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Multimethod and Interpersonal Assessment in Medical Settings: A Case Study from the Dermatology Unit

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ABSTRACT

Psoriasis is a chronic skin disease with multifactorial aetiology. The psychological impact of skin diseases is increasingly recognised, but only scant attention has been given to the possible role of couple relationships as protective factors for dermatology patients. This article presents a multimethod assessment conducted along with physical examination at a Dermatology Unit. Specifically, the assessment includes measures of emotion regulation and attachment. The first aim of the article is to support an integrated assessment of dermatological and psychological factors together. The second aim is to highlight the possible role of couple relationships in the management of skin diseases.

KEY WORDS: attachment; emotion regulation; couple relationships; psoriasis; psychosomatic medicine.

INTRODUCTION

Psoriasis is a chronic inflammatory and hyperproliferative skin disease. It is one of the most common dermatological diseases and it affects approximately 2% of the world's population.

According to the current understanding, psoriasis is a complex disorder caused by the interplay of many different factors. Its aetiology appears to be multifactorial but some evidence suggests T-lymphocyte-based immunopathogenesis. Several studies highlight associations between psoriasis and specific medical conditions and lifestyle factors such as obesity, osteoporosis and cigarette smoking (Mattozzi, Richetta, Cantisani, Macaluso, & Calvieri, 2012; Naldi et al., 2005; Richetta et al., 2011). Additionally, Kabat-Zinn et al. (1998) provided evidence that a stress-reduction programme (MBSR) helps skin clearing in psoriatic patients undergoing phototherapy (UVB) and photochemotherapy (PUVA). Also, Fortune et al. (2003) demonstrated stress to be a major determinant of the outcome of treatments such as phototherapy. Thus, the psychological impact of skin diseases such as psoriasis is increasingly recognised (Wittkowski, Richards, Griffiths, & Main, 2004; Schwartz, 2012) and the role of psychological distress in the onset, exacerbation and perpetuation of symptoms in these diseases is well established (Millard, 2005).

When analyzing literature regarding psychological factors involved in skin diseases it is possible to individuate two different kinds of studies: some are focused on "internal aspects" and others are focused on "external (context) aspects". If we look at the former kind, literature highlights the high prevalence of psychiatric disorders (in particular major depression, anxiety) among people affected by chronic physical disorders, in particular skin diseases, such as psoriasis, atopic dermatitis and urticaria (Ponarovsky, Amital, Lazarov, Kotler, & Amital, 2011). With specific reference to psoriasis, Kurd, Troxel, Crits-Christoph, and Gelfand (2010) demonstrated both an increased risk of depression and anxiety and a higher risk of suicidality.

On the other hand, with regard to the latter kind – what we called "external (context) aspects" – psychological implications refer to social interactions and affect the overall quality of life. Difficulties could emerge in workplaces or during social activities (De Korte, Sprangers, Mombers, & Bos, 2004). Thus, at the intersection between the former and the latter level, these kinds of difficulties might be the effect of internalized stigma and a bidirectional influence may exist between social functioning difficulties and "dermatological shame" (Kellett & Gilbert, 2001).

Finally, special attention should be given to aspects such as *emotion regulation* – defined as the ability to modulate positive and negative emotional responses to internal and external stimuli (Gross, 2007). In fact, this construct seems to unify internal and external elements, including various processes that reside both within individuals (e.g., internal regulation of emotion) and external to the individual (Gross & Thompson, 2007; Spinrad, Stifter, Donelan-McCall, & Turner, 2004). For example, a recent study within a cognitive framework points out that early maladaptive schemas (EMS) – which are cognitive as well as emotional patterns related to personal childhood – are strongly related to psychological distress in dermatology patients (Mizara, Papadopoulos, & McBride, 2011).

Taking the above-mentioned considerations into account, we will now report the complete psychological assessment of a patient affected by psoriasis and his partner. The aim of the article is to discuss, in depth, psychological factors implicated in dermatology in order to support the integration of psychological and medical examinations in common clinical practice and health-care institutions.

ROLE OF EMOTION REGULATION IN SKIN DISEASES

Prior research in the field of dermatology pointed out the importance of emotions for dermatology patients. Research focused primarily on the alexithymia construct ([a] lack, [lexis] word, [thymos] emotion) – a personality trait characterising people with an impairment in mental representations of emotion – defined by difficulty in identifying feelings and the bodily sensations of emotion; difficulty in describing feelings to other people; restricted imaginative processes, as evidenced by lack of fantasies; and externally oriented cognitive style (Sifneos, 1973; Willemsen, Roseeuw, & Vanderlinden, 2008).

