

Comment on “Fibromyalgia, perfectionism, and interpersonal style: Further evidence for a person-centered approach”

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Dear Editor,

We read with interest the article by Maes *et al.* examining perfectionism and other-directed interpersonal styles in women with fibromyalgia (FM) compared with women with rheumatoid arthritis (RA) [1]. The study addresses a clinically relevant question and is commendable for attempting to move beyond a purely symptom-centered account of FM. The reported between-group differences are notable, and the topic is timely given the growing interest in person-centered formulations of FM. At the same time, previous literature suggests that the relationship between personality-related constructs and FM is more nuanced than a straightforward case-control distinction. For example, perfectionism has been linked to poorer health functioning in women with FM, yet prior work did not support a simple conclusion that perfectionism is globally elevated as a uniform trait across all such patients [2]. Likewise, personality research in FM has suggested that these variables may be more useful for identifying subgroups than for defining an FM-specific profile *per se* [3].

Our main concern, therefore, is not simply that the present study is cross-sectional, but that it may not have adequately distinguished relatively stable personality characteristics from state-dependent distress and illness-related self-report bias. All principal constructs—perfectionism, subjugation, approval-seeking, and self-sacrifice—were assessed exclusively through self-report questionnaires [1]. However, the FM group also showed markedly elevated anxiety and depression scores on the Hospital Anxiety and Depression Scale, and the manuscript further reports correlations between HADS scores and several target variables. This issue is especially important because prior work has shown that the effect of personality dimensions, particularly neuroticism, on fibromyalgia impact can be mediated by anxiety and depression [4]. Under such conditions, the observed differences may reflect not only enduring interpersonal or perfectionistic tendencies, but also the psychological burden of current illness, negative self-appraisal, and distress-related response style.

The authors attempted to address this issue by comparing the RA group with a subgroup of 22 FM patients scoring below 8 on both HADS subscales. Although thoughtful, this additional analysis does not fully resolve affective confounding. The comparator remained the full RA cohort rather than an equivalently emotion-matched RA subgroup, and HADS was not modeled as a continuous covariate across groups within a unified multivariable framework. As a result, the subgroup analysis demonstrates only that lower-HADS FM patients still reported higher maladaptive schemas than the overall RA sample; it does not establish that these differences are independent of residual mood burden or other state-related reporting effects. This distinction is particularly relevant when considering constructs such as self-sacrifice and other-directedness, because related literature has already linked self-silencing and self-sacrificial behavioral patterns to symptom burden in women with FM, again raising the possibility that such measures partly capture illness-shaped adaptation rather than disease-specific personality structure [5].

We therefore suggest a more cautious interpretation. The present data support an association between FM status and higher self-reported maladaptive perfectionistic and other-directed schemas [1]. They do not yet justify the stronger inference that these differences represent FM-specific personality features that should directly inform screening algorithms or indications for additional psychotherapy. Future work would be strengthened by affectively matched comparator groups, multivariable analyses with continuous adjustment for anxiety and depression, and the addition of clinician-rated or informant-based measures to reduce exclusive reliance on self-report. Such steps would better separate enduring personality structure from the psychological consequences of living with chronic pain.

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