, admitted – self-injury), 3. Malingering: consciously simulated injuries and diseases to obtain material gain, 4. special forms, such as the Gardner Diamond Syndrome, Münchhausen Syndrome and Münchhausen-by-Proxy Syndrome.

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

Introduction

Specific evaluation and classification of factitious disorders has led to improved understanding and development of successful treatment strategies [1].

Patients with factitious disorder feign or intentionally produce physical or psychological symptoms in themselves or others. Factitious disorders (ICD-10: F 68.1, L98.1; DSM-IV, 300.16/ 300.19) are defined as self-harming behaviors which directly or indirectly cause subjective, clinically-relevant harm without being directly linked to suicidal intent.

Factitious disorders affect an estimated 0.05-0.4 % of the general population. Although the disorder can be seen in any clinical discipline, the prevalence of factitious disorders seems to be highest in dermatology patients. A survey of doctors in various specialties found that dermatologists reported factitious disorder among 2 % of all patients in clinical dermatology units. Self-harming behaviors are 3–8 times more common among women, with the exception of malingering which is more common among men. Malingering is usually related to an incentive such as obtaining sick leave or committing insurance fraud.

Artificially produced symptoms may be produced by a various causes ranging from mechanical injuries to self-induced infections or applying toxic substances to the skin (Table 1). Symptoms of a hemostatic defect may be caused by jamming the extremities, creation of petechiae, as well as self-medicating such as taking heparin injections.

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Table 1: Genesis of self inflicted dermatosis.

Mechanical
• Squeezing, rubbing, jamming, biting, cutting, poking, hemostatic origin, disfigurement
Toxic damage
• Acid, lye, thermal injury (burns, scalds)
Self-induced infections
• Wound-healing disorders, abscesses
Medications
• Covertly taking prescription medication Injections: heparin, insulin

Table 2: Classification of self inflicted dermatosis.

Dermatitis artefacta syndrome
• In the narrow sense, unconscious self-harm
Dermatitis paraartefacta syndrome
• Impulse control disorders, often manipulation of existing skin lesions • Often partly conscious, admitted self-injury, also known as skin-picking syndrome
Malingering
• Willful deception by feigning injury or disease in order to gain something
Special forms
• Gardner-Diamond syndrome • Münchhausen syndrome • Münchhausen-by-proxy syndrome



Figure 1: Extensive scars, self inflicted dermatosis in the face.

“Atypical appearances are typical.”



Figure 2: Instruments for self-manipulation.



Figure 3: Extensive scars: self inflicted dermatosis in the face.

There is a wide range of psychopathological causes of factitious disorders.

In the current classification there are three groups as well as additional special types (Table 2, Figures 1–3).

Dermatitis artefacta syndrome

The clinical appearance of dermatitis artefacta syndrome (ICD-10 F 68.1, unintentional L98.1), depends on the type of manipulation used. In principle, the appearance of artificially produced symptoms can mimic any skin disorder. “Atypical appearances are typical”, i.e., patients with dermatitis artefacta syndrome often have lesions at atypical sites or with an atypical morphology, histology, or disease that relapses for reasons that are unclear. Physicians should be alert to the presence of foreign, toxic, or infectious substances. The consequences are serious when the patient’s deception leads to harmful or unnecessary procedures being performed by a physician based on the patient’s feigned symptoms (Münchhausen syndrome and Münchhausen-by-proxy syndrome, addiction to surgery).

Psychological symptoms

Dermatitis artefacta syndrome, that is, unconscious self-harm, may be caused by a severe emotional disorder in the patient’s biography. Such symptoms are interpreted as a re-activation of a childhood injury or trauma and represent a non-verbal “cry for help.” The harmful behavior usually occurs in secret, often in a dissociative state with amnesia. Afterward the patient may not recall his or her actions nor understand the related emotional state. Patients with dermatitis artefacta syndrome typically give a “hollow history” [2]. They are usually vague about their disorder and its development, describing its onset as a sudden event that occurred without any warning or symptoms. Typically the patients themselves are surprised about their skin condition and are unable to specify or describe in detail when the lesions first appeared or to disclose much information about their development. The patient’s medical history often has significant gaps. Usually patients are unemotional when relating their medical history - as if talking about someone else – and when giving details on the often disfiguring lesions. Patients also often fail to report any pain associated with the lesions, as one would normally expect. The family of the patient tends to be angry and accusing and often feel that the treating physicians are incompetent. There is a wide range of psychopathological causes of factitious disorders. Severe personality disorders are common (primarily emotionally unstable personality disorder, i.e., borderline personality disorder (ICD-10: F 60.31) or narcissistic, histrionic, and dissocial as well a dependent personality disorders (Table 3, Figure 4).



