



Dissociation and conversion symptoms in dermatology

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Abstract Dissociation and conversion (defined as the somatic component of dissociation) can play an important mediating role in the exacerbation of the stress-reactive dermatoses (eg, psoriasis, idiopathic urticaria, atopic dermatitis), dermatoses that are exacerbated by excessive scratching (eg, lichen simplex chronicus, prurigo nodularis) and koebnerization, and the self-induced dermatoses (dermatitis artefacta, acne excoriée, skin picking disorder, trichotillomania, onychotillomania/onychophagia). Dissociative symptoms often coexist with obsessive-compulsive symptoms in the more severe cases of the self-induced dermatoses.

Dissociation can play an important role in cutaneous sensory disorder (eg, scalp dysesthesia syndrome, stomatodynia/glossodynia, vulvodynia/scrotodynia, medically unexplained anesthesia). Dissociation typically occurs in the context of extreme psychosocial stress and a history of severe abuse/neglect during early life. Dissociative patients may experience a sense of detachment from their body and present in a state of extreme self-neglect, including denial of serious skin disorders. Amnesia is one of the core symptoms of dissociation; therefore, patients, who self-induce their skin lesions during a dissociative episode often deny self-inducing their lesions; it is important to recognize that this is distinct from malingering, and the lesions are not intentionally induced. Dissociation and conversion symptoms are typically present in the complex dermatology patient and should be assessed using a comprehensive biopsychosocial approach.

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Dissociation is characterized by a discontinuity or disruption in the normal integration of consciousness, identity, memory, body representation, perception (involving all senses including sensations arising from the skin), motor control, and behavior.¹ The term *conversion* has been used in the past to refer to the somatic component (perception, motor control, behavior) of dissociative reactions.²

Dissociation severity lies on a continuum from minor symptoms (eg, occasional absentmindedness or minor scratching behavior during stress), which are a part of normal experience, to pathologic dissociation encountered in dissociative disorders and other psychiatric disorders such as posttraumatic stress disorder. In contrast to factitious disorders and malingering, the physical symptoms in dissociation are not intentionally induced.

Dissociation and conversion can play a role in the mediation of symptoms that are encountered in clinical dermatology. Dissociative symptoms often occur in the aftermath of extreme psychosocial stress¹ and/or psychologic trauma, including

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childhood sexual abuse or neglect. Phenomenologically, when the psychological consequences of extreme stress are overwhelming for the individual, they can lead to dissociation or *conversion* of the overwhelming emotional symptoms into somatic complaints, including those affecting the skin.³

Psychologic stress can have a direct impact on the skin via psychoneuroimmunologic and autonomic reactions.⁴ In contrast to other organ systems, the efferent autonomic innervation of the skin is largely sympathetic, which can result in a heightened cutaneous reactivity, especially during times of stress and sympathetic activation.^{4,5} The actions of the immune system and the autonomic nervous system are coordinated by the hypothalamic-pituitary-adrenal axis, which plays a central role in the regulation of epidermal barrier function, cutaneous immune function, and cutaneous adnexal and dermal functions that are important in maintaining local and systemic homeostasis.⁴

Dissociation may be experienced¹ as both (i) positive symptoms, such as intrusions into awareness, without conscious effort, of sensory symptoms or unexplained physiologic reactions (eg, unexplained pruritus, pain or idiopathic urticaria, cutaneous flashbacks manifesting as unexplained cutaneous sensory symptoms,⁶ or unexplained exacerbations of some stress-reactive dermatoses, such as psoriasis or atopic dermatitis⁷), and/or (ii) negative symptoms, which are associated with a discontinuity with physical or mental functions (eg, unexplained numbness, amnesia of the self-induced nature of the lesion encountered in some patients with dermatitis artefacta [DA] or trichotillomania) that are normally readily accessible in the nondissociated state.^{1,8}

