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Research Article / Araştırma

Relationship between adverse childhood experiences, close relations and emotion regulation: Chronic idiopathic urticaria patients

Çocukluk çağı olumsuz yaşantı, yakın ilişkiler ve duygu regülasyonu arasındaki ilişki: Kronik idiyopatik ürtiker hasta grubu

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Key Words:
Chronic Idiopathic Urticaria, Emotion Regulation, Relationship Scales Questionnare (RSQ), Adverse Childhood Experiences (ACEs)

Anahtar Kelimeler:
Kronik İdiyopatik Ürtiker, Duygu Düzenleme, Yakın İlişki, Çocukluk Çağı Olumsuz Yaşantı

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ABSTRACT

Objective: Urticaria is a very common disease in the community and its etiology is still unclear. It is considered in a psychodermatological and psychosomatic disease category because it is in close relationship with emotional factors. In this study, the relationship between chronic idiopathic urticaria and some psychological conditions will be evaluated. **Method**: This study was carried out on 80 chronic idiopathic urticaria patients and 80 control group volunteers who applied to a dermatology clinic. Information and consent form from the participants and questionnaires prepared by the researcher were applied to the patient and control groups. **Results**: There was no significant difference between the chronic urticaria patient group and the control group in terms of scale and sub-dimensions. Depression, anxiety, negative ego and somatization were statistically significant and high in women compared to men. **Conclusion**: Organic, psychological and social factors are involved in the formation and development of skin diseases evaluated in the psychosomatic category.

ÖZ

Amaç: Ürtiker toplumda çok sık karşılaşılan bir hastalık olup etiyolojisi halen netleşmemiştir. Emosyonel faktörlerle sıkı ilişki içerisinde olması nedeniyle psikodermatolojik, psikosomatik bir hastalık kategorisinde değerlendirilmektedir. Bu çalışmada kronik idiyopatik ürtiker ile bazı psikolojik etkenler arasındaki ilişki değerlendirilecektir. **Yöntem**: Bu çalışma bir dermatoloji kliniği'ne başvuran 80 kronik idiyopatik ürtiker hastası ve 80 kişilik kontrol grubu gönüllüsü üzerinde gerçekleştirilmiştir. Hasta ve kontrol grubuna katılımcılardan bilgilendirme ve onam formu, araştırmacı tarafından hazırlanan soru formları uygulanmıştır. **Bulgular**: Kronik ürtiker hasta grubu ile kontrol grubunun ölçek ve alt boyutları açısından karşılaştırılmasında gruplar arasında anlamlı farklılık bulunamamıştır. Hasta grubunda kadınlarda erkeklere kıyasla, depresyon, anksiyete, olumsuz benlik ve somatizasyon istatistiksel olarak anlamlı ve yüksek bulunmuştur. **Sonuç**: Psikosomatik kategorisinde değerlendirilen deri hastalıklarının oluşumunda, gelişiminde fiziksel, psikolojik ve sosyal faktörler önemli bir yere sahiptir.

INTRODUCTION

Urticaria is defined as skin lesions that occur with itchy, swollen, and red plaques on the skin. It is characterized by a raised, red, and itchy rash caused by a small amount of fluid leaking from the blood vessels just below the skin surface. The duration of these lesions for less than six weeks is called acute, and the longer duration is called chronic urticaria. An important part of the population, such as 15-20%, has an urticaria attack at least once in a certain period of their life and the prevalence of chronic urticaria in adults is estimated to be between 0.5% and 5%. There is little data available on the prevalence of chronic urticaria in children. The emergence of the disease is multifactorial. Its etiology is thought to be

idiopathic and closely related to emotional factors. Although it is known that physical conditions such as infections, heat, cold, pressure, food additives, vitamin D deficiency, and autoimmune diseases cause urticaria, organic causes cannot be found in approximately 80% of the patients. The relationship between psychological factors and chronic urticaria is a factor in its inclusion in the psychosomatic category. In these patients, complex mental and physical processes interact with each other. Chronic urticaria has a significant impact on one's life due to the constant itching sensation, regular recurrence, and unknown etiology (1,2).

