

Comparison of Stress Coping Styles, Defense Mechanisms, and Type D Personality in Patients with Psoriasis and Seborrheic Dermatitis and Healthy Individuals

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ABSTRACT

The present study aimed to compare stress coping styles, defense mechanisms, and Type D personality in patients with psoriasis, seborrheic dermatitis, and healthy individuals. This causal-comparative study included patients with psoriasis and seborrheic dermatitis who visited the Razi Specialized and Subspecialized Dermatology Clinic in Rasht during the spring of 2021. From this population, 60 patients with psoriasis or seborrheic dermatitis and 30 healthy individuals, who were companions of the patients, were selected through convenience sampling. Data were collected using the Stress Coping Styles Questionnaire (Lazarus & Folkman), the Defense Style Questionnaire (Andrews et al.), and the Type D Personality Scale (Denollet). Data analysis was performed using one-way analysis of variance (ANOVA) in SPSS version 2023. The results indicated significant differences among the groups in emotion-focused coping style ($F = 38.88, p = .001$), neurotic defense mechanisms ($F = 69.91, p = .001$), immature defense mechanisms ($F = 27.25, p = .001$), and the Type D personality components of negative affectivity ($F = 3.96, p = .022$) and social inhibition ($F = 112.59, p = .001$). The findings of this study suggest that differences in coping styles, defense mechanisms, and Type D personality components may play an important role in the development and persistence of psychological responses in dermatological patients. In other words, distinct personality and emotional patterns among individuals with psoriasis and seborrheic dermatitis may influence how they experience and manage disease-related stress.

Keywords: Psoriasis, Seborrheic Dermatitis, Stress Coping, Defense Mechanism, Type D Personality

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Introduction

Chronic dermatological disorders such as psoriasis and seborrheic dermatitis are no longer viewed merely as physical ailments but as complex biopsychosocial conditions in which emotional, cognitive, and personality-related factors exert a decisive influence on their onset, course, and management (1). These conditions, which affect the skin's integrity and appearance, have been consistently linked to psychological

distress, social stigmatization, and diminished quality of life. The interaction between psychological stress and physiological processes is now recognized as bidirectional: stress can exacerbate inflammatory skin conditions, while visible dermatological symptoms can in turn heighten emotional distress, creating a self-perpetuating cycle of psychological and somatic strain (2, 3). Within this context, coping styles, defense mechanisms, and personality factors—particularly Type D personality—play crucial roles in shaping patients' adaptation to chronic illness and their overall psychosocial functioning.

Psoriasis and seborrheic dermatitis are chronic inflammatory diseases influenced by genetic, immunological, and environmental factors (3). Psychological stress has been identified as both a trigger and an exacerbating factor for these disorders, with numerous studies indicating that emotional distress contributes to flare-ups through neuroimmune pathways involving cortisol and inflammatory cytokines (2). Beyond physiological pathways, however, the psychological experience of these patients is marked by embarrassment, avoidance of social situations, and a pervasive sense of rejection (4). The constant visibility of the disease can cause patients to internalize stigmatizing attitudes, which further fuels negative affectivity, anxiety, and depression (1). This dynamic emphasizes that the management of dermatological conditions cannot be isolated from the individual's emotional and personality structure.

Coping with chronic skin diseases requires a complex set of adaptive strategies. According to Lazarus and Folkman's transactional model of stress, coping refers to the cognitive and behavioral efforts to manage internal and external demands that are appraised as taxing or exceeding one's resources. The distinction between problem-focused and emotion-focused coping has been widely applied in clinical psychology to understand how individuals respond to illness-related stress. In patients with psoriasis and seborrheic dermatitis, research shows a tendency toward emotion-focused coping strategies such as avoidance, denial, and rumination, which correlate with higher psychological distress and lower treatment adherence (5, 6). In contrast, problem-focused coping, which involves active engagement with the source of stress, is associated with better psychological outcomes and higher resilience. However, the persistence of chronic and uncontrollable symptoms often makes emotion-focused strategies more likely, even when maladaptive.

