Clinics in Dermatology (2013) **31**, 11–17

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Clinics in Dermatology

Psychological evaluation of the dermatology patient: a psychoanalyst's perspective

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Abstract Psychoanalysis contributed to the body representation in medicine with a biographic focus in which language, dreams, sexuality, unconscious wishes, and the relationship with the doctor play a fundamental role. In spite of being invisible to the gaze, this anatomy has its fundamental piece on the skin. A piece that has the status—given by Freud—of "erotogenic zone par excellence." In this paper, different levels of psychological/psychiatric functioning and some character types elucidated by psychoanalytic work with dermatology patients are described. Some therapeutic strategies are suggested as a way of orientation to the dermatologist's management of difficult patients.

Introduction

An African patient refuses to take several remedies simultaneously. The doctor asks him, "When your father went hunting a wild and big animal, did he use only one arrow?" Once the doctor got the negative answer, he said, "Neither can I 'kill' a severe disease without using many drugs, the same as your father couldn't beat the beast without using many arrows."

In this way, finding the contact and the accurate symbol, the doctor provoked the patient's adhesion to treatment generating at the same time confidence and esteem.[1]

This is an example of the use of symbols to build a therapeutic doctor-patient relationship. Sometimes, the displacement of meaning, which in this case runs from arrow to medication, takes place involving words, parts and functions of the body,…and the doctor himself!

In *Studies on Hysteria,* Freud[2] opened the first gap in the mechanic conception of the body. Psychoanalysis explored a fantastic anatomy invisible to the gaze. Doing that, it provided new "arrows" to beat the "beast" that has been provoking somatic symptoms: it added to the body representation in medicine, a biographic focus in which language, dreams, sexuality, unconscious wishes, and the relationship with the doctor play a fundamental role. In spite of being invisible to the gaze, this anatomy has its fundamental piece on the skin. A piece that has the status—given by Freud—of "erotogenic zone par excellence."[3]

Psychoanalytic evaluation can contribute to the dermatologic practice at many different levels: (1) by establishing the level of psychological/psychiatric functioning during the consultation; (2) by typifying the kind of unconscious conflicts and emotions that the patient expresses through his or her complaints and symptoms; (3) by detecting the defense mechanisms that the patient uses to cope with reality, with stress and with the disease; (4) by choosing the treatment taking into account the unconscious preferences and meanings of the prescriptions; and (5) by giving skills to improve the doctor-patient relationship.

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http://dx.doi.org/10.1016/j.clindermatol.2011.11.002

Background

According to psychoanalysis, in many diseases the etiological agents are necessary but not sufficient conditions[4]; therefore, its psychological interpretations are not incompatible with the recognition of the simultaneous existence of physical or biological agents in the multiple causes of diseases.

Psychoanalytic work regarding psychosomatic problems of the skin is divided into 3 groups. The first considers the disease or the different skin lesions as symptoms and signs with a meaning to be interpreted.[5,6] The second group interprets the skin disease as a result of a regression, a disease of crisis or a disruption and/or disorganization against quantitative excesses that would be equivalent to what is commonly called stress.[7] A third group lays special emphasis on the immature defense mechanisms,[8] poor symbolization capacity, or narcissistic vulnerability.[9,10]

Even with dissent, psychoanalysts agree on the importance that early tactile exchanges with the mother and the loved ones have as an intervening factor in some skin disorders. They also describe experiences of humiliation and abandonment,[11] lived as the experience of being in the flesh or protected with an armour or shield,[12,13] symbiotic relational modes,[8,13] attachment or separation-individuation difficulties[14,15] that would mean abandoned patients, patients who abandon others, or patients with distant-proximity conflicts,[14,16] lack of stimulation of the skin needed for its sense of limit and restraint,[18] and alterations of subjective identity.[14]

The most quoted analyst is Didier Anzieu.[17,18] In his opinion, the psychic apparatus develops taking as its starting point a basis provided by physical experiences of a biological nature in which the skin plays a fundamental role. By means of the physical stimuli, the skin can provide the psychic apparatus with the representations that constitute the ego as well as its main functions. In this way, a construction of the self that Anzieu calls "ego-skin" can be developed; one that carries out a series of fundamental functions to provide the ego with the capacity of reception, perception, protection, cohesion, support, integration of sensations, identity, and energy. The pathology of the ego-skin shows us how the ego can make use of skin perceptions to communicate with others and try to defend itself from either internal or external dangers. This ego will be much more pathological and primitive, the greater the number of failures it presents in its abstract functions and the greater its need of concrete perceptive experiences (experiences that have not been symbolized or integrated among each other), to be able to maintain its existence.