The relationship between skin diseases and psychology has been known for a long time. Numerous studies to reveal this relationship in recent years have shown that psychological factors such as depression and stress have different effects on skin diseases. Chronic urticaria, which is in the psychophysiological disorders group in the psychodermatological disease classification developed by Jafferany and Franca, is seen as a type of disorder triggered and aggravated by psychological stress. Urticaria has a negative impact on all aspects of an individual's life, especially physical and psychological health (3,4).

A close relationship is defined as a mutual and strong dependence established between two individuals. It is also defined as the phenomenon that shapes one's pattern of having relationships with other people. This behavioral structure, which starts in childhood and will continue throughout life, emerges as the main determinant in social perception, relational behavior, expectation, belief, and social capacity use of others. This attachment behavior, which was established in childhood as an instinctive tendency, shapes the social interactions of the individual throughout life. Non-positive experiences experienced in childhood have negative effects on the individual's perception of self and environment. The negative perception created by the individual about himself/herself and his/her environment creates the basis for insecure attachment, problems in close relationships, and personality traits with anxious or avoidant attachment style (5,6)

Emotion regulation means that people manage their emotional experiences for personal and social purposes. It is a complex and multifaceted process and is developmentally important. Emotion regulation has a central role in ensuring social competence and psychological well-being and protecting it from the risk of emotional psychopathology. The development of emotion regulation is based on early neurobiological development. It is shaped by personality traits and guided by emotion management strategies and ego. The inability to express emotions correctly or the inappropriate expression of the individual against the emotional intensity experienced by the individual negatively affects the individual. Most of the time, this negative situation can lead to health problems and behavioral reactions and increase the sensitivity level of the person to somatic disorders (7,8).

Preschool plays a key role in emotional regulation difficulties. In this period, the impact of family relations, environmental conditions and negative examples experienced by the child on emotion regulation skills are inevitable. Adverse Childhood Experiences (ACEs) involving traumatic experiences such as physical or emotional abuse, neglect and domestic communication disorders that occur in a person's childhood may lead to future mental, psychiatric or physical disorders. These individuals may have to cope with adverse health outcomes throughout their lives, including chronic illness, mental health disorders, and overall health-related decline in quality of life (9,10,11).

Since interventions to prevent adverse childhood experiences at an early age are thought to reduce the risk of chronic urticaria formation and persistence, taking steps to prevent adverse childhood experiences is important for public health.

This study aimed to investigate the emotional factors underlying chronic urticaria, which is a common skin disease in the society and to analyze the psychological and social factors in the formation of skin diseases examined in the category of psychosomatic diseases. It is considered that the analyzed factors will contribute to a better understanding of the effects on the activity of chronic urticaria.

MATERIALS AND METHODS

This study included 80 patients selected from people clinically diagnosed with chronic idiopathic urticaria who applied to the Istanbul Şişli Hamidiye Etfal Training and Research Hospital Dermatology Clinic between December 2019 and April 2020 with swelling, redness and itching anywhere on their body for at least six weeks. 80 healthy volunteers were included in the study as the control group. Participants consist of individuals aged eighteen and over and those under the age of 18 were not included in the study. Participants with a psychiatric diagnosis and those with infection, food, or drug-induced urticaria were excluded from the study.

The data of the research were obtained by using the scale form applied to each participant individually. From the participants in this study; Information Sheet and Consent Form, Sociodemographic Data Form prepared by the researcher, Brief Symptom Inventory (BSI), Relationship Scales Questionnaire, Difficulties in

Emotion Regulation Scale Short Form (DERS-SF) and Adverse Childhood Experiences Scale were asked to fill.

Information about the purpose of the study was provided in the İnformation Sheet and Consent form that the participants were asked to fill out. In the form, it was stated that participation in the research was voluntary and that the participants had the right to leave in case of any discomfort while answering the research questions. It was also stated that if they accept to take part in the research, all their answers would be kept confidential and the results would be used for scientific purposes.