Emotion regulation refers to the "conscious and nonconscious strategies [people] use to increase, maintain, or decrease one or more components of an emotional response" (Gross, 2001, p.215). Thus, *emotion regulation* is a multicomponential process that unfolds over time and specific strategies can be differentiated along the timeline of the unfolding emotional response. Particular attention has been given to two particular emotion regulation strategies: *cognitive reappraisal* (which consists of attempts to think about the situation so as to alter its meaning and emotional impact) and *expressive suppression* (which consists of attempts to inhibit or reduce ongoing emotion-expressive behaviour) (Gross, 1998). Individual differences in the use of these emotion regulation strategies seem to have implications for affect, well-being and social relationships. Prior studies show that reappraisers experience and express greater positive emotion and less negative emotion, whereas suppressors experience and express less positive emotion, but greater negative emotion. Moreover, research data indicate that using reappraisal is associated with better interpersonal functioning and well-being; conversely, using suppression is associated with worse interpersonal functioning and well-being (Gross & John, 2003).

Regarding dermatology patients who, for example, suffer from stigma (Roosta, Black, Peng, & Rileym, 2010), emotion regulation might be one mechanism underlying the relationship between stigma and psychopathology. In fact, current research on coping with stigma has examined emotion regulation strategies, such as *cognitive reappraisal*, as moderators of the association between stigma and health (Miller & Kaiser, 2001).

Our point of view is that, as we previously stated, *emotion regulation* can be a more comprehensive framework for understanding the diverse meanings and different ways dermatology patients suffer psychologically.

ROLE OF ATTACHMENT AND COUPLE RELATIONSHIP IN SKIN DISEASES

Mikulincer, Shaver, and Pereg (2003) argued that as a result of specific experiences of security and successful distress-alleviation experience with attachment figures, individuals develop effective strategies for regulating negative emotions, as well as representations of their own worth and resources. In adulthood, partners are considered as attachment figures that might play an important role in enhancing emotion regulation (Feeney & Collins, 2004), although several motivational systems (e.g., *caregiving* and *sexuality*) are supposed to be integrated and balanced in a romantic relationship in

addition to the *attachment system* (Castellano, Velotti, & Zavattini, 2010; Shaver & Mikulincer, 2006).

Security of attachment is related to constructive conflict strategies, ability to self-disclose and to elicit self-disclosure in others, most reciprocity and flexibility (Feeney, 2008; Keelan, Dion, & Dion, 1998), whereas a large body of research has confirmed that an array of challenges face adults with insecure attachment style. Attachment anxiety (characterised by a persistent fear of abandonment within relationships) and attachment avoidance (characterised by discomfort with closeness and intimacy) have been linked to higher levels of psychological distress (Davila & Bradbury, 2001), destructive behaviours during problem discussions (Simpson, Rholes, & Phillips, 1996), negative behaviours during support interactions (Collins & Feeney, 2004), and lower relationship satisfaction and declines in relationship quality over time (Castellano, Velotti, & Zavattini, 2010).

In order to focus again on the core interests of the article, it is important to state that several studies show that attachment insecurity is greater in a variety of populations with disease than in healthy controls. Research carried out in Canada (USA) pointed out that patients affected by ulcerative colitis without p-ANCA (a marker of immunological dysregulation specific to that pathology) had a significantly higher prevalence of avoidant attachment style (59%) compared to those patients in which the p-ANCA were present (22%). The relationship between insecurity and diseases seems to be particularly pronounced for attachment avoidance (Maunder & Hunter, 2008; Porcelli, 2009).

In particular, attachment avoidance has also been reported to be more frequent in patients with diffuse plaque psoriasis than in patients with other skin conditions (Picardi et al., 2005). Specifically, an association between insecure attachment and dermatological diseases has been reported in vitiligo patients (Picardi et al., 2003a) and patients with alopecia areata (Picardi et al., 2003b).

There are several complex pathways by which insecure attachment could impair health and influence recovery. Insecure attachment may influence stress regulation so that the subjective stress perception is stronger, it may affect the physiological stress response itself, it may undermine the perception of social support.