According to Anzieu,[17] the more altered the ego of the patient, the deeper and more serious the skin disease he or she might suffer could be. He also wonders, basing himself on Spitz,[19] if atopic dermatitis have the function of providing oneself with the stimuli that the child lacked, or if they rather constitute a way of asking to be provided with them.

Another very well-known concept among psychoanalysts is "the second skin."[20] "In its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary."[20]

But this internal function—that of containing the parts of the Self—initially depends on the relationship with another person who must be experienced as capable of fulfilling that function. On the contrary, confusions regarding identity shall take place, and pseudo independence shall be developed, using the hyperactivity or muscular development as a "second skin": a substitute for the failed skin container function.[20]

Consoli[21] has stressed the importance of tenderness in the psychic development and in the physical treatment and psychotherapy of skin patients. She enriched concepts like stress and quality of life, analyzing them with psychoanalytic contributions, such as overdetermination of symptoms, timeless functioning in stress trigger factors, transference and counter transference in doctor-patient relationships, and so forth.

Koblenzer[11,22] has published numerous case reports obtaining remissions through insight psychotherapy on patients with recalcitrant dermatoses who were not successful with traditional dermatologic treatments. Improvement took place after verbalization and awareness of feelings of guilt, rage, and abandonment. According to Koblenzer, in some cases of established dermatoses, location of lesions is determined by the symbolic meanings these lesions have to the patient.[23]

Poot[24] has described family interactions that play an important role in the psychodynamics of skin patients and in the doctor-patient relationship where they are unconsciously reproduced.

Regarding skin in general, it has been said that experiences of infantile helplessness and loss of protection could result in skin disorders in the somatic plane, in hypersensitivity or toughness in terms of character, or in different behaviors of attachment in the behavior plane.[6] The relationship between pruritus and anxiety and between crusts and the need for protection in front of a state of neglect has been emphasized.[25] Allergy has been associated with symbiotic relationships and identity disorders, as well as with primitive identification mechanisms.[26] Sami-Ali[27] stressed the alternation and possible equivalence between skin manifestations and psychotic disorders. Skin has also been linked with skin proxemics,[17,28,29] the symbolization of space,[17] and some states of mourning.[30] By describing the articulation of the skin with the operation of unconscious, it has underlined its relationship with sexuality, with the urge to touch and look, with the barrier function of protective shield, and so forth.[15] In the psychoanalytical conception, body parts, organs, actions, and functioning are engaged with

primitive feelings and archaic fantasies,[3,17] because when we touch a spot, we awake a memory that can evoke a series of historical events and repressed ideas.[2,14]

Establishing the level of psychologic/psychiatric functioning during the consultation

Dermatologists describe some typical cases with diagnoses not literally included in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV): "Dermatitis artefacta," "Allergic to everything," "Neurotic excoriations," "Delusional parasitosis," "Pathomimia," and so forth, but in spite of that, they have their own right of existence. Sometimes they are included within other generic names that can appear as the cause of the disorder (for example factitious disorder as a cause of dermatitis artefacta).[16] Gupta and Gupta[31] have made a big effort toward enhancing the classification knowledge and providing useful information for everybody. At the same time, they showed how many overlaps and difficulties exist in framing the syndromes clearly delimited in dermatology with the parameters, boundaries, and diagnoses thought by psychiatrists for mental disorders.

The analyst's experience is very similar: on one hand, the analyst must not forget the parameters of medicine and psychiatry to evaluate the patient before deciding the beginning of a psychoanalytic therapy. On the other hand, the analyst's lens—and more than lens, listening—allows him to define concepts, parameters, and types of patients whose subjective richness cannot be found in the generalization of DSM-IV.

A great contribution has been made by Hart et al[16] when they say that "the diagnosis of the underlying psychiatric conditions in psychodermatology involves several dimensions. Evaluating each of these provides the psychodermatologist with more opportunities to develop an effective treatment."

Some of the dimensions they described are the following: the level of functioning, the different physical and psychosocial stressors influencing the level of functioning, and the concurrent affective components. The levels of functioning are based on the work of psychoanalyst Otto Kernberg.[32] He proposes the existence of 3 comprehensive structural organizations: the neurotic organization, the borderline organization, and the psychotic organization of the personality. These organizations mediate between the etiologic factors and the direct behavioral manifestations of the disease and are reflected in the predominant characteristics of the patient, mainly regarding the patient's level of identity integration, the kinds of defensive operations usually used, and the patient's capacity for reality testing. These characteristics can be seen in Table 1. These structural criteria can complement ordinary descriptions of the patients, either behavioral or phenomenological,[32] and contribute to the differential diagnosis. They do not imply a reductionism: for example, "to say that a patient is a borderline only connotes that his performance reflects certain defects in the integration and differentiation of intra psychic structures, characterizing a borderline level of personality organization. The style or pattern, however, may be narcissistic, childish, paranoid, schizoid, sadomasochistic, cyclothymic, etc."[33] The type of transference in the analysis with the therapist is an additional important feature for the diagnosis.