Empirical findings demonstrate that individuals with psoriasis use more avoidant and emotion-based coping mechanisms compared to healthy populations (7). These strategies may temporarily alleviate anxiety but often perpetuate psychological suffering and reduce perceived control. Similar tendencies are reported in seborrheic dermatitis, where emotional hyper-reactivity and low self-efficacy hinder adaptive adjustment (4). The chronic nature of these diseases and their social consequences may thus lead to reliance on coping mechanisms that maintain distress rather than resolve it. Studies have also revealed that the quality of coping is intertwined with personality and defense processes, shaping how patients interpret, internalize, and respond to their illness experience (8, 9).

Defense mechanisms, as unconscious strategies to reduce anxiety and maintain psychological equilibrium, represent the deeper structure underlying coping styles (10). These mechanisms protect individuals from emotional pain but can distort reality when used excessively or rigidly. Mature defenses, such as humor and sublimation, promote adaptation, whereas neurotic and immature defenses—like projection, denial, and repression—are associated with maladjustment and psychological distress (11). In the context of chronic illness, maladaptive defenses can manifest as denial of symptoms, externalization of blame, or withdrawal from interpersonal contact, all of which contribute to poorer emotional outcomes and disease management.

Evidence shows that individuals with depression or personality disorders rely more heavily on immature and neurotic defenses compared to healthy individuals (12, 13). These defense styles often overlap with avoidant coping, creating a rigid psychological pattern that restricts emotional flexibility.

Psychodynamic research has emphasized that defense mechanisms serve as mediators between internal conflict and observable coping behavior. Prout et al. (2019) demonstrated that the interplay of resilience and defense mechanisms predicts emotion regulation capacity in psychodynamic therapy, underscoring their centrality to adaptive functioning (14). In dermatological patients, where illness itself often triggers feelings of shame, rejection, and helplessness, maladaptive defenses can sustain a negative self-concept and intensify social avoidance. Moreover, personality traits influence the type and frequency of defense mechanisms used. Individuals characterized by higher neuroticism and negative affectivity are more likely to rely on immature defenses, which in turn heighten stress sensitivity and emotional dysregulation (11).

The concept of Type D (“distressed”) personality integrates two key personality dimensions—negative affectivity and social inhibition—that are highly relevant to psychodermatology. People with Type D personality tend to experience chronic emotional distress, maintain pessimistic outlooks, and suppress emotional expression, leading to social withdrawal and physiological stress responses (7). This personality profile has been linked to poor health outcomes, including cardiovascular and inflammatory disorders, and may play a role in the persistence of dermatological symptoms (1). Negative affectivity encompasses chronic tendencies toward worry, irritability, and dysphoria, while social inhibition reflects discomfort in social interactions and reluctance to express emotions. These features often mirror the lived experience of patients with visible skin diseases, who face both internalized stigma and external social rejection (4).

Neuroimaging and affective neuroscience research provide further insight into the emotional processes underlying such personality tendencies. Studies differentiating guilt and shame have shown that shame is particularly associated with self-referential negative appraisal and withdrawal tendencies—emotional states that reinforce social inhibition and internalized distress (15). Vaish (2018) conceptualized guilt and related moral emotions as adaptive mechanisms fostering social cohesion, yet when dysregulated, they contribute to chronic self-blame and emotional exhaustion (16). In dermatological patients with Type D traits, such maladaptive guilt and shame may amplify the psychosomatic burden and impede recovery.

The interdependence of stress, coping, and personality also involves biological mechanisms. Psychological stress activates the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system, leading to increased cortisol and inflammatory cytokine levels that can aggravate skin lesions (2). Conversely, the visible and chronic nature of skin conditions induces emotional stress that feeds back into the neuroimmune system, perpetuating inflammation. Type D personality traits and maladaptive coping styles intensify this cycle by maintaining chronic physiological arousal and emotional suppression (3). Furthermore, inadequate emotion regulation and immature defense mechanisms hinder patients from processing distress adaptively, leading to somatization and exacerbation of symptoms (9, 10).

Cultural and contextual factors modulate these psychological dynamics. In collectivist societies, individuals with chronic visible illnesses often experience stronger stigma and concealment tendencies due to the importance of social appearance and conformity (17). This leads to increased social inhibition and reliance on maladaptive defenses such as repression and denial. Iranian studies have found that ego strength and defensive functioning differ significantly between individuals with psychiatric conditions and healthy

controls, reflecting the broader role of cultural context in shaping personality organization and emotion regulation (13, 18). In addition, the cultural emphasis on social presentation and interpersonal reputation may exacerbate the emotional impact of dermatological disorders (4, 7).