These studies are focused only on individuals and do not explore the possible role of their partner in the context of the pathology. Focusing on reciprocity in a couple relationship, some theorists and researchers proposed a new typology regarding attachment matching – what Fisher and Crandell (2001) referred to as "complex attachment" – to capture the dual nature of attachment in the couple. Each partner functions as an attachment figure for the other, which means that "each partner can tolerate the anxieties of being dependent on the other and also being depended on by the other" (Fisher & Crandell, 2001, p. 20). They applied their model in describing possible matching as follows: *Secure couple attachment:* characterised by symmetry, ability to be dependent on the other and be depended on by the other; overt expression of need to be in contact and to be comforted; *Insecure couple attachment: dismissing-dismissing,* in which each partner denies the aspects of vulnerability and dependence; *preoccupied-preoccupied,* in which both partners refer to uniform feelings of deprivation and the mutual belief that the other cannot soothe their need for comfort; *dismissing-preoccupied*, in which the preoccupied partner feels constantly deprived and abandoned, while the dismissing partner seems to be bothered by their partner's need for dependence (a high level of conflict is related to the pattern "chase and dodge"). *Secure/Insecure couple attachment:* the secure partner could offer an emotional experience potentially corrective for the other, who in turn could behave more flexibly. Conversely, under certain

circumstances, the secure partner could become more rigid and inflexible in satisfying the insecure partner's tendencies.

From this point of view, it might be interesting to investigate the possible role of attachment matching in dermatology patients who are involved in couple relationships.

CASE STUDY

METHOD

PARTICIPANT SELECTION

We recruited a patient affected by psoriasis within a larger empirical study that is currently being conducted in a large hospital in Italy. The patient, an adult man, had a diagnosis of *psoriasis vulgaris* (moderate severity, PASI[1] index = 13.5), he had a middle-class income and a high school education level. His partner – an adult woman – had a similar background but had never been diagnosed with a chronic dermatological disease. They had been together for more than five years.

Personal information was collected after the nature of the procedure had been fully explained to the patients and after having received informed consent. Questionnaires were then completed in a quiet room inside the hospital by the patient. Interviews were conducted during a second meeting with each participant separately, then audiotaped and transcribed verbatim. Meanwhile, the partner completed the same measures except for one instrument specifically designed for assessing the quality of life in dermatology patients (*Dermatology Life Quality Index – DLQI*).

MEASURES

SKIN DISEASE SEVERITY

PSORIASIS AREA AND SEVERITY INDEX – PASI

An MD Specialist in Dermatology and Venereology assessed the disease severity using the *Psoriasis Area and Severity Index*. The PASI is the most widely used tool for the measurement of severity of psoriasis, estimated by three clinical signs: erythema (redness), induration (thickness) and desquamation (scaling). It combines the assessment of the severity of lesions and the area affected into a single score in the range 0 (no disease) – 72 (maximal disease). The body is divided into four sections (head, arms, trunk, legs). Each of these areas is scored by itself and then the four scores are combined into the final PASI. In clinical practice, PASI<10 generally marks "slight psoriasis", PASI 10–20 marks "moderate psoriasis", and PASI >20 marks "severe or very severe psoriasis". Lesions affecting particular areas (e.g., hands, face, genitals) are considered "severe or very severe" despite the fact that only a limited area is involved.

SELF-REPORT ASSESSMENT

DIFFICULTIES IN EMOTION REGULATION SCALE – DERS

Participants completed the *Difficulties in Emotion Regulation Scale – DERS* (Gratz & Roemer, 2004). The DERS is a 36-item self-report measure developed to assess difficulties in emotion regulation. Items are scored on six scales: *Non-acceptance of emotional responses* (6 items); *Difficulties in engaging in goal-directed behaviour* (5 items); *Impulse Control Difficulties* (6 items); *Lack of Emotional Awareness* (6 items); *Limited Access to Emotion Regulation Strategies* (8 items); and *Lack of Emotional Clarity*

[1] PASI = Psoriasis Area and Severity Index.

(5 items). Participants are asked to indicate how often each of the 36 items apply to them on a five-point Likert scale ranging from 1 (*almost never*) to 5 (*almost always*). Higher scores in every case indicate greater difficulties in emotion regulation (i.e., greater emotion dysregulation). We used the DERS Italian validation (Giromini, Velotti, de Campora, Bonalume, & Zavattini, 2012) which showed good validity and an adequate internal consistency.