The Sociodemographic Data Form was prepared to obtain data on some variables thought to be related to adverse childhood experiences, close relationships and emotion regulation in patients with chronic idiopathic urticaria. This data form includes the questions about each participant's gender, age, marital status, educational status, with whom they live, regularly used medication, chronic urticaria duration, frequency of relapse, conditions that trigger the attack, the presence of another organic disease, whether there are psychiatric disease and skin disease in the family.

The Turkish form of the Adverse Childhood Experiences Scale (ACE-TR) was developed in 1997 by the CDC and Permanente with sub-scales such as interrogating domestic emotional violence, physical violence, sexual violence, abuse, whether there were emotional and physical neglect and divorce in the first 18 years of a person's life. It was translated into Turkish by experienced people working in the field, paying attention that it is easy to understand and does not lose meaning. The validity and reliability study was conducted by Gündüz et al. This scale consists of 10 items and allows a double answer as "Yes" and "No". Cronbach alpha value was found as 0.742 (12).

The relationship scales questionnaire is a 30-item scale developed by Griffin and Bartholomew in 1994, and its standardization study for Turkish adaptation was carried out by Sümer and Güngör in 1999. There are 17 items in this adapted scale. The reliability coefficient of the scale is 0.54 and the internal consistency coefficient between the items is 0.78 (13).

Difficulties in Emotion Regulation Scale Short Form (DERS-SF) was developed as a 36-item scale by Gratz and Roemer (2004) to identify and measure individuals' emotional regulation difficulties. In 2016, a short form of Difficulties in Emotion Regulation Scale was created by Bjureberg et al. Yiğit and Yiğit (2017) adapted the 16-item short form of the scale to Turkish, and validity and reliability studies were carried out (14).

The brief symptom inventory is the short form of SCL-90-R developed by Derogatis (1993) to screen psychiatric symptoms and various psychological symptoms of the individual. A study on the Turkish validity and reliability of the scale was conducted by Şahin and Durak (1994), which was developed under the name of the Brief Symptom Inventory (15).

Descriptive statistics of the data in our study are given as a number, percentage, minimum and maximum values (min./max.), mean and standard deviation (SD). In statistical analysis, chi-square, Mann Whitney U test if the number of groups compared was two and the Kruskal Wallis test if more than two were used. In the study, the presence of a possible correlation between the scores from the scales and subscales applied to the patient group was examined. Spearman correlation test was used for correlation analysis. In cases where the P-value was less than 0.05, the difference between groups was considered to be significant. Since the complete presentation of the tables exceeded the volume of this study, only the statistically significant parts of some tables were included in the findings section.

ETHICAL PERMIT

With the application to the chairmanship of the Ethics Committee of the Rectorate of Istanbul Gedik University and the approval number 20788822-050.01.04/155199 received on 29.01.2020, it was decided that the study was ethically appropriate.

RESULTS

The distribution of sociodemographic variables belonging to the chronic urticaria patient group is shown in Table 1. It was determined that the distribution of sociodemographic variables of the control group was also similar to the patient group.

Table 2 includes the comparison of the min., max., mean and SD values of the patient and control groups from the short symptom inventory and sub-dimensions, difficulties in emotion regulation scale and its sub-dimensions, adverse childhood experiences scale and its sub-dimensions and the scale and sub-dimension scores of the patient and control groups. The analysis was conducted to determine whether there was a difference between the chronic urticaria patient group and the control group in terms of short symptom inventory and sub-dimensions. As a result of the analysis, no significant difference was found between the groups in terms of "depression", "anxiety", "somatization", "hostility" sub-dimensions and total scale score. However, a significant difference was found in terms of the negative ego sub-dimension.

The analysis was conducted to determine whether there was a difference between the chronic urticaria patient group and the control group in terms of close

relationship and sub-dimensions. As a result of the analysis, there is no significant difference for both groups in terms of the relationship scales questionnaire sub-dimensions and the total score of the scale.