Recent theoretical advances suggest that coping, defense mechanisms, and personality traits form an integrated regulatory system governing both emotional and behavioral responses to stress (10, 19). Coping strategies represent conscious adaptive efforts, defense mechanisms operate largely unconsciously, and personality structures provide the enduring framework within which these processes unfold (14). Research testing the interrelations among these dimensions has revealed that maladaptive personality configurations tend to predict avoidant and defensive coping patterns, while mature personality traits correlate with constructive coping and adaptive defenses (19). Duru (2024) further illustrated this link by demonstrating that pessimism and defensive coping contribute to indecisiveness and avoidance behaviors among adolescents (6), suggesting that defensive cognitive patterns can generalize across psychological and somatic domains.

Overall, the existing literature demonstrates that psoriasis and seborrheic dermatitis are closely tied to psychological constructs such as stress coping, defense mechanisms, and Type D personality. These constructs interact dynamically, shaping the emotional and behavioral adaptation of affected individuals. Understanding these interconnections can provide a more comprehensive framework for psychodermatological assessment and intervention, emphasizing that effective treatment must integrate psychological and behavioral dimensions alongside dermatological care.

The present study aimed to compare stress coping styles, defense mechanisms, and Type D personality traits among patients with psoriasis, seborrheic dermatitis, and healthy individuals.

Methods and Materials

Study Design and Participants

The present study employed a causal-comparative research design. The statistical population consisted of patients with psoriasis and seborrheic dermatitis who attended the Razi Specialized and Subspecialized Dermatology Clinic in Rasht during the spring of 2021. From this population, 60 patients diagnosed with psoriasis or seborrheic dermatitis and 30 healthy individuals (companions of the patients) were selected through convenience sampling.

The research procedure was as follows: after obtaining the necessary approvals from Islamic Azad University, an announcement for participation was distributed, including the researcher's contact number. Patients who contacted the researcher and verbally expressed informed consent were sent the questionnaires online. Ethical considerations were carefully observed throughout the study. Participants were assured of the confidentiality of their personal information. Participation was voluntary, and participants could withdraw at any time. They were not required to provide their names or identifying information. At the end of the study, participants were reminded that all data would be used solely for statistical analysis.

Data Collection

Coping Styles Questionnaire. The revised version of the Coping Styles Questionnaire developed by Folkman and Lazarus in 1985 consists of 50 items that assess two coping strategies—emotion-focused and

problem-focused—on a 4-point Likert scale ranging from 0 (never), 1 (rarely), 2 (often), to 3 (always) (Folkman & Lazarus, 1985). The emotion-focused coping strategy is represented by items 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 16, 21, 25, 26, 27, 31, 32, 34, 35, 37, 38, 41, 44, 46, 47, 49, and 50, while the problem-focused strategy includes items 1, 4, 5, 14, 15, 17, 18, 19, 20, 22, 23, 24, 28, 29, 30, 33, 36, 39, 40, 42, 43, 45, and 48. Folkman and Lazarus (1985) reported Cronbach's alpha coefficients ranging from .59 to .88 for this instrument. Clark et al. (1995) reported correlations of .95 with the Coping Style Inventory and .68 with the Multidimensional Coping Inventory, supporting its convergent validity, and reported Cronbach's alpha coefficients ranging from .73 to .94 for its subscales. In the Iranian validation of the questionnaire, Padyab et al. (2012) conducted a parallel analysis and, after removing 10 items, retained 7 factors, reporting Cronbach's alpha coefficients ranging from .60 to .84.