Emotion Regulation Questionnaire – ERQ

Participants completed the Emotion Regulation Questionnaire – ERQ (Gross & John, 2003). The ERQ is a 10-item self-report questionnaire rated on a seven-point Likert scale that consists of two scales corresponding to two different emotion regulation strategies: *cognitive reappraisal* and *expressive suppression*. *Cognitive reappraisal* (6 items) is a form of cognitive change that involves construing a potentially emotion-eliciting situation in a way that changes its emotional impact. *Expressive suppression* (4 items) is a form of response modulation that involves inhibiting ongoing emotion-expressive behaviour (Gross, 1998). A recent study confirmed the reliability, validity and factorial structure of the Italian version of the ERQ (Balzarotti, John, & Gross, 2010).

Individuals differ in their use of emotion regulation strategies and these differences have implications for well-being, social relationships and affect. “Reappraisers” express greater positive emotion and less negative emotion so that this strategy is associated positively with well-being and with better interpersonal functioning, whereas “suppressors” more frequently express less positive emotion, but greater negative emotion. Suppression is therefore associated with worse interpersonal functioning.

Attachment Style Questionnaire – ASQ

Participants completed the *Attachment Style Questionnaire – ASQ* (Feeney, Noller, & Hanrahan, 1994). The ASQ is 40-item self-report questionnaire designed to measure adult attachment, specifically five dimensions of adult attachment: *Confidence* (8 items), *Discomfort with Closeness* (10 items), *Need for Approval* (7 items), *Preoccupation with Relationships* (8 items) and *Relationships as Secondary* (7 items). Each item is rated on a six-point scale, ranging from 1 (*totally disagree*) to 6 (*totally agree*). The five scales are to be considered associated with the two latent factors *Anxiety* and *Avoidance.* Similarly to the original version, the Italian version of the ASQ seems to be a valid and reliable measure (Fossati et al., 2003).

Dyadic Adjustment Scale – DAS

Participants completed the *Dyadic Adjustment Scale – DAS* (Spanier, 1976), a multidimensional measure of satisfaction in an intimate relationship. The 32-item questionnaire yields a total score (*Dyadic Adjustment*) and four subscores (subscales): *Dyadic Satisfaction*, *Dyadic Cohesion*, *Dyadic Consensus* and *Affectional Expression*. The Italian version of the measure shows good psychometric properties (Gentili , Contreras, Cassaniti, & D'Arista, 2002).

Dermatology Life Quality Index – DLQI

The patient completed the *Dermatology Life Quality Index – DLQI* (Finlay & Khan, 1994). The DLQI was the first dermatology-specific quality-of-life instrument. It is a simple 10-item validated questionnaire. The DLQI total score is calculated by summing the score of each question, resulting in a maximum of 30 and a minimum of 0. The higher the score, the more the quality of life is impaired. The DLQI score can also be expressed in a range of six subscales that highlight the more problematic areas for the patient. Also, the DLQI Italian version shows good psychometric properties (Mazzotti, Barbaranelli, Picardi, Abeni, & Pasquini, 2005).

INTERVIEW

ADULT ATTACHMENT INTERVIEW – AAI

The participants were both administered the Adult Attachment Interview (George, Kaplan, & Main, 1985). The AAI is a semi-structured interview that evaluates the state of mind toward attachment on the basis of the description of the experiences with attachment figures during childhood. Interviews are audiotaped and then transcribed verbatim. The coding process (Main, Goldwyn, & Hesse 2002) divides interviews into two principal categories (two-way classification): Secure or Insecure. Moreover, insecurity of attachment includes four subclassifications: *Dismissing* (Ds), *Preoccupied* (E), *Unresolved/Disorganized* (U) and *Cannot Classify* (CC).[2] Interviews that are classified Secure (F) characterise individuals who are comfortable in discussing early attachment relationships and who consider the importance of attachment-related experiences in their own development, whose narrative is fairly objective, clear, succinct yet complete. Interviews classified as Dismissing (Ds) characterise individuals underestimating the importance of attachment relationships in their lives, often denying or minimising affect and negative childhood experiences and overemphasising their sense of independence and strength. Preoccupied (E) interviews characterise individuals excessively involved and confused with regard to attachment relationships, with a passive sense of still wanting to please attachment figures, expressing involving anger, or overwhelmed by past traumatic experiences. An Unresolved/Disorganized classification (U) is assigned to interviews during which individuals exhibit disorganisation in their discourse when asked to reflect upon their experiences of loss or trauma, while a Cannot Classify category (CC) is assigned to interviews during which individuals do not express any specific mental strategy.

