

CASE REPORTS

Behaviour therapy of psoriasis— a hypnoanalytic and counter-conditioning technique

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Summary

In the case described, an account is given of psoriasis in a female aged 38 who presented with a history of a rash of increasing severity for 20 years, originating during a period of severe emotional stress in a susceptible personality type.

During the whole of this period, there was never a time when she had been clear, and exacerbations had been most severe during her two pregnancies.

She was treated under hypnosis by a six-point schedule. This involved analysis and discussion, with interpretive (insight) psychotherapy and desensitization by reciprocal inhibition as described by Wolpe.

As well as the disappearance of the rash, overall improvement in personality was a notable impression gained from the self-rating Personality Schedule score at the end of treatment.

Introduction

The treatment of psoriasis by topical application is notoriously ineffective and the condition commonly pursues a variable and fluctuating course. The systemic use of folic acid antagonists and corticosteroids is reserved for the pustular variety and even so is fraught with hazards (Ryan & Baker, 1969). If it can be shown that stress is a factor in the appearance and exacerbation of psoriasis, the prescription of anxiolytic drugs may have a beneficial effect (Grayson, 1962; Levy, 1963; Padilla, 1965). Depression is also often an important part in the psychopathology of this problem, and sufferers have been shown to respond dramatically to anti-depressants (Bethune & Kidd, 1961; Hill, 1965; Lester *et al.*, 1962; Obermayer, 1955).

The author has elaborated a six-point treatment schedule using hypnosis for the relief of psychosomatic illness, phobic anxiety and behavioural problems as follows: (1) relaxation under hypnosis, (2) hypnoanalysis and interpretive (insight) therapy, (3) counter-conditioning, (4) practical retraining, (5) assertive retraining, (6) self-hypnosis. This particular case was treated as a dermatological response

to anxiety, and a similar technique has been applied to a wide range of neurotic illness, details of which will be reported in a later paper.

Case report

This patient, seen in private practice, revealed an emotional childhood in which she described herself as shy and withdrawn, suffering from nervous dyspepsia, with twitching of the eyes and frequent nightmares. In her relationship with her parents, she felt resentment towards her father, who favoured other members of her family, and ambivalence towards her mother, who was instrumental in sending her to boarding school. This resulted in a great deal of tension, insecurity and anxiety until the age of 16. She was self-conscious with a sense of inferiority, much bothered by criticism and prone to blushing. In the family history her father had a patch of psoriasis on the elbow, her brother had 'nervous skin trouble' and her sister had an incurable skin condition. The provoking emotional factor was her rejection by a man much older than herself, her constant embarrassment by him in the presence of others making her feel 'hot under the collar', with the subsequent appearance of a rash on the back of her neck. Eventually she married this man, but he thought he had contracted V.D. and, as a consequence, sexual intercourse was a rare and frightening experience from which she gradually withdrew in spite of negative blood tests. During this period the rash spread to other parts of the body as described below and treatment by her G.P. resulted only in transient improvement with frequent and inevitable relapses. In addition, in each of her two pregnancies there had been an acute exacerbation of the rash.

On examination, the patient was an anxious-looking woman with affected areas at the back of the neck clearly defined to the margin of the scalp as reddish dry raised lesions partly covered by scales, with other areas of small bleeding points exposed due to scratching. Similar lesions were present on the extensor surfaces of both elbows and knees.

At the first meeting, the patient was asked to rate herself using the Willoughby Personality Schedule (Short Clark-Thurston Inventory) (Fig. 1). This is a test of neuroticism, relating mainly to common types of social situations, information for which does not usually emerge from routine history taking. About 80% of neurotic patients are revealed as having scores over 30 (Wolpe, 1958). The score for this case was 54.

Treatment

(1) *Relaxation in hypnosis.* The object is the canalization of attention on the voice of the therapist to the exclusion of all other afferent stimuli. Hypnosis was induced by a technique of eye fixation with progressive relaxation and the visualization of scenes of complete serenity. The patient was instructed to maintain this feeling whilst she was regressed into memories of situations of maximum trauma, and subsequently through all stages of treatment.

