Rosacea and Personality

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Sir,

Rosacea is a common facial disease (1). Research on possible psychosomatic causes of the origin of rosacea is relatively scant and in general fairly old. Guilt and shame, mostly concerning sexual problems and social anxiety, were previously thought to play a considerable part in the aetiology of rosacea, and it was asserted that patients with rosacea had homosexual fantasies and signs of paranoia (2, 3). Suggestions have been made that rosacea patients show signs of immaturity, strongly inhibited affective responses, shyness, lack of self-confidence and feelings of inadequacy (4). In comparison with patients with alopecia areata and lichen planus, rosacea patients have a greater tendency to neurotic disorders, self-aggression, self-criticism and a greater discrepancy between desires and capabilities. Higher states of permanent anxiety were also noted compared to the other groups of skin disease patients; in many cases traumatic situations preceded the outbreak of rosacea (5–7). Other authors assert that no satisfactory single cause for the onset of rosacea has been found (8) and that there is no consensus regarding the role that personality factors play in rosacea (9).

The aim of our study was to investigate how rosacea patients handle and react to aggression and personal detachment, and whether they exhibited differences in those respects when compared to psoriatic patients and to healthy controls.

MATERIALS AND METHODS

A group of 51 rosacea patients (35 females and 16 males; mean age 50, median 49, range 20–82 years) and a gender-matched group with 42 psoriasis patients (27 females and 15 males; mean age 47, median 50, range 20–78 years) were studied. Also studied were 47 office employees without skin disease (32 females and 15 males; mean age 47, median 46, range 29–60 years). The rosacea patients were all consecutive dermatological patients at the Karolinska Hospital in Stockholm and were all examined by the same dermatologist. Their symptoms varied from moderate to severe. The mean duration of disease was 9.5 years. The psoriasis patients were also consecutive patients at the Swedish Psoriasis Organization in Enskede outside Stockholm, and their symptoms varied from mild to more serious. Mean duration of disease was 24.5 years. The office employees with healthy skin had jobs in medical administration in a county council, and they were randomly chosen from the employment list. A modified version of Schalling's (10) Karolinska Scales of Personality (KSP) was used. The factors studied from the test were inhibition of aggression, verbal aggression, indirect aggression, irritability and aggression in the form of guilt, as well as detachment in relation to other people. Comparisons were done between the rosacea group and the control groups. Variance analyses were performed with the one-way ANOVA method. The Alpha level for significance was set to $p<0.05$, two-sided.

RESULTS

No statistically significant differences were found between the rosacea group and the control groups in any of the six categories (Table I). However, the rosacea group tended to score lower on the degree of "verbal aggression" compared to the corresponding group of healthy office employees ($p=0.069$), but not compared to the psoriasis group.

DISCUSSION

The starting-point for our assumption was the body of studies indicating that rosacea patients show a higher degree of aggression towards themselves (5–7). The assumption was further strengthened by the fact that no previous study had shown any form of externally directed aggressive behaviour in rosacea patients. Consequently it was assumed that they would show significantly lower degrees of aggressive behaviour in the form of indirect aggression, verbal aggression and

Table I. *Patients with rosacea as compared to psoriatics and healthy controls. Mean score ± SD. No statistical difference was shown.*

KSP[a] scores	Rosacea ($n=51$)	Psoriasis ($n=42$)	Healthy skin ($n=47$)	All controls (psoriasis + healthy skin) ($n=89$)
Verbal aggression	11.5 ± 2.7	12.3 ± 2.8	12.5 ± 2.5	12.4 ± 2.6
Indirect aggression	10.0 ± 2.2	10.5 ± 2.4	10.4 ± 2.4	10.5 ± 2.4
Inhibition of aggression	23.6 ± 4.6	23.5 ± 5.2	23.4 ± 3.7	23.4 ± 4.4
Irritability	10.5 ± 2.3	10.9 ± 2.8	11.2 ± 1.8	11.0 ± 2.3
Guilt	12.1 ± 2.4	11.4 ± 2.7	12.0 ± 1.9	11.7 ± 2.3
Detachment	20.0 ± 4.4	19.3 ± 5.3	19.3 ± 3.5	19.3 ± 4.4

[a]Results of KSP interviews/questionnaires. KSP = Karolinska scales of personality.

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irritability. In this study no significant results were noted in any of the six categories investigated by KSP. Only a tendency toward a lower degree of aggression was noted compared to the control group without skin problems, but not compared to the psoriasis patients. Therefore, our conclusion is that the present study gave no support for the hypothesis of a specific rosacea personality regarding ways of handling aggression and detachment to other people. Our results correspond with those who state that there is no consensus on the possible aetiological role that psychological factors play in rosacea (8, 9)

The group of persons studied was fairly large (51 rosacea patients and 89 controls), and the statistical power was sufficient to identify any true differences between groups. The use of psoriasis patients as controls can be debated, since this disease has been discussed as having some psychological connection (11). The speculations about psoriasis and psyche, however, have mostly focused on the possible stress relationship, and not on personality factors. However, including another group with a skin disorder decreased the risk of getting results measuring patients with skin disorders in general and not rosacea in particular.

We suggest that future psychosomatic research in rosacea should take a closer look at stress and its possible influences on the course of the disease rather than on aspects of personality. It has been noted in the past that as many as 91% of patients have experienced a stressful or traumatic situation before the outbreak of their rosacea (6). To be able to achieve a more accurate measurement of this, Holmes & Rahe's "social readjustments rating scale" (12) might be used.

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