Defense Style Questionnaire-40 (DSQ-40). The Defense Style Questionnaire-40 developed by Andrews et al. in 1993 consists of 40 items that assess 20 defense mechanisms grouped into three levels: mature (items 2, 3, 5, 25, 26, 30, 35, 38), neurotic (items 1, 7, 21, 24, 28, 32, 39, 40), and immature (items 4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 27, 29, 31, 33, 34, 36, 37). The questionnaire is rated on a 9-point Likert scale ranging from 1 (strongly disagree) to 9 (strongly agree) (Andrews et al., 1993). Andrews et al. (1993) reported Cronbach's alpha coefficients of .68, .58, and .80 for the mature, neurotic, and immature subscales, respectively, in both healthy and anxiety-disordered groups. Their study also found significant group differences in mature ($F = -0.95, p < .05$), neurotic ($F = 0.40, p < .05$), and immature defenses ($F = 0.44, p < .05$). In Iran, Heidari Nasab et al. (2007) reported Cronbach's alpha coefficients of .81 and .87 for this instrument and satisfactory correlations with personality traits based on the NEO Personality Inventory–Revised, indicating acceptable validity.

Type D Personality Scale. The Type D Personality Scale developed by Denollet (2005) was used to assess Type D personality. This 14-item self-report questionnaire measures two components: negative affectivity (items 2, 4, 5, 7, 9, and 12) and social inhibition (items 1, 3, 6, 8, 10, 11, and 14), rated on a 5-point Likert scale ranging from 1 (false) to 5 (true). Items 1 and 3 are reverse scored. Denollet (2005) reported Cronbach's alpha coefficients of .88 and .86 for the negative affectivity and social inhibition subscales, respectively. Correlations of .68 between negative affectivity and neuroticism and $-.59$ between social inhibition and extraversion were also reported, indicating satisfactory construct validity.

Data analysis

For descriptive statistics, the mean and standard deviation were calculated. Data analysis was conducted using inferential statistical methods, including analysis of variance (ANOVA) and the Fisher statistic. To assess test assumptions, the Shapiro–Wilk test, Levene's test, and Box's M test were applied, with significance levels set at .05 and .01. Data were analyzed using SPSS software, version 23.

Findings and Results

Table 1 shows that the mean scores of emotion-focused coping, neurotic and immature defense mechanisms, and Type D personality components in the two patient groups (psoriasis and seborrheic dermatitis) were higher than those of the healthy individuals.

Table 1. Mean and Standard Deviation of Coping Styles, Defense Mechanisms, and Type D Personality Components

Variable	Component	Psoriasis <i>M (SD)</i>	Seborrheic Dermatitis <i>M (SD)</i>	Healthy Individuals <i>M (SD)</i>
Coping Styles	Problem-focused	35.66 (4.61)	35.53 (4.73)	34.93 (4.90)
	Emotion-focused	43.33 (4.14)	42.93 (4.57)	34.60 (4.26)
Defense Mechanisms	Mature	24.20 (2.52)	24.46 (2.06)	23.80 (2.10)
	Neurotic	30.93 (3.16)	31.73 (3.39)	23.33 (2.48)
	Immature	78.60 (4.48)	72.66 (3.07)	65.26 (10.35)
Type D Personality	Negative affectivity	8.00 (0.91)	8.13 (0.63)	7.60 (0.72)
	Social inhibition	78.60 (4.48)	72.66 (3.07)	65.26 (10.35)

The results presented in Table 2 indicate that there were statistically significant differences among the groups in emotion-focused coping style ($F = 38.88, p = .001$), neurotic defense mechanisms ($F = 69.91, p = .001$), immature defense mechanisms ($F = 27.25, p = .001$), and the Type D personality components of negative affectivity ($F = 3.96, p = .022$) and social inhibition ($F = 112.59, p = .001$).

Table 2. One-Way Multivariate Analysis of Variance Among Psoriasis Patients, Seborrheic Dermatitis Patients, and Healthy Individuals

Variable	Component	Source	Sum of Squares	df	Mean Square	F	Sig.
Coping styles	Problem-focused	Between groups	9.15	2, 87	4.57	0.20	.817
	Emotion-focused	Between groups	1458.75	2, 87	729.38	38.88	.001
Defense mechanisms	Mature	Between groups	6.75	2, 87	3.37	0.67	.513
	Neurotic	Between groups	1289.60	2, 87	644.80	69.91	.001
	Immature	Between groups	2677.42	2, 87	1338.71	27.25	.001
Type D personality	Negative affectivity	Between groups	4.62	2, 87	2.31	3.96	.022
	Social inhibition	Between groups	265.48	2, 87	132.74	112.59	.001

Table 3 shows the results of the Bonferroni post hoc test, indicating significant pairwise differences in the mean scores of emotion-focused coping, neurotic and immature defense mechanisms, and Type D personality components. The Bonferroni test results demonstrate that both the psoriasis and seborrheic dermatitis groups scored significantly higher than healthy individuals in emotion-focused coping, neurotic and immature defense mechanisms, and Type D personality components.