If the general, the dermatologist (ie, not the psychodermatologist) is able to differentiate the neurotic, borderline, and psychotic levels of functioning; having a "macroscopic" psychiatric/psychological viewpoint is of much help in managing the consultation, while at the same time keeping the usual dermatology "lens." And what about the analyst? Once the analyst counts with the dermatologic diagnosis given by the dermatologist, plus the psychiatric diagnosis and the assessment of the personality organization established during the interview, the analyst enters another level of analysis, typifying the kind of unconscious conflicts, wishes, and emotions that the patient expresses through his or her complaints and symptoms and detecting the defense mechanisms that the patient uses to cope with reality, with stress, and with the disease. If an interdisciplinary team is working, as every prescription has an unconscious meaning, the team can help the dermatologist

Table 1 Structural Diagnosis

	Identity	Defensive organization	Reality test
Neurotic organization of the personality	Integrated. Stable object relationships. Representations of herself or himself and the objects accurately delimited	Repression. High level of defenses based in the repression.	Conserved +++
Borderline organization of the personality	Poorly integrated. Unstable object relationships. Diffusion of the identity.	Splitting. Disavowal. Primitive defenses.	Conserved +
Psychotic organization of the personality	Not integrated. Undifferentiated relationships.	Splitting. Disavowal. Repudiation. Primitive defenses.	Seriously altered. Confusional

(Adapted from Kernberg[32] and Garza Guerrero[33] with modifications.)

to choose the treatment when many possibilities are available and can give the dermatologist skills to improve the doctor-patient relationship.

Freud also described certain character types elucidated by the psychoanalytic work.[34] Our study proposes something similar: not to describe a personality or psychopathology other than those already existing, but rather to describe problems that are quite often at stake, sometimes coexisting in the same patient, sometimes taking part of the characteristics found in different psychopathologies and personality disorders. Unfortunately, there is no simple "cook book" approach to their management[23]; however, some strategies[35] are suggested as a way of orientation.

The "fragmented" patient[35]

Caresses, holding, touching, and manipulation of the baby are key actions for the acquisition of a sense of unity and support and for the building of a unified body image based on the integration of sensations and "common sense."[17] Some patients who lacked these stimuli developed either an unconscious tendency to separate others, or an obsession to join everything they relate with.

Patients seeking to join

This obsession can be addressed to the people who want to bind, to the groups they belong to both in business and socially, as well as to objects, which leads them to develop tasks or hobbies that require sewing, tying, gluing, and so forth. Through these activities the patients try to unite pieces of their body they do not feel are integrated; mixed feelings or split aspects of their own identity, which have been projected into external objects or people or into their own body taken as an external object. In the dermatologic consultation, we can find complaints regarding body parts that are rebels, that do not respond to the "orchestra" of the body or evolve in an uneven way and resist healing.

The characteristics of the skin, which differ according the areas of the body (eg, thicker, more moist, more or less vascularized, with more or less hair or glandular distribution), force the dermatologist to prescribe treatments with different products for each area: lotions and shampoos for the scalp, pastes for the wet zones, creams and emulsions for dry areas, corticoids of different intensity, and excipients with different absorption and penetration capacity. This all has biological roots, rational justifications, and therapeutic effects, but in the archaic and irrational world of the patient where unconscious fantasies take place, these decisions sometimes favor the ideas and sensations of body fragmentation.

Patients use very illustrative words regarding this problem to refer both to their body status (sometimes talking about an internal organ, other times talking about the skin) and to the status of a family, company, country, or object of possession. For example, a patient said: "seeing my parents fight, first I left home. Then I went back for my mother, but I felt [like] a porcelain fixed with glue."

Patients seeking to fragment

When given this trend, the dominant features are (1) each doctor who sees them describes them in a different way; (2) they have several symptoms and/or conditions, which are treated by different doctors and they might even undergo different parallel treatments for the same condition; (3) the different health professionals who see the patients do not get in touch with each other and, if they do, it is just to criticize or to oppose each other. In consequence, there is no one in charge of the patient "as a whole."

