

Satisfaction with life and coping skills in the acute and chronic urticaria

Blažević Zelić, Sandra; Rubeša, Gordana; Brajac, Ines; Vučić Peitl, Marija; Pavlović, Eduard

Source / Izvornik: **Psychiatria Danubina, 2016, 28, 34 - 38**

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:184:049527>

Rights / Prava: [Attribution 4.0 International](#)/[Imenovanje 4.0 međunarodna](#)

Download date / Datum preuzimanja: **2024-07-26**



Repository / Repozitorij:

[Repository of the University of Rijeka, Faculty of Medicine - FMRI Repository](#)



SATISFACTION WITH LIFE AND COPING SKILLS IN THE ACUTE AND CHRONIC URTICARIA

Sandra Blažević Zelić¹, Gordana Rubeša¹, Ines Brajac², Marija Vučić Peitl¹ & Eduard Pavlović¹

¹Department of Psychiatry, University Clinical Hospital Rijeka, Rijeka, Croatia

²Department of Dermatovenerology, University Clinical Hospital Rijeka, Rijeka, Croatia

received: 3.11.2014;

revised: 28.1.2015;

accepted: 16.7.2015

SUMMARY

Background: The purpose of this study was to examine the differences in satisfaction with life and coping strategies between patients with acute and chronic urticaria.

Subjects and methods: Sixty patients with urticaria were divided into 2 groups after 6 weeks of standardized dermatology treatment (33 patients with acute and 27 patients with chronic urticaria). At baseline, all patients answered the following questionnaires: Satisfaction with Life Scale (SWLS), Personal Wellbeing Index (PWI-A), The Multidimensional Coping Inventory (COPE) and General questionnaire (age, gender, education, employment, marital status). After six weeks all the participants were re-tested with 2 questionnaires: SWLS and PWI-A.

Results: Six weeks after the initial testing there was a statistically significant difference in satisfaction with life between patients with acute and chronic urticaria. Patients with acute urticaria were more satisfied with their lives than patients with chronic urticaria. Also, there was a statistically significant difference in the use of emotion-focused coping, seeking social support for emotional reasons and seeking social support for instrumental reasons. Patients with acute urticaria used emotion-focused coping and sought social support for emotional and instrumental reasons to a greater degree than patients with chronic urticaria.

Conclusion: Patients with acute urticaria were more satisfied with their lives than patients with chronic urticaria. Patients with acute urticaria used emotion-focused coping and sought social support for emotional and instrumental reasons to a greater degree than patients with chronic urticaria.

Key words: coping skills - satisfaction with life - social support - urticaria

* * * * *

INTRODUCTION

Psychodermatology studies the impact of psychological factors on the occurrence, course and treatment of skin diseases (Kotrulja & Šitum 2004). Psychodermatological disorders are divided into three groups: psychosomatic disorders (urticaria, acne, alopecia), primary psychiatric disorders (illusions of parasitosis, dismorphismobias, trichotillomania) and secondary psychiatric disorders (hemangiomas, KS sarcoma) (Koo & Lebwohl 2011).

Urticaria is one of the most common diseases in the field of dermatology. The prevalence is between 0.5 and 1%, higher in the population of women, in the age 30-40 years. It is characterized by the spontaneous appearance of efflorescence and/or angioedema, which may, according to some studies, last for months or years (Weller et al. 2010). Diagnosis of acute urticaria is based on the clinical picture and the duration of not more than 6 weeks. The appearance of wheal daily or almost daily for 6 weeks or longer is defined as a chronic urticaria (Murat Sušić 2011).

Psychological distress has an important role as a trigger in the exacerbation of the disease (Malhotra & Mehta 2008). Barbosa et al. (2011) have demonstrated a high level of psychological distress, which may exacerbate the social, emotional and general health perception and interpersonal relationships in patients with urticaria.

Numerous studies have shown that the quality of life in these patients decreased to the same extent as in patients with coronary disease, and it is evident in the limitation of social functioning and difficulties in daily activities (O'Donnell et al. 1997). There are many studies showing that chronic urticaria significantly reduces the quality of life, especially in the areas of functioning and emotional functioning, while the impact on the appearance of physical symptoms is significantly weaker (O'Donnell et al. 1997, Staubach et al. 2006, Ozkan et al. 2007, Engin et al. 2008, Uguz et al. 2008, Potocka et al. 2009). Dermatological diseases have a negative effect on patients' quality of life, and can manifest as psychological stress, stigma, and shame which leads to a significant reduction in emotional and social wellbeing, as well as labor productivity. These factors can significantly affect the course and progression of the disease and the patient's response to treatment. Therefore, in dermatological diseases, it is particularly important to include the measurement of the patient's life satisfaction in relation to the disease (Anderson et al. 1997, Finlay 1997).