DISCUSSION

We continue by reporting the results of the psychological assessment conducted after the usual medical examination. Several research data highlight a decrease of quality of life in people affected by cutaneous diseases (Potocka, Turczyn-Jablonska, & Kiec-Swierczynska, 2008) connected with the severity of the disease.

In order to debate the potential protective factors in psoriasis, we selected a patient who, despite the severity of the disease (moderate severity; PASI: 13.5), refers only to a small effect of psoriasis on his life. In fact, the *Dermatology Life Quality Index* score (DLQI=2) shows no great effect on daily activities, work or personal relationships due directly to the cutaneous disease. The following considerations start from the evidence we have just stated.

[2] The AAIs were administered and coded in line with the Main, M., Goldwyn, R. , & Hesse, H. Coding System (University of Berkeley, California, USA) by a Psychologist considered a reliable judge (since 2011).

When we examine regulation strategies, the preference for the emotion regulation strategy of "cognitive reappraisal" (*Emotion Regulation Questionnaire*: reappraisal=5.17 / suppression=3.25), which is positively associated with well-being and a better interpersonal functioning (Gross & John, 2003), is remarkable. These data are confirmed by the absence of difficulties in emotion regulation detected by the *Difficulties in Emotion Regulation Scale* final score (overall score DERS=51). In particular, the low scores in specific DERS subscales (e.g., *Goals*=7; *Clarity*=4; *Strategies*=9) might suggest a tendency to declare a stronger than expected management of emotions. Thus, the patient seems inclined to use cognitive reappraisal as a strategy to reduce the unpleasant emotional arousal evoked by stressful situations (as being affected by a chronic skin disesase inevitably is), and to manage negative emotions.

Regarding adult attachment evaluation, we considered different levels of awareness, represented by a self-report measure (ASQ; higher level of awareness) and an interview (AAI; lower level of awareness). As Shaver and Fraley (2010) note, these two measures of attachment are only moderately related, where "One asks about a person's feelings and behaviors in the context of romantic or other close relationships; the other is used to make inferences about the defenses associated with an adult's current state of mind regarding childhood relationships with parents" (Shaver & Fraley, 2010). In fact, if we look at the state of mind regarding attachment (past experiences with attachment figures) – as emerged from the coding of the *Adult Attachment Interview* transcript – we find a classification of *Security* (F), although aspects of dismissing stance appear (*AAI Classification of Attachment*: F2, dismissing or restricting of attachment, Table 1).

Table 1. Patient final ratings and classification AAI Secure - F2 (somewhat dismissing or restricting of attachment)

Scales Scored for Experience		
	Mother	Father
Rejecting	1	1
Involving/Reversing	1	1
Pressured to Achieve	1	1
Neglecting	(1)	(1)
Loving	7	6
Scales for States of Mind Respecting the Parents		
	Mother	Father
Idealizing	2	2
Involving Anger	1	1
Derogation	1	1
Scales for Overall States of Mind		
Overall Derogation of Attachment		1
Insistence on Lack of Recall		1
Metacognitive Processes		6.5
Passivity of Thought Processes		1
Fear of Loss		/
Higher Score for Unresolved Loss		1
Higher Score for Unresolved Trauma		1
Overall "U"		1
Coherence of Transcript		7
Coherence of Mind		7
CLASSIFICATION		**F2**

In a different way, the *Attachment Style Questionnaire*'s results are of particular interest. Referring to the romantic attachment models - that represents the ground basis to the development of the ASQ -, the patient reported a low score on both dimensions *Avoidance* (T=45) and *Anxiety* (T=37), although avoidance score is higher than anxiety's. Focusing on the subscales, *Discomfort with Closeness* score (40) suggests the presence of a dismissing stance whereas the high score on *Confidence* (42) confirms security of attachment. The evidence from this single case seems to be partially in line with the literature which highlights a major frequency of attachment avoidance in dermatological samples, especially in psoriatic patients (Picardi et al., 2005).

In conjunction with the patient's individual assessment, from our point of view it is important also in medical settings - as well as other clinical contexts - to refer to the partner's individual results in order to better understand the interpersonal nature of well-being and the role of couple (what we called "context aspects" in the introduction). In this case, both partners report a good level of couple adjustment, as shown from the *Dyadic Adjustment Scale* score (T>52, both of them); specifically they show a high level of dyadic *Cohesion* (Patient, T=68; Partner, T=61) [Table 2].