Negative symptoms, resulting from a sense of detachment from the body, can also present as a state of extreme self-neglect, including neglect of a specific somatic finding, such as a slowly progressive skin lesion⁹ that may be a malignancy. Amnesia of autobiographic information is a common feature of dissociation.¹ Depersonalization, where patients may experience a sense of detachment from their body, and derealization, where patients experience a sense of detachment from their surroundings, are also features of dissociation.¹

The integument can be the focus of tension-reducing behaviors and can serve to “ground” the dissociative patient who is experiencing depersonalization or numbness. The self-induced dermatoses (DA and body-focused repetitive behaviors such as trichotillomania, skin picking disorder, and onychotillomania), when severe, often have dissociative features in addition to obsessive-compulsive features.¹⁰ Dissociative patients, who are often in a chronically hyperaroused state, may have a greater propensity to scratch during sleep, have no witnesses to this behavior, and no recollection of having self-induced their lesions other than reports of bleeding skin lesions or blood on the bedsheets upon awakening.

Dissociative symptoms can be a feature of a wide range of psychiatric disorders¹ that are also encountered in psychosomatic dermatology, including posttraumatic stress disorder, major depressive disorder, anorexia nervosa and bulimia nervosa, and severe borderline personality disorder. A study of

somatic symptoms in 28 psychiatric inpatients⁸ found a significantly higher ($P < .001$) number of somatic complaints, as per review of the patients' charts, in patients who had high dissociation scores (12.4 somatic symptoms on average) ($n = 14$) versus the controls ($n = 14$) who did not have significant dissociation (3.1 somatic symptoms on average); in the dissociation group 21.4% reported dermatologic complaints, whereas there were no reports of dermatologic complaints in the control group without dissociation.⁸ The high dissociation group also reported on average 4.7 (standard deviation = 4.3) episodes of self-destructive behavior compared with 0.5 (standard deviation = 0.6) in controls ($P < .01$).¹¹ In a study of 316 nonclinical community-based participants and 44 psychiatric outpatients,¹² medically unexplained cutaneous sensory symptoms (“burning,” “crawling sensation,” “tingling,” “pricking or pins and needles,” “pain,” “skin tender to touch,” “numbness,” “moderate to severe itching,” and “easy bruising”) correlated directly (Pearson $r = .56$, $P < .001$) with dissociation scores; among all nine cutaneous sensory symptoms, pain, itching, and numbness were the best predictors of dissociation (adjusted $R^2 = .34$, $P < .001$).¹² In a study of 49 dermatology patients and 49 healthy controls, patients with chronic dermatologic diseases reported more traumatic experiences and higher dissociation scores.¹³ In this paper, we have reviewed the literature on the association of dissociation and dermatologic disorders.

Historical perspective

Historically, the literature on stress and psychosomatic reactions made reference to “hysteria” or “hysterical conversion” and their accompanying dissociative and somatic symptoms.⁸ In the late 19th century, Pierre Janet (1859-1947) suggested that memories of traumatic experiences may be stored outside of conscious awareness and manifest as somatic symptoms.⁸ Dissociation tended to refer to the separation of mental events from normal consciousness (with symptoms such as amnesia, depersonalization, and “alter” personality states), whereas somatization and conversion tended to refer to somatic complaints in the absence of any physical disorder.⁸

Modern psychiatry recognizes a strong association between dissociation and conversion or somatization.⁸ In the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5),¹ the *absence* of a physical basis for the somatic symptoms in somatization is no longer a requirement for diagnosis. The DSM-5¹ uses a multifactorial biopsychosocial approach in dealing with somatic symptoms and recognizes that it is not appropriate to make a mental disorder diagnosis solely because a medical cause cannot be determined.

In the DSM-5, somatization disorder has been replaced with *somatic symptom disorder*,¹ which does not require an absence of a physical basis for the somatic symptoms. Medically unexplained symptoms remain a core feature of *conversion disorder*, which is defined by the presence of one or more medically unexplained symptoms of voluntary motor

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