Barbosa and colleagues found that 56.9% of patients suffering from chronic urticaria have alexithymia, which is positively correlated with insecure attachment, psychopathological symptoms and self-destructive defensive mechanisms (Barbosa et al. 2011). The more the chronic urticaria patients used emotion-

focused coping skill, the more severe urticaria symptoms they manifested (Chung et al. 2010), while avoiding is the main coping skill in dermatological diseases (Korabel et al. 2013). Patients with skin diseases significantly more often withdraw in the face of stress and problems, they do not seek solutions, avoid or negate difficulties. They confront neither the difficult situations nor the accompanying emotions (Korabel et al. 2013). Patients with chronic idiopathic urticaria have significantly less family support and more negative coping tendencies, according to Yung et al. (2005). Previous research of the chronic urticaria opens the question whether the same findings can be found in acute urticaria, or is there the possibility that coping styles in acute urticaria are completely different, which is the topic of this research.

Psychiatric and psychological factors play an important role in at least 30% of dermatological diseases, and are essential in the treatment and prevention of these diseases. Therefore, it is important to take into account the bio-psychosocial model that links psychological and social factors with the primary dermatological factors in the treatment of patients with urticaria (Badoux & Levy 1994, Gupta & Gupta 2003, Pasaoglu et al. 2006, Staubach et al. 2011). The objectives of this study were to examine coping strategies and satisfaction with life in patients with acute and chronic urticaria.

SUBJECTS AND METHODS

Subjects

The study included 60 patients aged 18-65 years at the Department of Dermatology, University Hospital Rijeka, who sought help for the first episode of urticaria, and who did not have a psychiatric or a personality disorder, as well as any other dermatological disease. No patient during the dermatological treatment of urticaria was subjected to psychological or psychiatric treatment. They all had identical and standardized dermatological treatment; therefore, there was no possibility of the impact of different psychotropic effects of dermatological therapy on all measured items. After 6 weeks, depending on the progress of the disease, the patients were categorized into two subgroups: acute (duration of disease less than 6 weeks) and chronic (duration of disease longer than 6 weeks). The selection of participants was performed by dermatovenerologist, specialist at the Department of Dermatology, University Hospital Rijeka. He made a dermatological examination and established the diagnosis of urticaria in a doctor's office or during hospitalization (in accordance with the International Classification of Diseases - ICD-10). Then the psychiatrist was invited to exclude the existence of psychiatric illness on the basis of clinical experience and in accordance with the ICD-10. The psychiatrist explained the research methodology and conducted a study after obtaining participant's consent. Questionnaires were given to the patients at their first visit to the

dermatologist and psychiatrist. Testing included the questionnaires indicated below, and after 6 weeks of treatment all the participants were re-tested with 2 questionnaires - Satisfaction with life scale (Diener et al. 1985) and Personal wellbeing index (International Wellbeing Group 2006). Patients with other dermatological diseases, as well as those who suffer from psychiatric disorders were excluded from the study.

Instruments

In this study the following questionnaires were used: Satisfaction with Life Scale (SWLS) - short scale of 5 items that measures overall satisfaction with life; Personal Wellbeing Index (PWI-A) which consists of one item and measures the subjective dimension of quality of life on a scale of 1 (very dissatisfied) to 10 (very satisfied); The Multidimensional Coping Inventory (COPE) which defines three types of coping strategies: problem-focused coping, emotion-focused coping and avoidant coping (Carver et al. 1989); General questionnaire (age, gender, education, employment, marital status).

Statistical analysis

The collected data were analyzed by an independent statistician using SPSS version 17.0 for Windows. For all the data using the above-mentioned questionnaires basic descriptive statistical parameters are shown. Reliability tests were examined by Cronbach's alpha test. Applied tests had satisfactory reliability. T-test for independent causes was used to estimate the differences between groups of participants.