Table 1. Sociodemographic variables related to the patient group

Demographic variables (patient group)	Patient		Control	
	N	%	N	%
Gender				
Female	55	68,8	55	68,8
Male	25	31,2	25	31,2
Age Group				
18-24	11	13,8	9	11,3
25-34	25	31,2	37	46,3
35-44	27	33,8	22	27,4
45 and above	17	21,2	12	15,0
Education Status				
Literate	22	27,5	10	12,5
Secondary school graduate	11	13,8	13	16,3
High school graduate	26	32,5	16	20,0
Universty graduate	21	26,2	41	51,2
Marital status				
Married	52	65,0	54	67,5
Single	28	35,0	26	32,5
Number of children				
2 and below	65	81,2	71	88,8
3 and above	15	18,8	9	11,2
Number Of Siblings				
2 and below	17	48,6	10	20,0
3 and above	18	51,4	40	80,0
Working Status				
Not working	32	40,0	27	33,8
Have a regular job	37	46,2	41	51,2
Have an irregular job	4	5,0	5	6,2
Student	7	8,8	7	8,8
Living with				
Spouse / Children	54	67,5	53	66,3
Mother / Father / Brother-Sister	18	22,5	21	26,3
Alone	8	10,0	6	7,4
Disease Duration (Month)				
0-36 months	50	62,5		
37-72 months	15	18,8		
73-108 months	6	7,5	-	-
109-144 months	7	8,8		
145 months and above	2	2,4		
Frequency of Recurrence				
Chronic Intermittent	43	53,8	-	-
Chronic Continuous	37	46,2		
Additional Organic Disturbance				
Yes	22	27,5	-	-
No	58	72,5		
Regular Drug Use				
Yes	62	77,5	-	-
No	18	22,5		
Another Skin Disease In The Family				
Yes	28	35,0	-	-
No	52	65,0		
Psychiatric Diagnosis In The Family				
Yes	24	30,0	-	-
No	56	70,0		
Urticaria Severity				
Light	18	22,5		
Middle	38	47,5	-	-
Severe	24	30,0		
Attack-Triggering Causes				
Stress, No Reason	80	84,2		
Air, Water	7	7,4	-	-
Food	2	2,1		
Physiological Causes	6	6,3		

The analysis was conducted to determine whether there was a difference between the chronic urticaria patient group and the control group in terms of adverse childhood experiences total score. As a result of the analysis, there is no significant difference in terms of adverse childhood experiences total score.

The analysis was conducted to determine whether there was a difference between the chronic urticaria patient group and the control group in terms of difficulties in emotion regulation and its sub-dimensions. As a result of the analysis, no significant difference was found between the groups in terms of "openness", "impulse", "strategies", and "not accepting" sub-dimensions. However, a significant difference was found in terms of total scale score and "Purposes" sub-dimension.

The relationships between the scales applied to the patient group and the scores from the subscales were analyzed with the Spearman correlation test. The significant results are shown in Table 3. When the table was examined, there was a high positive correlation between the total Brief Symptom Inventory and the total Difficulties in Emotion Regulation ($p < 0.001$, rho = 0, 641). There is a positive and low level relationship between the Brief Symptom Inventory and the Adverse Childhood Experiences Scale. There is no relationship between the Brief Symptom Inventory and the total Close Relationship Scale. There is a moderate positive correlation between the total Difficulties in Emotion Regulation and the total Adverse Childhood Experiences Scale. There is a positive and low level relationship between the total Difficulties in Emotion Regulation and the total Relationship Scale. There is a positive and low level relationship between the total Adverse Childhood Experiences Scale and the total Relationships Scale Questionnaire.

Scale and subscale scores of chronic urticaria patients in our study were compared with various characteristics of the patients. In terms of not exceeding the volume of the article, the variables that make sense from the comparisons are presented in the following tables.

