

## PERSONALITY DISORDERS IN PSORIASIS<sup>1</sup>

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*Summary.*—Rubino and Zanna (5) have responded to our comments (1) on their report (4) on the association of personality disorders with psoriasis and have presented data comparing the personality characteristics of psoriasis patients with those in urticaria patients. The problems that remain with their methodology are that dental controls may not be equivalent to dermatologic conditions, and in the urticaria study, no data on premorbid functioning were provided to differentiate state vs trait phenomena, and they did not control for duration of illness.

Rubino and Zanna (5) responded to our comments (1) on their previous report (4) on the association of personality disorders with psoriasis and presented some new data. Although we appreciate their responding to our call for additional data, there are a few important points that we would like to clarify.

First, they describe their original dental controls as frequently having chronic pain, but the amount of pain at the time of the study was not specified and might be difficult to judge as equivalent to that of a dermatologic condition. In addition, the dental controls may not have disfigurement (and its accompanying self-image and loss of social functioning) equivalent to patients with a severe dermatologic condition since most suffered from Temporomandibular Joint Pain Dysfunction Syndrome.

Second, they argue that, “if only prospective research was considered, the literature on personality traits and on Axis II would shrink to a very small number of published articles” (5, pp. 1248-1249). Although this statement is correct, longitudinal work is a more solid basis for conclusions about behavioral phenomena which need to be followed for an extended period of time.

Our point about how gross skin lesions can lead to social anxiety and self-image distress is that stress, i.e., disfigurement, may be associated with the use of coping styles and defenses that would not be ordinarily part of the person’s nonstressed baseline functioning, i.e., state vs trait. This kind of phenomenon can be seen in patients with other serious medical conditions, prisoners of war, and in other stressful situations (2, 3). This is clear empirical support for the concept of the psychological stress of a medical illness leading to a change in one’s personality traits (“somatopsychic rebound”), in

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contrast to Rubino and Zanna's contention that there is no empirical support for this (5, p. 1249).

In response to our recommendation, Rubino and Zanna have provided in their response some initial data comparing patients with psoriasis and chronic urticaria. They found with a cross-sectional design, that there were higher frequencies of Dependent, Compulsive, Passive-Aggressive, and Borderline personality disorders in patients with psoriasis. We present here some aspects of this study that need to be considered.

First, we would like to know the illness status of the patients in both groups, i.e., current distress and disfigurement, quality of life, social and family functioning, in addition to length of illness, etc. These are characteristics that should be controlled, but for which no data were presented. The authors state that "we collected" the data for the comparison, which suggests the researchers were not blind to the diagnoses of the subject. Most important, however, is the lack of data on the premorbid functioning of the patients. Without longitudinal data, one could also conclude that psoriasis is more somatopsychic (effects psychological functioning) than urticaria.

Rubino and Zanna's idea that psoriasis is associated with personality disorders is not ruled out by these findings either. We wholly agree with their final comment that, "Further studies with larger samples with chronic skin diseases are certainly needed to reach firm conclusions on the issue." We would only urge the use of longitudinal designs.

#### REFERENCES

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*Accepted March 28, 1997.*