RESULTS

Average age of all the participants was 44.15 years. There were 46 women (77%) and 14 men (23%). Regarding the level of education, participants predominantly had secondary (59%) and higher education (19%). 15% of them finished primary school, 5% were skilled workers and 1 participant did not finish primary school. 71% of the participants were married, 22% were single, and 7% were divorced. 93% of the participants had children. 61% of the respondents were employed, and 39% were unemployed. After 6 weeks, patients were categorized into two groups: patients with acute urticaria (n=33) and patients with chronic urticaria (n=27). No statistically significant differences were observed between the examined groups in terms of their sociodemographic characteristics.

As shown in Table 1, there was a statistically significant difference in satisfaction with life six weeks after the initial testing ($t=3.86$, $p<0.01$) between patients with acute and chronic urticaria. Patients with acute urticaria were more satisfied with their lives ($M=17.12$, $SD=3.31$) than patients with chronic urticaria ($M=13.41$, $SD=4.14$).

Table 1. Comparison of the results obtained in two groups of patients (acute and chronic urticaria)

Scales	M _{au}	SD _{au}	M _{cu}	SD _{cu}	t-test	df	p-value
Life satisfaction (SWLS)	16.30	3.97	14.33	4.98	1.71	58	0.093
Life satisfaction (SWLS) after 6 weeks	17.12	3.31	13.41	4.14	3.86	58	0.000
Life satisfaction (PWI-A)	6.18	1.99	5.89	2.03	-0.56	58	0.576
Life satisfaction (PWI-A) after 6 weeks	6.61	1.89	5.70	1.56	1.99	58	0.052
Problem-focused coping	53.76	12.95	50.5	14.9	0.9	57	0.373
Planning	12.61	2.76	11.46	3.66	1.37	57	0.176
Active coping	8.70	2.71	8.46	3.13	0.31	57	0.758
Positive reinterpretation and growth	9.03	2.99	7.85	3.59	1.38	57	0.172
Restraint coping (waiting)	7.12	3.27	7	2.73	0.15	57	0.880
Suppression of other activities	8.39	3.56	7.08	3.69	1.39	57	0.170
Acceptance	7.91	3.19	8.65	3.24	0.88	57	0.381
Emotion-focused coping	22.7	5.81	16.96	6.8	3.49	57	0.001
Seeking social support for emotional reasons	8.42	2.71	6	2.71	3.41	57	0.001
Seeking social support for instrumental reasons	7.94	2.59	6	3.29	2.54	57	0.014
Venting emotion/focus on emotions	6.33	2.64	4.96	2.63	1.98	57	0.052
Avoidance	15.94	8.74	14.69	6.72	0.60	57	0.550
Mental disengagement	9.91	4.67	7.96	3.99	1.69	57	0.096
Denial	2.42	2.46	2.50	2.50	-0.12	57	0.908

A statistically significant difference was also observed in the use of emotion-focused coping ($t=3.49$, $p<0.01$). Patients with acute urticaria ($M=22.7$, $SD=5.81$) used emotion-focused coping to a greater degree compared to patients with chronic urticaria ($M=16.96$, $SD=6.8$). In line with this, there was a statistically significant difference in social support seeking for emotional reasons ($t=3.41$, $p<0.01$). Patients with acute urticaria ($M=8.42$, $SD=2.7$) sought social support for emotional reasons to a greater degree than patients with chronic urticaria ($M=6.0$, $SD=2.71$). Additionally, there was a statistically significant difference in social support seeking for instrumental reasons ($t=2.54$, $p<0.05$). Patients with acute urticaria ($M=7.94$, $SD=2.59$) sought social support for instrumental reasons to a greater degree than patients with chronic urticaria ($M=6.0$, $SD=3.29$).

DISCUSSION

Quality of life, as a multidimensional concept that combines the dignity of persons with emotional, spiritual, psychological and physical components of personality, is significantly deteriorated in almost all chronic diseases (Cesarec et al. 2014). The ability to cope with the limitations and impossibilities can significantly affect the individual's perception of health and satisfaction with life (Testa & Simonson 1996).