When the table was examined, the Brief Symptom Inventory (BSI) scale scores showed a statistically significant difference between men and women. BSI scale scores were higher in women compared to men (Z=-3. 001, p=0. 003). "Depression" scores, one of the sub-dimensions of the BSI scale, showed a statistically significant difference between men and women. "Depression" scores were higher in women compared to men (Z=-2. 735, p=0. 006). "Anxiety" scores, one of the sub-dimensions of the BSI scale, showed a statistically significant difference between men and women. "Anxiety" scores were higher in women compared

Table 2. Descriptive Statistics Regarding Scores from Scales and Sub-Scales and Comparison of Scale and Sub-Dimension Scores of Patient and Control Groups (n = 80)

PATIENT GROUP					CONTROL GROUP					z	p
	Min.	Max.	Mean	SD		Min.	Max.	Mean	SD		
Total Brief Symptom Inventory	2	133	37,64	25,74	Total Brief Symptom Inventory	3	126	40,51	27,80	-0,630	0,529
Depression	0	31	10,83	7,38	Depression	0	40	11,95	8,74	-0,674	0,500
Anxiety	0	30	7,78	6,30	Anxiety	0	36	8,13	6,94	-0,050	0,960
Negative Ego	0	31	7,25	6,39	Negative Ego	0	40	9,94	8,34	-2,166	0,030
Somatization	0	27	6,05	5,43	Somatization	0	18	4,89	4,04	-1,220	0,222
Hostility	0	18	5,74	3,93	Hostility	0	20	6,15	4,52	-0,478	0,633
Total Relationship Scale Inventory	46	96	72,85	10,82	Total Relationship Scale Inventory	46	95	73,74	8,16	-0,440	0,660
Secure	11	35	21,33	4,48	Secure	11	35	22,31	5,42	-1,260	0,208
Fearful-Avoidant	4	25	15,46	5,57	Fearful-Avoidant	4	25	14,99	4,86	-0,614	0,539
Dismissive	11	35	22,38	5,47	Dismissive	11	32	23,00	4,65	-0,541	0,589
Anxious-Preoccupied	6	22	13,69	3,94	Anxious-Preoccupied	4	24	13,44	4,38	-0,399	0,690
Total Difficulties in Emotion Regulation Scale	17	67	30,50	10,42	Total Difficulties in Emotion Regulation Scale	16	73	33,33	12,48	-1,936	0,049
Openness	2	9	4,40	1,69	Openness	2	10	4,03	1,94	-1,506	0,132
Purposes	3	15	7,26	3,17	Purposes	3	15	8,36	3,20	-2,341	0,019
Impulse	3	15	5,20	2,51	Impulse	3	15	5,78	3,06	-1,676	0,094
Strategies	5	21	8,61	3,38	Strategies	5	24	9,65	4,19	-1,816	0,069
Not Accepting	3	14	5,03	2,46	Not Accepting	3	15	5,51	2,70	-1,551	0,121
Total Adverse Childhood Experiences Scale	0	7	2,13	1,82	Total Adverse Childhood Experiences Scale	0	8	1,80	1,72	-1,298	0,194

to men (Z=-2. 738, p=0. 006). "Negative ego" scores, one of the sub-dimensions of the BSI scale, showed a statistically significant difference between men and women. "Negative ego" scores were higher in women compared to men (Z=-2. 820, p=0. 005). "Somatization" scores, one of the sub-dimensions of the BSI scale, also showed a statistically significant difference between men and women. "Somatization" scores were found higher in females compared to males (Z = -2. 819, p = 0.005).

The close relationships scale total scores showed a statistically significant difference between those with and without a psychiatric diagnosis. Total scores of the close relationship scale were found to be higher in those with a psychiatric diagnosis (Z=-2. 002, p=0. 045). ACE's scores showed a statistically significant difference between those with and without a psychiatric diagnosis. ACE's scores showed a statistically significant difference between those with and without a psychiatric diagnosis. ACE's total scores were higher in those with a psychiatric diagnosis (Z=-3. 747, p<0. 001).