The patient might have suffered dysfunctional experiences during childhood, such as being subjected to sudden attachment-detachment shifts by caregivers. In consequence, the patient might protect him- or herself by resorting to splitting defense mechanisms, which could lead to a state of fragmentation. The patient is then forced to project onto the environment the fragmented aspects of his or her own self. In this way, the patient tries to divide the health professionals that are seeing him or her, reproducing with them not only his or her inner world but also the dysfunctional bonding of his or her parents.[24] Thus, the external group of professionals contains all the patient's contradictory aspects and, therefore, avoids a decompensation. At the same time, the disease grants the patient a sense of identity: being ill.

The strategy we used to face this problem was to gather the medical team (externally), the internal fragmented aspects of the patient, so as to play a supportive role for the patient. This could be achieved through the formation of interdisciplinary teams. To keep the focus, a treatment coordinator should also be available for each of the patients.

The patient who poses narcissistic demands

The demands most frequently found are the following[35]:

(1) The accusing demand: *"I asked for help and got none." "What I was given was not enough, was harmful to me."* (2) The demand for acknowledgement: *"I gave much but nobody acknowledged it."* (3) The demand for reciprocity: *"I was trusting but nobody trusted me."*

These demands are accompanied by feelings of humiliation and mistrust. These are patients who, in their private lives, depend on another person who deals with all the patient's problems either in a manifest or latent way, the same as parents do during early childhood.

This disease usually breaks out when the significant other fails the patient, turns the patient down ,or abandons the patient. The patients' typical reaction is to express bitter disappointment, resentment, and general distrust. They believe that others are to blame for what is happening to

them and aggressiveness is therefore turned outward. When doctors or psychotherapists see them and try to help, patients usually abandon treatment. As their system of beliefs strictly divides people into worthy or unworthy, because they function with the borderline/dissociative level described previously, they cannot afford to value doctors for their work, without feeling smaller in front of the doctors' narcissistic enlargement.

There are yet other patients who do not get involved with others and avoid any kind of commitment. They only consult in order to vent their feelings within a place they can control and where nothing is asked in return. They tend to abandon treatments and go from one doctor to another.

Unlike the previous group of patients we discussed (who go from initial dependence to abandonment), this other group behaves exactly in the opposite way: first they stop seeing their doctors and give up treatment, then they let time go by, and finally they consult in case of emergency, when their condition is so serious that they are completely unable to handle it by themselves.

The strategy we propose for both groups is to "be on the side of the patient." We should behave as if the fight against disease were a matter to be handled "among peers," within a "symmetrical" relationship. We should also take advantage of the patient's narcissistic acknowledgement to help the patient become responsible for his or her own treatment, but at the same time, giving the patient "holding" (support) in a subliminal way.

The patient with individuation problems

It has been said that dermatology patients are "marked" by life experiences both pleasant and unpleasant which are reflected on, in, and under the skin.[36] Actually, some patients find it very difficult to develop their own distinctive character traits and only manage to do so by resorting to body marks, stigmatizing nicknames, and permanent comparisons with others. In consequence, external changes that force them to assume a new role or more responsibility precipitate a crisis. Crisis could also be triggered when an unfair accusation or situation they cannot change makes them feel excluded. It is as if they needed new identifications, role models, or the parental teachings they lack. Incidentally, the disease appears as a response taking up that "empty" space.[35]

The strategy in these cases is not to heal the patient completely, because if the patient recovered completely, the patient would then lack those pivot points around which the patient's identity revolves. The patient's condition should improve but it would be better if some of his lesions were left untreated. In the meantime, the patient should be helped in the search and strengthening of models and identifications useful for the patient to face the new events and responsibilities of life.

The patient who cannot become aware of his or her condition

These patients need to be seriously ill to feel they do have a body. They have built a characterologic and affective shell as a defense mechanism so as not to feel hurt.[35]

Some patients are refractory to our wish to have sensitive interaction with them. They show themselves "hard" and impenetrable to our interpretations. In consequence, the symptoms of a skin disease are a means of expression and awareness of their own emotional status. For example, a lesion characterized by its impenetrability and scabby surface might well soothe a patient who feels he or she has no body boundaries, and it could also provide the patient with the category of a "protective barrier."

Other patients of this group seem to be "split in chambers." They resemble the obsessive ones, but whereas the obsessive patients try to control their unconscious cruelty through ceremonies and schemas, the "split in chambers" control their fear to be invaded, the suffering related to the other's coldness, or the unconscious threat of disintegration.

The work of psychotherapy aims at helping patients become aware of their own feelings and express them, rather than through their bodies, through the process of psychical work out, while at the same time building significant relationships.

The work with projection is usually very useful. It consists of detecting and describing the physical and emotional state of significant others around the patient, such as objects, pets, and movie characters and even friends and relatives, using this field as a "projective screen" to approach the patient to recognize his or her own emotions and reactions without feeling touched in an unbearable way.