Table 3. Bonferroni Post Hoc Test Results for Pairwise Mean Comparisons Among the Three Groups

Variable	Groups Compared	Mean Difference	Sig.
Emotion-focused coping	Psoriasis – Seborrheic Dermatitis	-0.20	1.000
	Psoriasis – Healthy	-3.73	.001
	Seborrheic Dermatitis – Healthy	-3.53	.001
Neurotic defenses	Psoriasis – Seborrheic Dermatitis	-0.80	.931
	Psoriasis – Healthy	-7.60	.001
	Seborrheic Dermatitis – Healthy	-8.40	.001
Immature defenses	Psoriasis – Seborrheic Dermatitis	-5.93	.005
	Psoriasis – Healthy	-13.33	.001
	Seborrheic Dermatitis – Healthy	-7.40	.001
Negative affectivity	Psoriasis – Seborrheic Dermatitis	-0.13	1.000
	Psoriasis – Healthy	-0.40	.001
	Seborrheic Dermatitis – Healthy	-0.53	.001
Social inhibition	Psoriasis – Seborrheic Dermatitis	-1.10	.001
	Psoriasis – Healthy	-4.06	.001
	Seborrheic Dermatitis – Healthy	-2.96	.001

Discussion and Conclusion

The present study sought to compare stress coping styles, defense mechanisms, and Type D personality traits among patients with psoriasis, seborrheic dermatitis, and healthy individuals. The results revealed statistically significant differences between the groups in emotion-focused coping styles, neurotic and immature defense mechanisms, and in both negative affectivity and social inhibition components of Type D personality. Specifically, patients with psoriasis and seborrheic dermatitis demonstrated a greater reliance on emotion-focused coping strategies, employed higher levels of neurotic and immature defenses, and exhibited higher levels of negative affectivity and social inhibition than healthy participants. These findings underscore the complex psychosocial dynamics of chronic dermatological disorders, indicating that maladaptive coping and personality-related emotional patterns play a critical role in shaping psychological adaptation and illness experience.

The finding that patients with dermatological conditions primarily relied on emotion-focused coping strategies aligns with prior research emphasizing the predominance of avoidance, denial, and rumination in individuals dealing with chronic stressors (5, 7). Chronic illnesses like psoriasis and seborrheic dermatitis present stressors that are often uncontrollable and recurrent, making problem-focused coping less feasible. Emotion-focused coping may thus serve as an immediate but temporary means of reducing distress; however, it tends to perpetuate anxiety and reduce long-term adjustment (6). Patients may use avoidance or cognitive suppression to manage the embarrassment and social discomfort associated with visible lesions, yet these strategies may ultimately intensify self-consciousness and social withdrawal. Consistent with previous reports, emotion-focused coping has been associated with poorer psychosocial adjustment and lower treatment adherence in dermatological conditions (1).

This reliance on emotion-focused coping can also be understood through the lens of social and cultural contexts. In societies where external appearance is tightly linked to self-worth and social status, chronic visible conditions elicit strong emotional reactions and defensive patterns (4). The Iranian social context, characterized by strong collectivist norms and high sensitivity to public image, may amplify this phenomenon. Similar qualitative findings from patients with atopic dermatitis showed that shame, guilt, and fear of social exclusion were recurrent themes that shaped emotional regulation patterns (17). As such, emotion-focused coping in dermatological patients may represent a cultural adaptation to avoid social embarrassment rather than purely individual maladjustment.

The significant difference found in neurotic and immature defense mechanisms between patients and healthy individuals further supports the interpretation that these disorders involve deeper psychological processes beyond conscious coping. Patients with psoriasis and seborrheic dermatitis demonstrated greater use of primitive and neurotic defenses such as denial, projection, displacement, and repression. These mechanisms serve to protect the ego from overwhelming anxiety but do so at the cost of distorting reality and restricting adaptive functioning (10, 11). The association between immature defenses and emotional dysregulation has been repeatedly documented in psychosomatic and personality research. For instance, Iwanicka et al. (2017) found that individuals with high stress levels and emotion-focused coping tendencies showed dominant patterns of primitive defenses, mirroring the defensive structure observed in the current sample (20).