Figure 4: 26-year-old woman with borderline syndrome.

Table 3: Frequent psychiatric disorders in self inflicted Dermatitis.

- Early personality disorders
 - emotionally unstable borderline personality
 - narcissistic personality disorder
 - histrionic personality disorder
 - dissocial personality disorder
 - dependent personality disorder
- Depressive disorders
- Anxiety disorders
- Obsessive-compulsive disorders
- Post-traumatic stress disorder



Figure 5: Differential-diagnosis: Delusion of parasitosis: secondary self inflicted skin lesions induced by bringing out the presumed parasites.

More than two-thirds of affected patients have a history of trauma such as sexual/physical abuse or neglect. Milder forms can occur in adolescents before or after misuse of alcohol, medication, or drugs.

Overt self-harm behaviors are also reported and are commonly referred to as open or conscious dermatitis artefacta syndrome. Overt self-harm can may be due to a perceived gain associated with being ill, or it may be closely related to dermatitis par-artefacta syndrome.

Differential diagnosis of self inflicted skin disorders

Self-harm may be associated with a manifest psychotic disorder including schizophrenia, a delusional disorder such as parasitosis (Figure 5), affective disorders, childhood autism or psychological behavioral disorders due to intoxication or the use of psychotropic substances as well as organic brain syndrome, seizures, certain sexual behavior, and suicidal tendencies.

More than two-thirds of affected patients have a history of trauma such as sexual/physical abuse or neglect.

Self-harm may be associated with manifest psychotic disease.

Table 4: Diagnostic criteria of dermatitis paraartefacta syndrome.**Diagnostic criteria of dermatitis para-artefacta (DSM IV) include:**

- Repeated lacking impulse control
- Increased tension before the action
- Enjoyment, pleasure, or release of tension when performing the action
- No causal relationship to other somatic or psychiatric disorders,
- The disorder results in clinically significant suffering

Table 5: Dermatitis paraartefacta syndrome in dermatology.**Skin and mucous membranes**

- Neurotic excoriations (skin-picking syndrome)
- Acne excoriée
- Pseudo-knuckle pads
- Morsicatio buccarum
- Cheilitis factitia

Skin adnexa

- Onychophagia, onychotillomania, onychotemnomania
- Trichotillomania, trichotemnomania, trichoteiromania

In all forms of delusional parasitosis, secondary self-inflicted skin lesions are reported in up to two-thirds of all patients.

In all forms of delusional parasitosis, secondary self-inflicted skin lesions are reported in up to two-thirds of all patients. Manipulation of the skin, which is intended to rid it of presumed parasites, results in self-inflicted lesions.

Self-harm can also accompany other organic diseases: e.g., Lesch-Nyhan syndrome, Cornelia-de-Lange syndrome, Rett syndrome, chronic encephalitis, neurosyphilis, temporal lobe epilepsy, neuroacanthocytosis, and organic brain disorders (oligophrenia, dementia syndrome).

The main feature of dermatitis para-artefacta syndrome is a loss of impulse control.

Dermatitis para-artefacta syndrome

Dermatitis paraartefacta syndrome are more common in dermatology and have a broader array of clinical appearances. Also referred to as skin-picking syndrome, this is a disorder of impulse control (ICD-10 F 63.8). The main feature is lacking impulse control and thus a failure to resist the impulse or temptation to perform an act repeatedly, without rational motivation, which is harmful to the person himself or to others (Table 4). The patient is partly conscious of the disorder and often admits to manipulation if queried. Causes include psychological stress, an unresolved conflict, or an uncontrollable urge to manipulate the skin.

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Often an insignificant lesion is excessively manipulated, in turn leading to more severe symptoms. Typical clinical appearances are described in the following (Table 5).

In skin-picking syndrome, previously also known as neurotic excoriations, self-induced lesions arise in conjunction with lacking impulse control.

Skin-picking syndrome

In skin-picking syndrome, previously also known as neurotic excoriations (ICD-10: F 68.1, L98.1, F63.9), self-induced lesions arise in conjunction with lacking impulse control. The clinical appearances range from excoriation, erosions, and crusts as well as atrophic scars and areas of hyperpigmentation as seen with repeated intense scratching (Figure 6). The arms and lower legs are most commonly affected. Skin-picking syndrome can also occur on the face, however, and is then traditionally called acne excoriée.

