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Article *in* Psychosomatics · May 2000

DOI: 10.1176/appi.psy.41.3.279 · Source: PubMed

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Dissociative Identity Disorder Presenting With Psychogenic Purpura

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Psychogenic purpura was first described in four women by Gardner and Diamond in 1955 as the occurrence and spontaneous recurrence of painful ecchymoses after minor trauma.[1] This phenomenon was initially thought to result from sensitization of patients against their own extravasated erythrocytes and thus was called "autoerythrocyte sensitization purpura" (Gardner-Diamond syndrome). This syndrome was renamed "psychogenic purpura" by Ratnoff and Agle, who postulated a psychogenic basis for the etiopathogenesis of the disorder; however, the exact mechanism of this syndrome is still unknown.

The primary clinical feature reported in the literature is recurring ecchymoses. Apart from skin lesions, different systemic symptoms have been mentioned,[1] including episodic abdominal pain, nausea, vomiting, arthralgia, headache, and other hemorrhages such as epistaxis, gastrointestinal bleeding, and bleeding from ear canals. Although bleeding from the eyes is very rare, especially in Western literature, seven cases have been reported in Turkey.[2] Some of the patients with psychogenic purpura also had dissociative reactions, conversion symptoms, and hysterical traits along with their hemorrhagic symptoms.[2,3] In this case report we describe a patient diagnosed with dissociative identity disorder (DSM-IV) who presented with psychogenic purpura in the form of bleeding from the eyes and various body surfaces.

Case Report

Ms. A. a 22-year-old widow, was referred to the Psychiatry Department of Istanbul Medical School by the Hematology Department for psychiatric evaluation of the following complaints: spontaneous and unexplained bleeding from the eyes, nose, ears, and mouth as well as several bruises, especially in the extremities.

Ms. A. was involved in a car crash with her family 2 years previously and had been admitted to the hospital with multiple fractures. One month later and after her discharge from the hospital she began to have "flashbacks" of the accident and developed startle responses upon hearing sounds of any car during daytime. During that year she had recurrent ecchymotic lesions in her arms, varying in size, sometimes as small as a coin and sometimes covering her entire arm. Six months before her referral to our department she was seen by a hematologist because of these lesions and her complaint about bleeding from her ears. Extensive hematological examinations and laboratory check-up revealed no abnormalities. During that time, Ms. A. also described bleeding from other parts of her body, such as her eyes, nose, mouth, and irregular menstrual bleeding. These bleedings occurred in staff's presence and were seen by examiners and interviewers; thus, when the patient cried her tears were filled with blood.

When questioned, she told about a man's voice inside her head that started to give her advice. This began a short time after the bleeding began. She knew this voice since age 17 and called it "my friend." This voice was different from her own voice and belonged to an older man who was not a friend or a relative and had a name of his own. When questioned in greater detail about other dissociative symptoms, she told about her amnesias. She did not have memory of any events between the ages 8–9 and 17–19. She also complained of not being able to remember what she had been doing during the greatest part of the day. At times she felt like a stranger in familiar places and to familiar people. Her family members indicated that she sometimes behaved childishly and played with toys or with the children of visiting friends. During psychiatric interviewing, when questioned about depression, she mentioned a 2-month period, before the interview, of depressed mood, diminished interest and pleasure in many activities, difficulty in concentrating, hopelessness, insomnia, and recurrent thoughts of death that ended in her attempt to commit suicide by swallowing a large number of pills.

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Regarding her personal history, Ms. A. is the eldest of five siblings. Her mother has sequela of poliomyelitis and uses crutches to walk, and her father is an alcoholic and a cannabis abuser who had beaten Ms. A. almost every day during her entire childhood. Her father did not let her continue her education after primary school, and she had to start working in a factory at age 12. When she was 13, her uncle, who was 19 at the time, stayed in their house, and he abused her sexually, getting into her bed and caressing her genital area. When she complained about this to her family, nobody believed her and the sexual abuse went on for about 2 years. At the age of 15, Ms. A. married a young man who worked at the same factory. Although both families at first objected to the marriage, she moved to her husband's house to live with his family. Ms. A. gave birth to a baby girl, but 2 months afterward her husband and his mother forced her to leave their house. Her daughter was taken away when she was 6 months old and she has not been able to see her again. Before returning to her parents' home she traveled to different cities and in one of them she lived for 2 years, but of this she has little memory. After returning home, her uncle, who was still living in the house, resumed sexual abuse, this time including intercourse.