Granieri and colleagues further elaborated that neurotic defenses, while less primitive, still maintain internal conflicts by channeling distress through mechanisms such as intellectualization or reaction formation (11). This defense configuration reflects a tendency toward internalized distress and chronic tension, both of which may exacerbate dermatological symptoms through stress-mediated physiological pathways. Prout et al. (2019) described defense mechanisms as integral to implicit emotion regulation, noting that maladaptive defenses can hinder resilience and maintain symptomatology (14). The high prevalence of such defenses among dermatological patients, therefore, suggests that psychological interventions focusing on awareness and restructuring of defensive patterns may yield therapeutic benefits.

Additionally, the results showed significant differences in Type D personality dimensions, particularly negative affectivity and social inhibition, between the clinical and healthy groups. These findings are consistent with prior evidence indicating elevated Type D personality traits among patients with chronic inflammatory and psychosomatic conditions (1, 7). Individuals with Type D personality are predisposed to chronic negative emotions such as worry, irritability, and guilt, as well as inhibition in social contexts that discourages emotional expression (19). This pattern creates a psychological environment conducive to prolonged stress activation, reduced coping efficacy, and avoidance of social support.

Negative affectivity in particular may play a mediating role in the relationship between personality and stress reactivity. Studies have shown that individuals high in negative affectivity perceive situations as more threatening, report higher physiological arousal, and are less likely to use adaptive coping mechanisms (16, 21). In dermatological patients, such hyperreactivity could amplify the perception of symptoms, increase focus on bodily sensations, and heighten emotional suffering. Moreover, social inhibition—a central feature of Type D personality—may contribute to the persistence of distress by limiting patients' willingness to seek emotional or medical support. These tendencies resonate with the qualitative findings by Ghorbanibargani et al. (2016), who reported that feelings of stigma and rejection were pervasive among psoriasis patients, reinforcing social withdrawal and silence (4).

The association between emotional suppression and skin conditions may also be explained by neurobiological findings. Woźniak et al. (2021) identified links between psychological stress, mast cell activation, and psoriasis severity, suggesting that chronic emotional suppression may sustain inflammation through the dysregulation of stress hormones and immune mediators (2). In parallel, research by Zhu et al. (2019) distinguished the neural substrates of shame and guilt, revealing that shame is particularly linked with self-referential negative cognition and social withdrawal (15). Since Type D individuals often experience heightened shame and guilt, their emotional suppression may indirectly contribute to the perpetuation of skin symptoms.

The current study's results also highlight the conceptual integration of coping, defense mechanisms, and personality traits as interdependent systems of emotional regulation. Consistent with the integrative perspective advanced by Silverman and Aafjes-van Doorn (2023), coping and defense mechanisms operate across a continuum from conscious to unconscious levels of psychological regulation (10). Patients with dermatological conditions may demonstrate rigid defensive structures that inhibit adaptive coping, leading to persistent emotional dysregulation. This pattern aligns with the systematic review by Guadalupe and DeShong (2025), which emphasized that personality dimensions shape both the selection and efficacy of

coping strategies (19). Hence, the current findings support the notion that emotion regulation, personality structure, and coping behavior are dynamically linked in the context of chronic illness.

Similar to previous studies, the results suggest that maladaptive defense mechanisms and Type D personality traits may serve as predictors of poor psychological adjustment in dermatological populations (7, 12). Individuals exhibiting immature defenses and chronic negative affectivity may experience greater emotional vulnerability, lower resilience, and a more negative illness perception. Duru (2024) found that defensive pessimism and avoidance-based coping significantly predicted indecisiveness and psychological distress among adolescents (6). Although this study was conducted in an educational context, its findings are psychologically analogous, as both scenarios involve maladaptive self-protective responses that limit adaptability. Similarly, Derakhshan et al. (2016) showed that emotion-focused coping and rumination are strongly correlated with anxiety and depression, echoing the psychological patterns observed among the dermatological patients in this study (5).