Psychologically, this disorder is characterized by an inability to resist the impulse to scratch. Often, giving in to the impulse to scratch produces a release of tension. Comorbidities such as depression and anxiety disorders are common. When diagnosing and impulse control disorder, the presence of obsessive-compulsive disorder should be ruled out in the differential diagnosis.

A special form of skin-picking syndrome is acne excoriée, which is characterized by involvement of the face.

Acne excoriée

A special form of skin-picking syndrome is acne excoriée (ICD-10: F 68.1L70.5), which is characterized by facial involvement. In classic acne excoriée, patients excessively squeeze, scratch, or pick at initially minor lesions. Patients most often use their fingernails. Excessive picking at the lesions leads to excoriation, erosions, or ulcerations which sometimes heal with stellate-shaped scars and pigmentary disorders. Patients are often unable to resist the impulse to squeeze or scratch the lesions,

although they are willing to talk about the manipulation. Patients typically perform this behavior in front of a mirror, and this should also be queried when taking the patient's medical history.

Morsicatio buccarum

Morsicatio buccarum, or excessive cheek-biting (ICD-10: F68.1, K13.1), produces white bands of thickened oral mucosa or calluses along the occlusal line. The mucosal changes can arise from constant sucking and chewing on the oral mucosa. The lesions should be distinguished from lichen ruber or the oral mucosa and precancerous lesions/leukoplakia.

Morsicatio buccarum are whitish strips of oral mucosal thickening or calluses along the occlusal line.

Cheilitis factitia

Cheilitis factitia (ICD-10: F68.1, K13.0) is also referred to as lip-licker's dermatitis. The pathogenesis of the disorder involves chronic, cumulative damage to the skin from mechanical stress and saliva which acts as an irritant by creating excessive moisture (Figure 7). This ultimately leads to eczematous skin lesions as well as a predisposition to secondary impetiginization. Automanipulation usually affects limited, sharply-bordered areas extending beyond the vermillion border. Sucking on the lips and licking them can also produce symmetrically arranged lesions. In cheilitis artefacta, there is also additional trauma as a result of chewing of the lips.

Cheilitis factitia is also known as lip-licker's dermatitis.

Pseudo-knuckle pads

Pseudo-knuckle pads (ICD-10: F 68.1, M72.1) are caused by rubbing, massaging, chewing, or sucking, and are usually found on the finger joints. Clinically they appear to be thick, pad-like rough slightly scaling skin lesions. Mental retardation may be part of pathogenesis.

Pseudo-knuckle pads are caused by rubbing, massaging, chewing, or sucking, and are usually found on the finger joints.

True knuckle pads only occur in genodermatoses, without mechanical trauma, and are characterized by cell-rich fibrosis. In patients with pseudo-knuckle pads, careful discussion and education of the parents, followed by observation and increased awareness can help identify the responsible cause. After stopping the behavior, use of a skin care regime can be a substitute for the habitual behavior and can aid healing.

Onychophagia, onychotillomania, and onychotemnomania

Onychophagia

Onychophagia (ICD-10: F68.1, F98.8) refers to nail-biting or nail-chewing, usually with swallowing of the nail. It often occurs in combination with thumb-sucking. The constant traumatization with shortening of the distal nail plate can give rise to or trigger bacterial or viral inflammation, bleeding, and malformations. Onychophagia is usually seen in conjunction with unresolved conflicts or stress and generally affects patients during childhood or adolescence.

Onychophagia describes nail-biting or nail-chewing, usually followed by swallowing of the nail.

The disorder reportedly affects up to 45 % of young people. Clearly, not every patient with onychophagia has a severe personality disorder or is in need of urgent psychotherapy. The primary cause is stress combined with inadequate coping skills.

Onychotillomania

In onychotillomania, constant manipulation, picking at, and removal of the nails or trauma to the paronychia is believed to trigger self-induced nail disorders. These can range from onychodystrophy to severe paronychia.

Onychotemnomania

Cutting the nails too short can cause trauma of the nail plate or nail fold.

Trichotillomania, trichotemnomania, and trichoteiromania

Trichotillomania

Trichotillomania (ICD-10: F63.3, F68.1) involves repeated tearing out of the hair, resulting in significant hair loss (Figure 8). The clinical appearance may be divided into three zones, depending on the stage of the disorder:

Trichotillomania involves tearing out of the hair.

- Zone 1: long hair (regular, unaffected hair, normal haircut)
- Zone 2: missing hair (recent alopecia as a result of hair-pulling)
- Zone 3: re-growing hair (short and irregular patches of hair)



Figure 6: Skin-picking syndrome (Acne excoriée) with manipulation during psychosocial stress situation.