Apart from Ms. A.'s sexual abuse and dissociative history, she has feared being in social situations and performing in front of others since age 12. She also reported recurrent obsessional thoughts and repetitive behavior related to cleaning. For 10 years she has spent 1–2 hours daily washing the dishes.

On mental status examination, Ms. A. was found to be cooperative and well oriented to time and place. Her thought process was normal. She was depressed and had suicidal ideation along with obsessive thoughts and compulsions about cleanliness; however, she did not have any delusional thoughts and her affect was congruent with her thought content. During the interviews she had amnesias. She also described flashbacks related to the car accident, avoidance of stimuli associated with the trauma, and inappropriate arousal symptoms.

During hematological examinations, Ms. A. was observed shedding tears filled with blood. She did not have any premonition about the bleeding, and the bleeding was not considered factitious. The tears were analyzed with a light microscope, and they were full of erythrocytes. The erythrocytes in the teardrops were of the same blood type as the blood obtained by venipuncture.

Laboratory investigations, including complete blood cell count with differential bleeding time; clotting time; prothrombin time; thromboplastin time; platelet count; and morphology; fibrinogen; thrombocyte aggregation; factor V, VIII, IX, and XIII levels; and antinuclear antibodies and rheumatoid factor, carried out on several occasions, yielded no abnormalities. Endometriosis was eliminated on gynecological evaluation. Otorhinolaryngological and ophthalmological examinations revealed no cause for the bleeding. The result of the intradermal autoerythrocyte sensitization test was negative. EEG was normal.

Rorschach findings were as follows: stereotypy in thought, increased effort to control the aggression toward self, severe obsessive findings, depressed mood, and a tendency for introversion.

A Thematic Apperception Test showed that Ms. A. ignored her mother and had severe conflict with her. Her wish to escape from a conflictual environment, feelings of guilt and self-punishment, and ambivalence toward her family were prominent.

Through use of a "Draw a Person Test," conflict with her father, introversion, anxiety, and guilty feelings were seen. Her score in the Dissociative Experiences Scale was 34.

Discussion

Dissociative Identity Disorder (DID) is a chronic dissociative disorder, and its cause generally involves a traumatic event such as sexual or physical abuse in childhood.[4] It may overlap with other psychiatric disorders and present with associated symptoms rather than as the main features of the disorder.[5] Thus, it has been defined as a "polysymptomatic" and a "polysyndromic" disorder.[6]

Using SCID and SCID-D, this patient was diagnosed according to DSM-IV, Axis I with 1) dissociative identity disorder, 2) major depression, 3) posttraumatic stress disorder (chronic), 4) obsessive-compulsive disorder, 5) social phobia, and 6) psychological factors affecting medical condition; and on Axis II with 1) obsessive-compulsive personality disorder and 2) avoidant personality disorder. In this case the multiple diagnoses and the sexual and physical trauma during childhood seem to be consistent with the diagnosis of DID. There have been many comprehensive studies of DID in recent years, and in an epidemiological study, DID prevalence was found to be 0.4% in Turkey.[7,8] Kiziltan et al.[9] reported that psychiatric comorbidity is high in DID and that DID patients have an average of 9.3 comorbid diagnoses on two axes.

It has been reported that new lesions can be induced by hypnotic suggestion in psychogenic purpura.[1] Because dissociative populations are also characterized by high hypnotizability,[10] there might be a relationship between these two clinical pictures.

Janet[10] identified some patients with bleeding from mouth, nose, uterus, and skin as a result of rupturing of superficial blood vessels. He reported that this kind of hemorrhage resembles the "stigmata" of Christian saints.[11] It is quite improbable that this religious factor could have played a part in symptom formation for this Moslem patient. In Turkish culture, "shedding bloody tears" is a very common idiom, and it is used both in daily language and literature to express extreme sorrow and emotional suffering. It is noticeable that seven cases of eye bleeding have been reported previously in Turkey.[2] Apart from this, we have not been able to find any other references to a psy-

chogenic purpura case with bleeding from the eyes in Western literature.

Psychogenic purpura is a rare syndrome that may occur in association with dissociative disorder and traumatic events in childhood, and it may also have cultural correlates. Further, physicians who treat psychogenic purpura patients should keep in mind its association with trauma-related disorders.

The authors thank Dilek Tunalı, M.D., for contributing to the revision of this paper and Arşaluys Kayır, Ph.D., and Nilüfer Alçalar, Ph.D., for assistance on applications of psychological tests.

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