Results of this study indicated that after 6 weeks of testing satisfaction with life in patients with acute urticaria was significantly greater compared to patients with chronic urticaria, which is consistent with studies that show that deterioration in the quality of life is present in chronic dermatological patients. Specifically, 40% of patients believed that the quality of life is associated with the manifestation of symptoms on the

skin (Finley & Coles 1995). While in chronic urticaria rash is reoccurring, in acute urticaria it withdraws within six weeks, which supports the association between quality of life and the chronification of the disease, and emphasizes the need for the adequate treatment in the acute phase of the disease in order to reduce urtica and enable better quality of life for these patients. According to O'Donnell et al. (1997), quality of life in patients with chronic urticaria is reduced to the same extent as in cardiac patients, particularly in the area of social and psychological functioning.

Patients with acute urticaria used emotion-focused coping to a greater degree compared to patients with chronic urticaria, which is not in accordance with the study of Chung et al. (2010) that found positive association between chronification of the disease and the use of emotion-focused coping. Emotion-focused coping has the function of reducing or easing of affective arousal caused by a stressful situation. It includes expression of the feelings and seeking for social support (seeking advice, emotional support). This way of dealing prevails in situations where it is estimated that it is not possible to control stressful events or their outcomes (Lazarus 1993). Generally, it is shown in numerous studies that emotion-focused coping strategies and avoidance are usually useful in the initial stages of stressful events, as it is the case with acute urticaria. Therefore, we could presume that our results are more "justifiable" in relation to the research by Chung et al. (2010). Emotion-focused coping enables gradual confrontation with problems, as well as active and effective dealing with them. People tend to regulate their emotional state, mostly in order to maintain positive, or to reduce negative mood; this coping strategy is well adjusted for the scope. Effectiveness of emotion-focused coping is further enhanced by the fact

that it incorporates the components of social support, which also helps reducing negative emotional states (Kalebić 2007). The facts listed above support the results of our study. Namely, the subjects from acute urticaria group sought social support for emotional and instrumental purposes to a greater degree, and thus achieved better adaptation at the very beginning of the disease. Seeking social support is important because that is a way to get understanding, and to reduce negative emotions. Alexithymia is a personality construct characterized by inability to identify and describe emotions in the self. Alexithymic person cannot use emotion-focused coping, so they cannot reduce constant increased arousal to stressful stimuli, which leads to increase of stress, and all of that can cause symptoms of chronic urticaria.

Studies have shown great importance of the relaxation therapy programs and stress management in the treatment of urticaria. Psychological interventions can help patients to reinterpret events and develop appropriate strategies to cope with stressful situations, thus reducing the morbidity of this disease (Malhotra & Mehta 2008).