Figure 8: 22-year old Student with trichotillomania and adjustment disorder in a psychosocial stress situation at examination time. The 3-zone arrangement is clearly recognizable.



Figure 7: Cheilitis factitia (lip licking dermatitis) in impaired impulse control.

The underlying psychopathology in trichotillomania is lacking impulse control.

Trichotemnomania is a rare form of damaging the hair by cutting it.

In trichoteiromania, the ends of the hair appear white and frizzy.

Malingering is defined as intentional and conscious creation of physical or psychological symptoms.

The cause of the triple-zone appearance is that normal, long hair (zone 1) is easy to grab and pull out. Zone 2 is hairless, with small patches of blood where hair has recently been torn out. Older areas exhibit re-growth of hair (zone 3). Re-growing hair is shorter and cannot be easily pulled, which explains the presence of shorter hairs in zone 3.

If clinical examination reveals a triple-zone appearance, a diagnosis of trichotillomania is certain (Table 6).

If alopecia areata is considered in the differential diagnosis, a trichogram may be helpful. In alopecia areata, hair is seen in the telogen phase while in patients with trichotillomania, hair is usually pulled out in the telogen phase and thus most of the hair is in the anagen phase. Very rarely, after pulling the hair out, it is swallowed, sometimes leading to trichobezoar with ileus symptoms. There are only a few case reports of this happening, however.

The underlying psychopathology in trichotillomania is lacking impulse control. Patients have a tendency to play with or twist their hair, often in when anxious or with increased concentration in stressful situations. Differential diagnosis includes obsessive-compulsive disorders. Hair-pulling as a stereotyped movement disorder (ICD-10: F98.4) should also be excluded, a psychiatric disorder which also affects the skin and involves repetitive actions that are not appropriate to the actual situation and are not related to it.

Trichotemnomania

Trichotemnomania is a rare form of damaging the hair by cutting it [3].

Trichoteiromania

In this variant of self-induced hair loss, patients rub or scratch the scalp, causing variously severe pseudoalopecia (Figure 9). In trichoteiromania (Greek: teiro, or “I scratch”) the ends of the hair appear white and frizzy, which under light microscopy correspond to brush-like split ends (trichoptilosis).

Malingering

Malingering (ICD-10: Z76.5) is defined as intentional and conscious creation of physical and psychological symptoms (Figure 10). Malingering primarily involves mechanical injury from pressure, rubbing, cutting, burning, or self-induced infection with wound healing disorders, scald injuries, mutilation, caustic injuries, or applying toxic substances to the skin.

Table 6: Trichotillomania, trichotemnomania, trichoteiromania [3].

	Trichotillomania	Trichotemnomania	Trichoteiromania
Pattern of harm	Hair-pulling	Cutting hair	Breaking off of hair by rubbing and scratching
Clinical appearance	Typical triple-zone appearance with long, missing, and re-growing hair	Pseudoalopecia with what appears to be stubble	Pseudoalopecia with broken-off hairs, normal thickness, stubble with white, frizzy ends
Trichogramm	Reduced number of hairs in telogen phase	Normal hair root pattern	Dystrophic hair root pattern, partly reduced telogen component

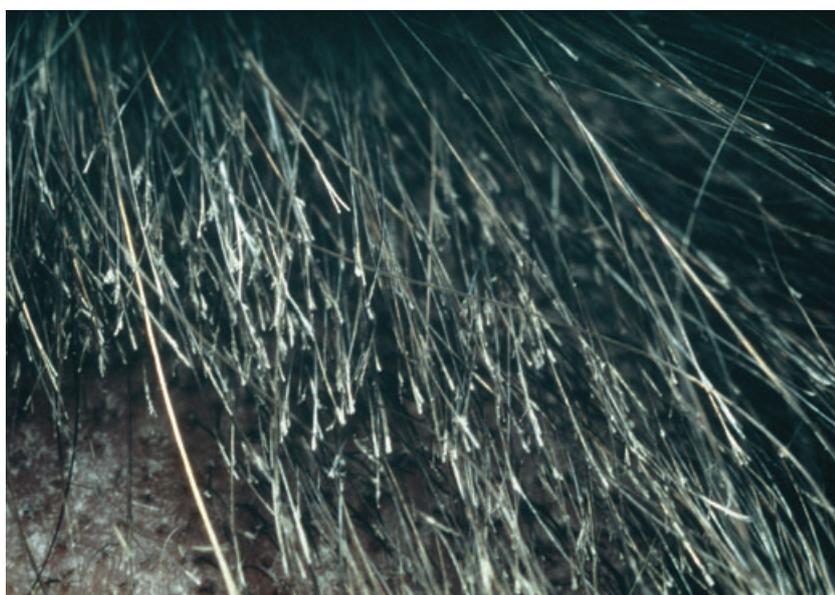


Figure 9: Trichoteiromania: whitish terminal hair ends due to mechanical-abrasive traumatization.