The present results also align with previous Iranian research showing that patients with psoriasis exhibit difficulties in emotion regulation and a higher prevalence of depressive symptoms compared to healthy individuals (7). Emotional dysregulation in such patients may stem from excessive reliance on avoidance and suppression as coping methods, which are in turn reinforced by neurotic and immature defenses. This reinforces the theoretical model proposed by Sala et al. (2015), who argued that emotion regulation and defense mechanisms are functionally interrelated components of psychological adaptation (9). Shehata et al. (2016) similarly demonstrated that the use of repressive or denial-based defense styles is associated with poorer emotional regulation and increased distress (8). Together, these studies provide convergent support for the present findings, suggesting that maladaptive coping and defense patterns contribute to the chronic emotional burden associated with dermatological disorders.

The findings also reinforce the psychodermatological framework, which posits that chronic skin conditions are influenced not only by biological mechanisms but also by psychological and behavioral responses (1, 3). Stress-induced immune dysregulation and inflammation may be potentiated by chronic emotional arousal, while avoidance-based coping perpetuates stress by preventing emotional resolution. As highlighted by Yeh et al. (2022), lifestyle and behavioral interventions—including exercise—can mitigate stress responses and improve skin condition, demonstrating the therapeutic potential of targeting psychological processes (3).

The convergence of findings across these dimensions underscores the need to conceptualize psoriasis and seborrheic dermatitis as multifactorial conditions that demand integrated biopsychosocial management. By identifying that patients rely more on emotion-focused coping, immature defenses, and Type D personality patterns, this study provides a psychological profile that can inform the design of supportive interventions aimed at improving mental health outcomes and, consequently, dermatological prognosis.

Despite the valuable insights gained, several limitations should be acknowledged. First, the study employed a cross-sectional and causal-comparative design, which limits the ability to infer causal relationships among coping styles, defense mechanisms, and Type D personality traits. Longitudinal studies would be needed to establish temporal and directional links between these psychological variables and disease progression. Second, the study relied on self-report questionnaires, which may be subject to biases such as social desirability, self-awareness limitations, or defensive responding. Third, the convenience

sampling method and relatively small sample size may restrict the generalizability of findings to broader populations, as participants were recruited from a single dermatology clinic. Additionally, the inclusion of only patients from one cultural and regional background limits cross-cultural interpretation of results, given that coping and defense patterns may vary across sociocultural contexts. Finally, the study did not control for potential confounders such as medication use, illness duration, or comorbid psychiatric symptoms, which could have influenced psychological responses.

Future studies should adopt longitudinal and mixed-method designs to capture the dynamic interplay between coping, defense mechanisms, and personality traits over time. Investigations using psychophysiological and neuroimaging measures could clarify the biological correlates of emotional regulation patterns in dermatological patients. Moreover, future research should examine the moderating role of gender, disease severity, and social support on psychological outcomes, as these variables likely influence coping behavior and personality expression. Expanding the research to include diverse cultural contexts would enhance the external validity of findings and reveal cultural nuances in defensive functioning and coping strategies. Finally, interventional studies testing the efficacy of psychotherapeutic approaches—such as cognitive-behavioral therapy, mindfulness-based interventions, and psychodynamic psychotherapy—in modifying maladaptive coping and defense patterns among dermatological patients would provide practical insights into clinical application.

Clinically, the findings highlight the necessity of integrating psychological assessment and intervention into dermatological care. Practitioners should routinely screen patients for maladaptive coping and Type D personality traits to identify those at risk of heightened emotional distress. Psychoeducation on stress management, adaptive coping, and emotional expression should be incorporated into treatment programs. Collaborative care models involving dermatologists, psychologists, and psychiatrists can foster a holistic approach that addresses both physical and emotional dimensions of the disorder. Interventions aimed at enhancing adaptive coping and modifying maladaptive defenses—such as relaxation training, cognitive restructuring, and interpersonal skills development—may significantly improve quality of life and treatment adherence. Additionally, promoting social support networks and addressing stigma through community education could reduce social inhibition and foster better psychosocial adaptation among patients with psoriasis and seborrheic dermatitis.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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