(2) *Hypnoanalysis and interpretation.* Exploration under hypnosis allows the patient to ventilate feelings experienced in situations of stress, and whilst the calming effect of hypnosis may be used for reassurance there is no doubt in my mind of the cathartic and beneficial effect of the process of abreaction. Whilst in the calm state the patient is given an explanation of the origin of her symptoms. In this case, verbalization confirmed by feelings of rejection in childhood, her unhappiness at school reinforcing the development of a marked anxiety in social situations, resulting in the avoidance of such situations and blushing when criticized. Into this personality structure feelings of anger, frustration and aggression developed in her relationship with the man who was to become her husband, and subsequently by the conflict caused by the highly traumatic sexual situation which resulted from the marriage.

Evidence exists of a constitutional factor in determining the weakness of organs (Wolberg, 1948). In this patient, her father was known to have had psoriasis, a brother had 'nervous skin trouble' and her sister an undiagnosed and incurable skin condition. In somatization reactions the organ chosen is likely to be one whose function was prominent at the time of the traumatic episode. The continuous barrage of stressful impulses saturate the patient with anxiety producing somatic symptoms resulting in pathological changes in predisposed organs (Wolpe & Lazarus, 1966). It was not long, therefore, before the blush of youthful embarrassment gave way to the rash on the neck after feeling 'hot under the collar', and spread to the typical extensor areas of elbows and knees.

(3) *Counter-conditioning.* A hierarchy of anxiety-provoking situations was constructed, from that producing the least anxiety to that producing the

most. This graduated from situations such as meeting neighbours unexpectedly whilst out shopping through numerous events in the social and family life of the suburban housewife to the maximum conflict producing episode in the marital situation. There is no doubt that whilst under hypnosis, conscious control is temporarily suspended and the therapist has direct access to the unconscious mind which responds to the signal of anxiety provoking memories. A process of counter-conditioning with reciprocal inhibition (Wolpe, 1958) was therefore embarked upon, the patient being asked to visualize scenes in the hierarchy already constructed in ascending order of severity, whilst retaining the feeling of calmness and content.

(4) *Practical retraining.* After each session the patient was directed to practice her newly acquired response by deliberately going out to meet the situation discussed. The patient attended weekly and by the fifteenth session the skin condition had completely resolved and she felt calm and relaxed in previously anxiety-provoking situations. In her relationship with her husband she stated, 'He says I am a new woman, able to relax and show him my affection'.

(5) *Assertive retraining.* In this definition, the patient was taught to have an improved image of herself so that anxiety would not occur and a more assertive response to the various life situations would result. Controlled behavioural responses were relearned in relation to situations of stress were combined with suggestions of ego-strengthening as used by Hartland (1966). For example, in this case the patient was told that she was attractive, alert, capable and efficient as a housewife and mother, well dressed and with a beautiful skin, etc. Once again, these ideas were more readily accepted under hypnosis, the critical processes of the conscious mind being temporarily in suspension.

(6) *Self hypnosis.* The patient was taught, whilst under hypnosis, to hypnotise herself and was instructed to use the technique for 15 min twice daily in her own home in order to consolidate her newly acquired ability to relax. In this state, auto-suggestion of loss of symptoms and positive suggestion of ego-strengthening completed the process.

At the end of treatment, further psychometric testing on the patient's self-rating Schedule showed the level of neuroticism to be reduced to 8 (Fig. 2).

Follow-up

Two months after cessation of treatment the improvement in the skin condition was maintained. At this point, the patient was 20 weeks pregnant but unlike previous occasions there had been no sign of a relapse. Her overall improvement in personality and her confidence in previously stressful

PERSONALITY SCHEDULE

INSTRUCTIONS

The questions in this schedule are intended to indicate various personality traits. It is not a test in any sense because there are no right and wrong answers to any of the questions in this schedule.

After each question you will find a row of numbers whose meaning is given below. All you have to do is to draw a ring around the number that describes you best.

- 0. means "No". "Never", "Not at all" etc.
- 1. means "Somewhat", "Sometimes", "A little" etc.
- 2. means "about as often as not", "an average amount" etc.
- 3. means "usually", "a good deal", "rather often" etc.
- 4. means "practically always", "entirely" etc.