Figure 10: Malingering: 44-year-old construction worker with skin lesions due to of constant intentional immersing of the hands in liquid cement without protective gloves. Numerous periods of disability certified by various doctors and desire for disability.

Another issue in dermatology are feigned diseases, often in conjunction with official evaluations for occupational diseases or insurance claims. These include manipulation of patch tests in patients undergoing an assessment as well as faking serious symptoms in order to receive sick leave. For instance, a patient may provoke a reaction to a contact allergen that is known to them, but fail to disclose this information to the physician.

Psychological symptoms

Malingering is conscious, intentional self-harm for the purpose of material gain or for another social advantage such as attention and concern within the family. The falsification of symptoms represents wilful deception of the doctor.

The psychosocial motivations behind malingering include avoidance of legal action, obtaining pain medication, avoidance of military service, or financial reward. Monetary gains may be in the form of a substantial pension or health insurance payment or reimbursement by traveller’s insurance. Intentional and consciously malingering is virtually untreatable using psychotherapeutic measures, since there is no motivation on the part of the patient. In general, psychotherapeutic care is only possible once the legal proceedings have concluded.

Special forms

Gardner-Diamond syndrome

Gardner-Diamond syndrome (ICD-10: F 68.1) is characterized by episodes in which painful blue maculae appear, along with various physical symptoms, and characteristic

Malingering is conscious, intentional self-harm for the purpose of material gain.

Gardner-Diamond syndrome is characterized by episodes in which painful blue maculae appear.

psychological symptoms [4]. Synonyms include painful ecchymosis syndrome, psychogenic purpura, bruising syndrome, and painful bruising syndrome. When it was first described, and tested with injection of autologous erythrocytes, the authors suggested that the disorder was caused by an autoimmune process involving autoerythrocytic sensitization. At present the prevailing opinion is that symptoms are due to a factitious disorder.

During prodromal stages, there is initial pruritus, the skin may feel taut or there may be burning pain, usually involving the extremities, most often the legs. This is followed by edematous erythema with ecchymotic lesions which heals within 1–2 weeks. Flare-ups are characteristic and lesions heal without any residual defects.

Generalized symptoms include attacks of abdominal pain, nausea, vomiting, diarrhea, weight loss, sudden headaches, vision impairment, paresthesia and other neurological symptoms as well as hematuria, hematemesis, metrorrhagia, and amenorrhea. The disorder occurs almost exclusively in women.

The personality structure of the patients reveals classic features of dissociative disorders including conversion disorders, masochism, depression, anxiety, and inhibited expression of emotions (repressed aggression).

Münchhausen syndrome

Münchhausen syndrome (ICD10:F68.1) is characterized by a triad of symptoms: migration from hospital to hospital, pseudologia phantastica, and self-harm.

Münchhausen syndrome (ICD10: F68.1) triad of symptoms: migration from hospital to hospital, pseudologia phantastica, and self-harm [5]. The disorder was named after Baron Karl Friedrich Hieronymus von Münchhausen (1720–1797), who was known as the “liar baron.” Originally, the disorder referred to feigning an acute disease with exaggerated, overly-dramatized symptoms and giving a false medical history. Characteristic symptoms include numerous hospitalizations and surgeries, sometimes with multiple, visible scars. There is often underlying mania or a severe personality disorder such as an antisocial personality or borderline disorder.

Münchhausen-by-proxy syndrome

Münchhausen-by-proxy syndrome usually involves a special form of child abuse in which a child is harmed by a person responsible for his or her care.

Münchhausen-by-proxy syndrome (ICD-10: F74.8) usually involves harming of a child by the person responsible for his or her care in order to seek contact with healthcare providers [6]. Münchhausen-by-proxy-syndrome is thus a special form of child abuse. In 1977 two cases of Münchhausen-by-proxy syndrome were published by an English physician. The name arose from the fact that the mother deceived the physician with erroneous reports of the diseases afflicting the child (by proxy) rather than referring to her own medical history.

Therapy of self inflicted dermatosis

In the treatment of self inflicted dermatosis, clear boundaries must be drawn with malingering, and any material gains prevented, yet at the same time prematurely confronting a patient with unconsciously produced symptoms can terminate the patient-physician relationship and may even result in suicide or attempted suicide [7] (Table 7). An overview of diagnostic and therapeutic approaches is shown in Figure 11.