The relationship between the BSI scale and subscale scores of chronic urticaria patients, the Close Relationships Scale and its subscale scores, the Difficulties in Emotion Regulation Scale and its sub-dimensions, the total scores of the ACE's and the people they live with were examined using the Kruskall Wallis test.

In the test results, a statistically significant difference was observed between the scores of "secure attachment", one of the sub-dimensions of the Close Relationships scale, and the people they lived with (KV=7. 774, p=0. 021). As a result of the post-hoc tests, "secure attachment" scores showed a significant difference between those living with their spouse / children and those living alone (p=0. 049).

A statistically significant difference was observed between the "fearful attachment" scores of the Close Relationships sub-dimensions and the people they lived with (KV=6. 531, p=0. 038). As a result of the post-hoc tests, the "fearful attachment" scores showed a significant difference between those living alone and those living with their spouse / children and mother / father / sibling (p = 0.003; p = 0.021, respectively).

A statistically significant difference was observed between the "dismissive attachment" scores, one of the sub-dimensions of the Close Relationships scale, and the people they lived with (KV=6. 458, p=0. 040). As a result of the post-hoc tests, "dismissive attachment" scores showed a significant difference between those living alone and those living with their spouse / children and mother / father / sibling (p = 0. 021; p = 0. 033, respectively)

A statistically significant difference was observed between the "openness" scores, one of the sub-

Table 3. Relationships between scores from scales and subscales applied to the patient group

Q		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1- Total Brief Symptom Inventory	r	1																	
	p	.																	
2- Depression	r	,925**	1																
	p	<0.001	.																
3- Anxiety	r	,929**	,823**	1															
	p	<0.001	<0.001	.															
4- Negative Ego	r	,831**	,777**	,744**	1														
	p	<0.001	<0.001	<0.001	.														
5- Somatization	r	,749**	,581**	,720**	,421**	1													
	p	<0.001	<0.001	<0.001	<0.001	.													
6- Hostility	r	,855**	,720**	,727**	,702**	,622**	1												
	p	<0.001	<0.001	<0.001	<0.001	<0.001	.												
9- Fearful-Avoidant	r	0,174	0,148	0,06	,288**	-0,001	,313**	,637**	-,363**	1									
	p	0,123	0,189	0,597	0,01	0,994	0,005	<0.001	0,001	.									
10-Dismissive	r	0,175	0,142	0,149	,257*	0,055	0,145	,735**	-0,159	,471**	1								
	p	0,12	0,207	0,186	0,021	0,626	0,199	<0.001	0,16	<0.001	.								
11- Anxious-Preoccupied	r	0,084	0,081	0,092	0,098	0,129	-0,012	,526**	0,152	0,07	0,084	1							
	p	0,458	0,477	0,418	0,388	0,254	0,915	<0.001	0,18	0,536	0,461	.							
12- Total Difficulties in Emotion Regulation Scale	r	,641**	,512**	,623**	,613**	,434**	,577**	,343**	-0,107	,441**	,284*	0,153	1						
	p	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0,002	0,344	<0.001	0,011	0,175	.						
13- Openness	r	,450**	,448**	,444**	,359**	,310**	,272*	0,114	-0,119	0,210	0,082	0,144	,589**	1					
	p	<0.001	<0.001	<0.001	<0.001	0,005	0,015	0,313	0,291	0,062	0,47	0,202	<0.001	.					
14- Purposes	r	,521**	,376**	,496**	,536**	,360**	,500**	,231*	-0,149	,339**	,291**	0,02	,846**	,451**	1				
	p	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0,04	0,186	0,002	0,009	0,859	<0.001	<0.001	.				
15- Impulse	r	,400**	,273*	,411**	,376**	,257*	,405**	,416**	0,032	,289**	,274*	,318**	,671**	0,165	,491**	1			
	p	<0.001	0,014	<0.001	<0.001	0,021	<0.001	<0.001	0,781	0,009	0,014	0,004	<0.001	0,143	<0.001	.			
16- Strategies	r	,571**	,476**	,524**	,558**	,357**	,534**	,365**	-0,058	,455**	,248*	0,148	,834**	,351**	,582**	,570**	1		
	p	<0.001	<0.001	<0.001	<0.001	0,001	<0.001	0,001	0,607	<0.001	0,026	0,191	<0.001	0,001	<0.001	<0.001	.		
17-Not Accepting	r	,392**	,338**	,386**	,450**	,235*	,325**	,292**	-0,151	,429**	,331**	0,042	,710**	,350**	,479**	,388**	,605**	1	
	p	<0.001	0,002	<0.001	<0.001	0,036	0,003	0,009	0,183	<0.001	0,003	0,714	<0.001	0,001	<0.001	<0.001	<0.001	.	
18- Total Adverse Childhood Experiences Scale	r	,319**	,235*	,298**	,299**	0,213	,403**	,337**	0,132	,285*	0,209	0,088	,447**	0,113	,382**	,407**	,364**	,282*	1
	p	0,004	0,036	0,007	0,007	0,058	<0.001	0,002	0,243	0,010	0,063	0,436	<0.001	0,320	<0.001	<0.001	0,001	0,011	.