Table 2. Participants self-report results

	Patient	Partner
DERS		
Non acceptance	9	16
Goals	7	14
Impulse	8	7
Awareness	14	20
Strategy	9	16
Clarity	4	8
Total	51	81
ERQ		
Suppression	3.25	3.25
Reappraisal	5.17	5.17
DAS		
Affectional Expression	63	50
Cohesion	68	61
Consensus	54	55
Satisfaction	60	44
Dyadic Adjustment	56	52
ASQ		
Avoidance	45	45
Anxiety	37	52
Confidence	42	37
Discomfort with Closeness	40	35
Relationships as Secondary	14	15
Need for Approval	11	26
Preoccupation with Relationships	23	26

Note: DERS: Difficulties in Emotion Regulation Scale; ERQ: Emotion Regulation Questionnaire; DAS: Dyadic Adjustment Scale; ASQ: Attachment Style Questionnaire

The partner also shows the ability to regulate emotions although to a lesser extent, as shown by the *Difficulties in Emotion Regulation Scale* (overall score DERS=81). Moreover, in line with the patient's result, the preference for the emotion regulation strategy of "cognitive reappraisal" (*Emotion Regulation Questionnaire*: reappraisal=5.17 / suppression=3.25) is remarkable. Regarding adult attachment evaluation (ASQ), the partner scores related to *Anxiety* (T=52) differentiate attachment styles between partners, while *Confidence* subscale account for security (37).

Finally, with respect to the state of mind in relation to attachment, the partner has been assigned to the *Secure* classification (F3: prototypically secure/autonomous; Table 3), showing a high level of transcript coherence and a good ability to recall memories and episodes from past experiences with attachment figures.

Table 3. Partner final ratings and classification - AAI Secure - F3 (prototypically secure/autonomous)

Scales Scored for Experience		
	Mother	Father
Rejecting	1	1
Involving/Reversing	1	1
Pressured to Achieve	1	1
Neglecting	1	1
Loving	8	8
Scales for States of Mind Respecting the Parents		
	Mother	Father
Idealizing	1	1
Involving Anger	1	1
Derogation	1	1
Scales for Overall States of Mind		
Overall Derogation of Attachment		1
Insistence on Lack of Recall		1
Metacognitive Processes		7
Passivity of Thought Processes		1
Fear of Loss		/
Higher Score for Unresolved Loss		1
Higher Score for Unresolved Trauma		1
Overall "U"		1
Coherence of Transcript		8
Coherence of Mind		8
CLASSIFICATION		**F3**

In reporting the descriptive analysis for this single case we aimed to discuss theoretical beliefs and suggest the importance of some constructs for better understanding the complex interplay between psychological factors and diseases, in the particular field of cutaneous diseases. We would state that some variables, such as emotion regulation ability, emotion regulation strategies and attachment, might play an important role in dealing with a chronic disease like psoriasis. Furthermore, we would suggest, in line with romantic attachment tradition, that experiencing a good couple relationship with a secure partner may help psoriatic patients deal with the skin condition and might play a fundamental role in the patient's quality of life. That might be especially true when a *secure-secure matching* characterises a couple (Fisher & Crandell, 2001). We gave a theoretical account of some of the processes through which these variables may act like protective factors for patients. The construct of attachment seems to be particularly suitable in explaining these links. Although literature points out that dermatological patients, e.g., psoriatic patients, are frequently characterised by avoidant attachment style, we wish to go a step forward: discussing the possible role of the partner, if present, in assuming the role of "secure base" helping the patient to deal with the dermatological

shame (Kellett & Gilbert, 2001) and the specific aspects of emotion dysregulation (Mizara, Papadopoulos, & McBride, 2011).

In conclusion, data literature and clinical evidences support a new way to conduct a dermatological consultation, being aware of the interplays between body and psyche that we have tried to address thoroughly in this article. It seems important to sustain psychodermatology (Poot, Sampogna, & Onnis, 2006), defined as "as much an ethos as a discipline, a professional, clinical and research-oriented awareness, and acceptance of the psychological and social implications of dermatological conditions" (Walker & Papadopoulos, 2005, p.xi). The integration of psychological and physical examinations in dermatology clinics surely requires more time to dedicate to the patient's consultation and a holistic, integrated view of patients. Moreover, an integrated assessment – which is a fundamental premise to an appropriate treatment – requires the clinical horizon to be widened to the relational environment in which patients are involved. On the basis of what we have tried to outline in this article, we believe – as well as many other scientists, researchers and clinicians – that a comprehensive manner to treat dermatology patients could be built in line with a new theoretical and empirical field at the intersection of psychology, psychiatry and dermatology.

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