Dermatitis artefacta syndrome

At the beginning of therapy, careful (non-accusatory) development of a therapeutic relationship is the primary task.

At the beginning of therapy, careful (non-accusatory) development of a therapeutic relationship is the primary task. Local measures to aid wound healing should be undertaken with mild therapies for self-induced lesions, e.g., for excoriations on the lower legs zinc oxide paste may be used.

Premature confrontation or embarrassing accusations should be avoided as these threaten to end the doctor-patient relationship and can lead to further autoaggressive behavior, including suicidal impulses, or to a “physician odyssey.”

In dermatitis artefacta syndrome, patients may not understand their unconscious physical manipulation and may not be able to talk about it since it often occurs in a dissociative state (Figure 12). Premature confrontation or embarrassing accusations should be avoided as these threaten to end the doctor-patient relationship and can lead to further autoaggressive behavior, including suicidal impulses, or to a “physician odyssey.” Psychotherapy is usually necessary. Psychodynamic therapy can help stabilize the personality. These measures generally require long-term hospitalization.

The treating physician should accompany the patient until he or she can switch to a specific outpatient therapy or be referred to a psychosomatic clinic or be motivated to begin psychopharmacotherapy. The patient should only be confronted with the need for psychiatric care or psychotherapy after a stable relationship of trust has been established between the doctor and the patient.

Table 7: Therapy.

Therapy	Dermatitis artefacta syndrome	Dermatitis paraartefacta syndrome	Malingering
Psychosomatic care (diary of symptoms)	+++	+++	+
Psychoeducation	+++	+++	+
Behavioral therapy	+	+++	–
Depth psychology/ psychoanalysis	+++	+	–
Psychopharmaceuticals	++	+	–
Confrontation	---	+/-	+++

+++ Very common indication, ++ Common indication, + Rare indication, +/- Questionable indication, – possible contraindication, --- absolute contraindication

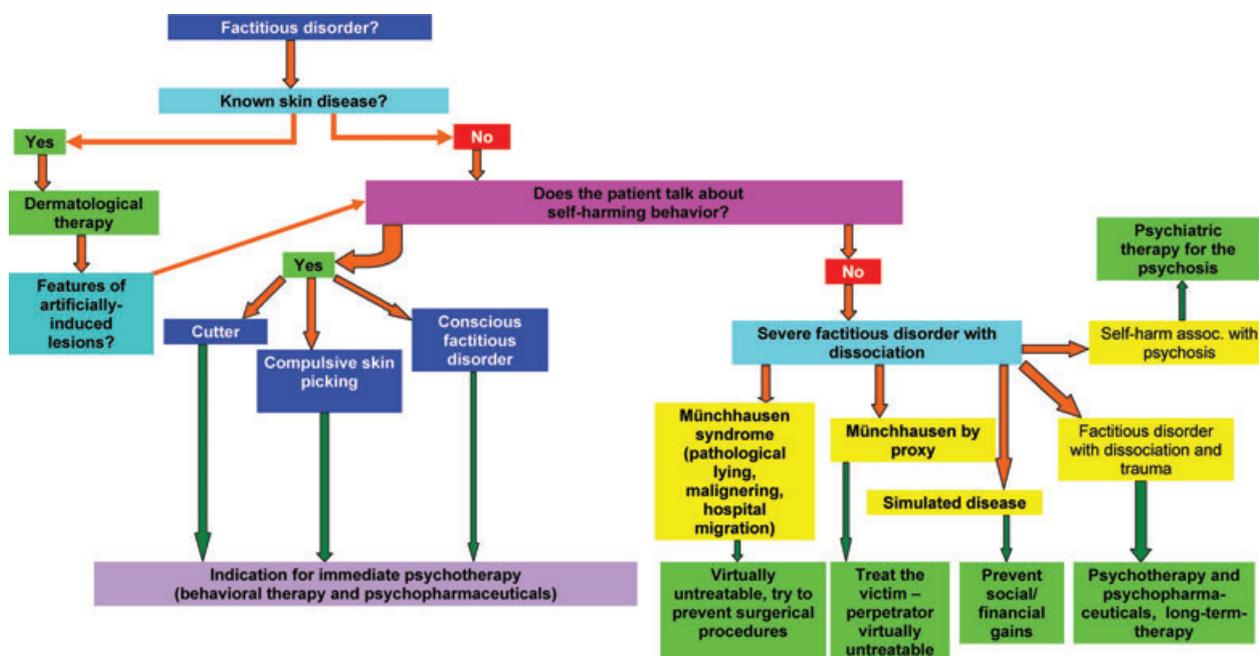


Figure 11: Algorithm self inflicted dermatosis.