dimensions of the Difficulty in Emotion Regulation, among the people they lived with (KV=7. 698, p=0. 021). As a result of the post-hoc tests, "openness" scores showed a significant difference between those living with spouse / children and those living with mother / father / sibling (p = 0. 039).

DISCUSSION

A total of 160 people were included in our study. 80 people, including 55 women and 25 men, participated in our study as a group of patients. 80 people, including 55 women and 25 men, participated in our study as a healthy individual. The average age of our patients was 36.42. This result was compatible with other studies. On the other hand, no statistically significant difference was found between the ages and genders of the participants in our study between the patient and control groups. Because chronic urticaria is most common in the middle ages, between the ages of 20-40. Furthermore, no statistically significant difference was found between the ages and genders of the participants in our study between the patient and control groups.

In our study, "depression", "anxiety", "negative ego", "somatization" were statistically significant and high in women compared to men when the distribution of symptoms was evaluated in the patient group. In a study by Badoux and Levy in which psychological symptoms were investigated with 74 chronic urticaria patients, the Brief Symptom Inventory (BSI) was used and the BSI scores were found to be higher in women compared to men (16). These results are compatible with our research.

Many studies to date have shown that traumatic and stressful childhood experiences, known as adverse childhood experiences, are associated with many disorders. However, little is known about the effects of patients with skin conditions such as chronic urticaria

Table 4. Comparison of scale and subscale scores of the patient group in terms of gender (statistically significant variables)

	Gender	N	Mean	Z	p
Brief Symptom Inventory	Male	25	25, 56	-3, 001	0. 003
	Female	55	43, 12		
Depression	Male	25	7, 64	-2, 735	0. 006
	Female	55	12, 27		
Anxiety	Male	25	4, 96	-2, 738	0. 006
	Female	55	9, 05		
Negative Ego	Male	25	4, 44	-2, 820	0. 005
	Female	55	8, 52		
Somatization	Male	25	3, 84	-2, 819	0. 005
	Female	55	7, 05		

Mann-Whitney U test

and the effects of adverse childhood experiences. McKenzie and Silverberg examined the relationship between adverse childhood experiences and atopic dermatitis, a skin disease, and they found that individuals exposed to more adverse childhood experiences had a higher prevalence of atopic dermatitis. Besides, when the clinical processes of some skin diseases were examined, it was observed that there may be complex and sometimes mutual interactions between biological, psychological, and social factors that may play a role in the formation and development of skin diseases (18,19).