CONCLUSIONS

Patients with acute urticaria expressed greater satisfaction with life compared to patients with chronic urticaria. Considering coping strategies, patients with acute urticaria used emotion-focused coping and sought social support for instrumental reasons to a greater degree than patients with chronic urticaria. Results of this study indicated the need for cooperation between dermatologists, psychiatrists and psychologists in the treatment of urticaria, because psychological approach can significantly improve the treatment and course of the disease, and thus the quality of life of these patients.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. Anderson RT & Rajagopalan R: Development and validation of a quality of life instrument for cutaneous diseases. *J Am Acad Dermatol* 1997; 37:41-50.
2. Badoux A & Levy DA: Psychological symptoms in asthma and chronic urticaria. *Ann Allergy* 1994; 72:229-34.
3. Barbosa F, Freitas J & Barbosa A: Chronic idiopathic urticaria and anxiety symptoms. *J Health Psychol* 2011; 16:1038-47.
4. Carver C, Scheier M & Weintraub JK: Assessing Coping Strategies: A Theoretically Based Approach. *J Pers Soc Psychol* 1989; 56:267-83.
5. Cesarec G, Martinec S, Basic I & Jakopic D: Effect of exercises on quality of life in women with osteoporosis and osteopenia. *Coll Antropol* 2014; 38:247-54.
6. Chung MC, Symons C, Gilliam J & Kaminski ER: Stress, psychiatric co-morbidity and coping in patients with chronic idiopathic urticaria. *Psychol Health* 2010; 25:477-90.
7. Diener E, Emmons RA, Lar RJ & Griffin S: Satisfaction with life scale. *J Pers Assess* 1985; 49:71-5.
8. Engin B, Uguz F, Yilmaz E, Ozdemir M & Mevlioglu I: The levels of depression, anxiety and quality of life in patients with chronic idiopathic urticaria. *J Eur Acad Dermatol Venereol* 2008; 22:36-40.
9. Finlay AY & Coles EC: The effect of severe psoriasis on the quality of life of 369 patients. *Br J Dermatol* 1995; 132:236-44.
10. Finlay AY: Quality of life measurement in dermatology: a practical guide. *Br J Dermatol* 1997; 136:305-14.
11. Gupta MA & Gupta AK: Psychiatric and psychological co-morbidity in patients with dermatologic disorders: epidemiology and management. *Am J Clin Dermatol* 2003; 4:833-42.
12. International Wellbeing Group: Personal Wellbeing Index. Deakin University, Melbourne, 2006.
13. Kalebić MB: Uloga izražavanja emocija i suočavanja sa stresom vezanim uz školu u percepciji raspoloženja i tjelesnih simptoma adolescenata. *Psychological themes* 2007; 16:1-26.
14. Koo J & Lebwohl A: Psychodermatology: The Mind and Skin Connection. *Am Fam Physician* 2001; 11:1873-8.
15. Korabel H, Grabski B, Dudek D, Jaworek A, Krzysztof G, Kiejna A et al: Stress coping mechanisms in patients with chronic dermatoses. *Archives of Psychiatry and Psychotherapy* 2013; 3:33-40.
16. Kotrulja L & Šitum M: Psihodermatologija. *Medix* 2004; 54/55:143-145.
17. Lazarus RS: From psychological stress to the emotions: a history of changing outlooks. *Annu Rev Psychol* 1993; 44:1-21.
18. Malhotra SDK & Mehta V: Role of stressful life events in induction or exacerbation of psoriasis and chronic urticaria. *Indian J Dermatol Venereol Leprol* 2008; 74:594-9.
19. Murat-Sušić S, Husar K, Kotrulja L, Puizina-Ivić N & Skerlev M: Enigma urtikarije u dječjoj dobi. *Paediatr Croat* 2011; 55:263-9.
20. O'Donnell BF, Lawlor F, Simpson J, Morgan M & Greaves MW: The impact of chronic urticaria on the quality of life. *Br J Dermatol* 1997; 136:197-201.
21. Ozkan M, Oflaz SB, Kocaman N, Ozseker F, Gelincik A, Büyükoztürk S et al: Psychiatric morbidity and quality of life in patients with chronic idiopathic urticaria. *Ann Allergy Asthma Immunol* 2007; 99:29-33.
22. Pasaoglu G, Bavbek S, Tugcu H, Abadoğlu O & Misirligil Z: Psychological status of patients with chronic urticaria. *J Dermatol* 2006; 33:765-71.
23. Potočka A, Turczyn-Jabłońska K & Merez D: Psychological correlates of quality of life in dermatology patients: the role of mental health and self-acceptance. *Acta Dermatovenerol Alp Panonica Adriat* 2009; 18:53-8, 60, 62.
24. Staubach P, Eckhardt-Henn A, Dechene M, Vonend A, Metz M, Magerl M et al: Quality of life in patients with chronic urticaria is differentially impaired and determined by psychiatric comorbidity. *Br J Dermatol* 2006; 154:294-8.

25. Staubach P, Dechene M, Metz M, Magerl M, Siebenhaar F, Weller K et al: High prevalence of mental disorders and emotional distress in patients with chronic spontaneous urticaria. *Acta Derm Venereol* 2011; 91:557-61.
26. Testa MA & Simonson DC: Assessment of Quality of life. *N Engl J Med* 1996; 335:520-2.
27. Uguz F, Engin B & Yilmaz E: Quality of life in patients with chronic idiopathic urticaria: the impact of Axis I and Axis II psychiatric disorders. *Gen Hosp Psychiatry* 2008; 30:453-7.
28. Weller K, Altrichter S, Ardelean E, Krause K, Magerl M, Metz M et al.: Chronic urticaria. Prevalence, course, prognostic factors and impact. *Hautarzt* 2010; 61:750-7.
29. Yung HY, Sun CC, Wu YC & Wang JD: Stress, insomnia and chronic idiopathic urticaria – a case control study. *J Formos Med Assoc* 2005; 104:254-63.

Correspondence:

Sandra Blažević Zelić, MD
Department of Psychiatry, University Clinical Hospital Rijeka
Cambierieva 17/7, 51000 Rijeka, Croatia
E-mail: sblazevic@yahoo.com