Dermatitis paraartefacta syndrome

The prognosis for dermatitis paraartefacta syndrome is better on the whole since these occur “semiconsciously.” Treatment primarily consists of behavioral measures for learning impulse control. This includes self-management techniques in which the patient learns self-observation, cognitive re-structuring, and relaxation techniques.

A discussion with the patient (psychoeducation) may be the first step in making him or her aware of the mechanism at work and may be lay the foundation for re-gaining impulse control. In trichotillomania in children, educating the parents about the disorder is often successful. Subsequent observation of oneself (or the child patient) and learning to gain control over one’s actions (in the sense of cognitive re-structuring) can often heal the disorder. If needed, keeping a diary (of hair-pulling in trichotillomania or manipulations) can also aid analysis and help gain control over the disorder. The patient should record the date, time and duration of manipulation as well as the place, situation, and emotional status and any other related information.

Anti-stress measures and substituting hair-pulling or skin-picking with alternative motor actions such as squeezing a ball may also be successful as are relaxation

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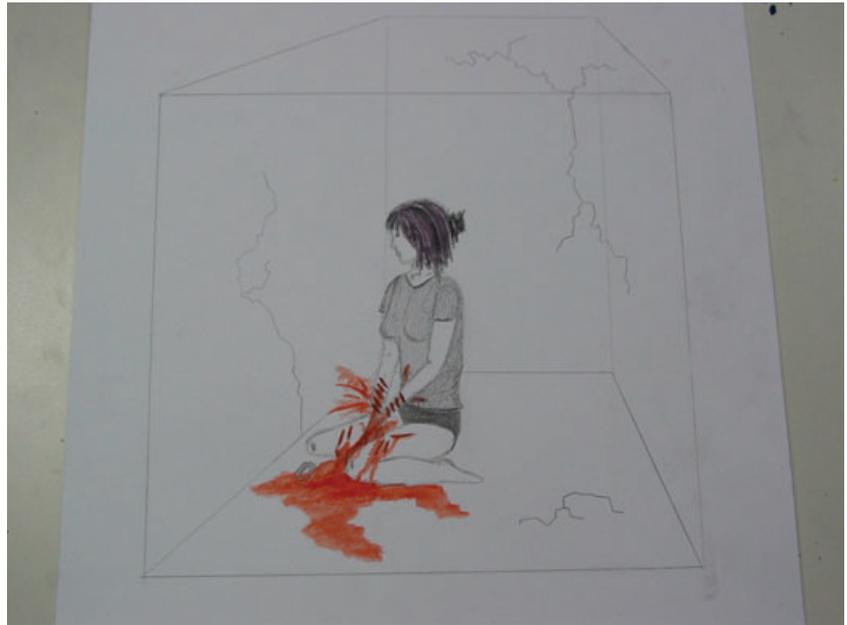


Figure 12: Cutting in art therapy.

techniques (Figure 13). In patients with a longer history of disease, intense conditioning of the actions, or with additional severe personality disorders, inpatient psychotherapy and neuroleptics may also be indicated.

In any therapy, the doctor should always treat the patient with empathy to convey understanding and acceptance of the patient's psychological conflict.

Malingering

It is all but impossible to treat a patient with malingering as there is no motivation to undergo therapy. First and foremost, the doctor-patient relationship must be re-structured, often with boundary-setting (confrontation), also in cooperation with insurers. Special consideration should be given, however, to any depressive or suicidal tendencies.

Psychopharmacotherapy of self inflicted disorders

Psychopharmaceuticals have proven effective in treating and stabilizing the usually serious symptoms. Appropriate therapies should be prescribed by physicians with the required knowledge of their use or administered in cooperation with an experienced specialist. Therapy with low-potency antipsychotic drugs to alleviate tension or with antidepressants to alleviate accompanying psychopathological symptoms may be useful, e.g., in depressive or obsessive compulsive disorders [8]. In dermatitis paraartefacta syndrome, such as trichotillomania, lacking impulse control may be treated with SSRIs (selective serotonin reuptake inhibitors) such as sertraline, paroxetine, citalopram, or fluoxetine [9]. In dermatitis artefacta syndrome, low-potency neuroleptics are usually more effective and are the preferred method of treatment.