1. Do you get stage fright?	0 1 2 3 ④
2. Do you worry over humiliating experiences?	0 1 2 ③ 4
3. Are you afraid of falling when you are on a high place?	① 1 2 3 4
4. Are your feelings easily hurt?	0 1 2 3 ④
5. Do you keep in the background on social occasions?	0 1 2 ③ 4
6. Are you happy and sad by turns without knowing why?	0 ① 2 3 4
7. Are you shy?	0 1 2 ③ 4
8. Do you day dream easily?	0 ① 2 3 4
9. Do you get discouraged easily?	① 1 2 3 4
10. Do you say things on the spur of the moment then regret them?	0 ① 2 3 4
11. Do you like to be alone?	0 1 ② 3 4
12. Do you cry easily?	0 ① 2 3 4
13. Does it bother you to have people watch you work even when you do it well?	0 1 2 3 ④
14. Does criticism hurt you badly?	0 1 2 3 ④
15. Do you cross the street to avoid meeting someone?	0 1 2 ③ 4
16. At a reception or tea do you avoid meeting the important person present?	① 1 2 3 4
17. Do you often feel miserable?	0 ① 2 3 4
18. Do you hesitate to volunteer in a class discussion or debate?	0 1 2 3 ④
19. Are you often lonely?	0 ① 2 3 4
20. Are you self conscious before superiors?	0 1 2 3 ④
21. Do you lack self confidence?	0 1 2 ③ 4
22. Are you self conscious about your appearance?	0 1 ② 3 4
23. If you see an accident does something keep you from giving help?	0 ① 2 3 4
24. Do you feel inferior?	0 1 2 3 ④
25. Is it hard to make up your mind until the time for action is past?	① 1 2 3 4
	<u>54</u>

FIG. 1. Personality Schedule before treatment.

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| 25. Is it hard to make up your mind until the time for action is past? | ① 0 1 2 3 4 |

8

FIG. 2. Personality Schedule after treatment.

situations was also noted. Three months after the birth of her child, that is 10 months after cessation of treatment, the skin remained clear.

Discussion

In the recent paper 'Psoriasis—treatment' (Dahl, 1971) no account is taken of the stress factor in the aetiology and exacerbation of psoriasis, although this is well known to general practitioners, dermatologists and patients alike, and for which reason anxiolytic drugs are often added to recognized treatment routine (Grayson, 1962; Levy, 1963; Padilla, 1965). Dr Harvey Baker (1971) states that 'there is little doubt that major emotional stress can sometimes contribute to the exacerbation and chronicity of this disease'. Furthermore, in a leading article of the *British Medical Journal* of the 12 July 1969, it is stated that 'the aetiology of all forms of psoriasis is still uncertain, but it is usually accepted as a genetically determined abnormality which may be brought to light by a variety of stimuli including, for example, streptococcal sore throats and emotional stress'.

Marks, Gelder & Edwards (1968), using hypnosis for the treatment of phobic anxiety, made 'repeated suggestion of improvement' without attention to underlying dynamics. They showed this to be inferior to systematic desensitization with relaxation. Jacobson (1938) required from 50 to 200 sessions of assiduous training to produce the relaxation necessary for therapy. By the technique described, no more than 5 min of each session will produce maximum relaxation.

Preliminary investigation in this case had suggested that the skin condition was a somatization reaction resulting from an acutely traumatic situation in an anxious personality. The attempted removal of symptoms without attention to underlying dynamics is a controversial proposal put forward by some behaviour therapists. This established case of psoriasis was traced back under hypnosis to these emotional factors. Attention was focused on the patient's feelings of resentment, her social anxieties

and her low self-esteem. Adult and childhood feelings of rejection were discussed and therapeutic suggestions of self-assertion and increased confidence were given. Training in self hypnosis served to sever some of the transference that had resulted and to enhance the anxiolytic effect of therapy. The overall result of treatment was the resolution of the skin condition with marked improvement in personality as shown on the patient's self-rating psychometric testing schedule.

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