Another strategy is using the different dermatological treatments beyond their specific action, as concrete elements that can help the patient define the boundaries of his or her body, or provide self-representation and the categories of open-close, hard-smooth, clean-dirty, and so forth.

Patients who feel hurt and exposed

Basically, we found 2 types of disorders linked to this variable: the wounded with injuries that do not heal and those allergic to everything.

The wounded patient with injuries that do not heal

In a contribution reporting on psoriasis, a scientific journalist used the following metaphor: Psoriasis is an immune system disorder that "erroneously seeks to heal a wound or fight against an infection it is not suffering."[37] Although intuitively, maybe she was the spokeswoman of 2 types of patients:

The marked or wounded by punishment

These types of patients have had mothers or fathers authoritarian, severe, or punishing and generally during childhood have suffered from corporal punishment that left them physical marks. These experiences were constituted in traumas that are similar to psychological marks. The appearance of lesions either in the body sites where they were punished or elsewhere also serves as a "memorial" of these traumas. Sami-Ali called "corporal superego"[27] to the imposition of norms on the body and through the body. In some cases, the lesions appear in the same place where the patients were severely punished in childhood, and in other cases in which extreme physical punishment has not been received, patients could feel the disease as a punishment that relieves their feelings of guilt.

The wounded by grief and the wounded by abandonment

Saying that someone is hurt by abandonment or after losing a loved one is a widely used metaphor. The problem of the "wound that never heals" is the result of difficulties in the separation-individuation process. It is associated with significant attachment to someone, and the experience of "shedding" that is lived when facing any dispute or threat of separation. It may also be associated with the experience of having attached emotionally to someone and living some experience of suffering as a direct result. This would explain why patients sometimes show that baffling behavior of going away and "disappearing" just when they are starting to feel emotionally attached to their therapist or dermatologist. When patients have difficulties in putting their feelings into words, they may grant a category of reality only to that where the body is present and they need to show the lesion in the skin as a real injury that "materializes" their suffering.

The patient with allergies to everything

Some patients with symbiotic characteristics can be compared with the character "Gurdulú" of "The Nonexistent Knight."[38] Such patients are "allergic to everything;[16]" anything the dermatologist prescribes harms them, either because it generates adverse reactions or because it ends up aggravating the skin disease and their general condition. Everything can penetrate, harm, and "intoxicate" them, resulting in a paradox, given the fact that they are impenetrable by the positive actions of the drugs or the treatment in general. These kinds of patients match the description of the "allergic object relationship,"[7] but they are not necessarily allergic from a medical standpoint, although they are convinced they are.

They usually have agglutinated families and act and feel as if distance from their relatives did not exist. This confuses the identity of themselves and others, generating confusion in the doctor, as they tend to merge consultations and treatments of different family members, seeking to save consultations (2 and even 3 persons for the fees of 1) or they tend to make use of an ointment, cream, or even the pill prescribed to another family member.

In other cases, the problem does not affect the whole personality, but it is manifested in certain situations through emotions and behaviors or through the use of some words. For example, patients use the verb "hook," "stick," or "absorb" to refer to their bonds with people, activities, and things. The use of these verbs reflects their tendency to share the universe, affects, climate, acceleration, and concerns of that thing, person, or environment around them, to which they remained "stuck" in some activity. Once the "hook" takes place, the possibility of separation is seen as a threat. And when the real separation occurs, either by external situations or by a change in that environment, the patient suffers from a decompensation of his or her disease. The environment can be represented by several people or even by just one. If the family atmosphere or environment they are attached to is hostile or anxious, the dermatological complaint is usually accompanied by phrases such as "I cannot take it anymore, I cannot stand it, I feel all itchy."

Conclusions

The psychoanalytic perspective contributes to the dermatology practice providing diagnostic dimensions, unconscious dynamics, fruitful explanations, and therapeutic strategies that help the physician to recognize the structural psychological needs of their patients. These needs are channelled through complaints, symptoms, behavior, and even the disease itself that patients bring to the consultation. Knowing the different levels of diagnoses and communication gives very good clues about how to proceed,[16] opens the door to explore different therapeutic options, improves the physician-patient relationship, and facilitates referral to psychotherapy when needed. Psychoanalytic psychotherapy could help dermatology patients to face their disease and, in some cases, can help them improve or even heal, provided it is accompanied by the appropriate skin treatment given by the dermatologist. The cases in which psychoanalytic psychotherapy could be of most help are those in which the disease has become a means of emotional expression, a surrogate form of identity, or a defense against the mental illness or psychological suffering the patient feels unable to face.

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