Summary

Self-harm is one of the greatest diagnostic and treatment challenges in all of medicine. The prognosis depends on the severity of the factitious symptoms: good for milder forms of the disease, but in severe disorders, despite the availability of therapy, the prognosis is only moderate to poor or even - as seen in Münchhausen syndrome – poor to desolate. If the patient poses an acute threat to himself or others, and if there is no motivation for therapy, it may be necessary to take legal action to commit the patient to a psychiatric ward (after consultation with a psychiatrist and with the assistance of the court system). Physicians should be alert to the possibility of self inflicted dermatosis when making a diagnosis, and if the diagnostic criteria are fulfilled, therapy should be promptly initiated. Given the limited data in this area, more research is needed in the future. <<<

Conflict of interest

None.

Correspondence to



Prof. Dr. med. Wolfgang Harth
Klinik für Dermatologie und Allergologie
Vivantes Klinikum Spandau
Neue Bergstraße 6
D-13585 Berlin
Tel.: +49-30-130-13-1551
Fax: +49-30-130-13-1554
E-mail: wolfgang.harth@vivantes.de

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Therapy with low-potency antipsychotic drugs to alleviate tension or with antidepressants to alleviate accompanying symptoms may be useful.



Figure 13: Reduction of tension with a ball.

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Fragen zur Zertifizierung durch die DDA

1. Woran erkennt man einen Artefakt-Patienten in der Praxis?

- a) Unfähigkeit, die Hauterkrankung zu erklären
- b) detaillierte Anamnese
- c) subjektiv starke Beschwerden
- d) soziales Umfeld unterstützt die ärztlichen Bemühungen
- e) hohe emotionale Beteiligung

2. Bei welcher Hautkrankheit können psychosomatische Aspekte vernachlässigt werden?

- a) malignes Melanom Stadium IV
- b) Paraartefakte
- c) Alopecia areata
- d) Psoriasis vulgaris
- e) keine der genannten Erkrankungen

3. Mögliche Therapiewege bei Artefaktpatienten sind:

- a) keine Psychotherapie
- b) psychosomatische Grundversorgung
- c) Selbsthilfe
- d) ambulante Psychotherapie
- e) alle sind möglich

4. Welche der folgenden Störungsbilder gehört primär **nicht** zu den Artefakten?

- a) Simulation

- b) Dermatozoenwahn
- c) Paraartefakte
- d) Münchhausen by Proxy
- e) Trichoteiromanie

5. Welche der folgenden Erkrankungen gehört zu den Artefakt Erkrankungen?

- a) Acne excoriée
- b) systemischer Lupus erythematoses (SLE)
- c) körperdysmorphe Störung
- d) Neurodermitis
- e) Urticaria factitia

6. Das Münchhausen-Syndrom ist gekennzeichnet durch:

- a) seltene Form der Vaskulitis
- b) seltene Form der Neurodermitis
- c) seltene Haardystrophie
- d) Krankenhauswandern, Vortäuschen von Symptomen und Pseudologia phantastica
- e) Krankenhauswandern, Vortäuschen von Symptomen und Introversion

7. Die artifizielle Störung kann folgende Körperbeschwerden beinhalten:

- a) Onychophagie
- b) Trichoteiromanie

- c) Trichotemnomanie
- d) Simulationen
- e) alle sind möglich

8. Zu den selektiven Serotonin-Wiederaufnahmehemmer (SSRI) gehört **nicht**:

- a) Sertralin
- b) Metoprolol
- c) Fluoxetin
- d) Citalopram
- e) Paroxetin

9. Mögliche Indikationen für eine Psychotherapie bei Hautpatienten sind:

- a) Aids-Phobie
- b) Depression
- c) Artefakte
- d) Anpassungsstörung
- e) alle sind möglich

10. Die Therapie der Artefakte ist:

- a) alleinige blande Lokalthherapie
- b) alleinige Konfrontation
- c) immer tiefenpsychologische Therapie
- d) möglicherweise verhaltenstherapeutische Konzepte
- e) immer Psychopharmaka (niedrigpotente Neuroleptika)

Liebe Leserinnen und Leser,

der Einsendeschluss an die DDA für diese Ausgabe ist der 18. Juni 2010.

Die richtige Lösung zum Thema „HIV – aktueller Stand der Therapie“ in Heft 1 (Januar 2010) ist:

1b, 2c, 3d, 4e, 5a, 6c, 7b, 8e, 9a, 10d.

Bitte verwenden Sie für Ihre Einsendung das aktuelle Formblatt auf der folgenden Seite oder aber geben Sie Ihre Lösung online unter <http://jddg.akademie-dda.de> ein.