Table 5. Comparison of scale and subscale scores of the patient group in terms of psychiatric diagnosis (Statistically significant variables)

Close Relationship Scale	Yes	24	76, 66	-2, 002	0,045
	No	56	71, 21		
Adverse Childhood Experiences Scale	Yes	24	3, 25	-3. 747	<0,001
	No	56	1, 64		

Table 6. Comparison of the scale and subscale scores of the patient group in terms of the people they live with (Statistically significant variables)

Living with	N	Mean	KV	p
Secure				
Spouse / Children	54	22, 20		
Mother / Father /Brother-Sister	18	19, 50	7, 774	0. 021
Alone	8	19, 50		
Fearful-Avoidant				
Spouse / Children	54	14, 85		
Mother / Father /Brother-Sister	18	15, 27	6. 531	0. 038
Alone	8	20, 00		
Dismissive				
Spouse / Children	54	21, 83		
Mother / Father /Brother-Sister	18	21, 94	6. 458	0. 040
Alone	8	27, 00		
Openness				
Spouse / Children	54	4, 14		
Mother / Father /Brother-Sister	18	5, 38	7. 698	0. 021
Alone	8	3, 87		

It was observed that the chronic urticaria, one of the skin diseases, was associated with many research results related to physical and emotional comfort, social relationships and daily life activities because of its clinical features. For example; Michaelsson stated that 11-21% of psychological factors played a direct role in the onset of chronic urticaria. Champion et al., stated that the facilitating role was 24-68% and that there was no organic cause at 70-90% in chronic urticaria. When the causes that trigger attacks related to the patient group were examined in terms of our research findings, it was observed that "stress" and "no reason" played an active role in 84.2% of the patients, "air" and "water" in 7.4%, "food" in 2.1% and "physiological reasons" in 6.3% of the patients. Failure to find a reason at a rate of 84.2% in our study is compatible with other research findings (20-22).

In the relevant literature, there are many scientific reports on interpersonal relationships in psychodermatological diseases such as chronic urticaria, atopic dermatitis, psoriasis, alopecia areata and vitiligo. These reports show that attachment insecurity is more common in patients with dermatological problems. Janković revealed that psoriasis patients, which are very common in society from skin diseases, had higher anxiety-related attachment and higher avoidance-related attachment. Besides, this study showed similarities with studies showing that insecure attachment could increase body sensitivity in some skin diseases. Individuals with avoidant attachment are affected by negative situations in relationships, his/her sensitivity to the body increases and somatization occurs. It was observed that patients with skin conditions had higher levels of continuous anxiety compared to healthy individuals and patients who perceived their social support as higher had lower levels of depression and anxiety. In our study, when the scale and subscale scores of chronic urticaria patients and the relationship between the people they live with were examined, a statistically significant difference was observed between the scores of "secure attachment", one of the sub-dimensions of the close relationships scale, and the people they lived with (KV=7. 774, p=0. 021).

Post-hoc tests showed a significant difference in secure attachment scores between those living with their spouse / children and those living alone (p=0. 049). Demirci et al. revealed that there was a relationship between insecure attachment styles and depression, anxiety and low quality of life in people with psoriasis. They also supported the idea that attachment insecurities may impair the physiological stress response by increasing perceived stress in these patients (23-25).

As part of a multi-center study conducted in 13 European countries organized by the European Association of Dermatology and Psychiatry, the attachment styles and satisfaction of dermatological outpatient patients were researched. According to this study, in which a total of 3.635 adult patients were included, it was observed that dermatological outpatient clinic patients were less dependent than other patients, were less disturbed by intimate relationships, and experienced similar anxiety in relationships. Participants with secure attachment styles reported significantly less stressful life events over the last 6 months than those with insecure attachment styles. Patients with secure attachment styles tended to be more satisfied with their dermatologists than unsafe patients. These results suggest that safe attachment of dermatological outpatient patients may be a protective factor in stress management (26). In our study, a significant positive relationship was found between chronic urticaria patients with insecure attachment and impulse, which is the sub-dimension of the difficulties in emotion regulation.

The British Association of Dermatologists reported that the psychosocial effects of 85% of patients with skin diseases are an important component of the disease, and psychiatric cases in the family may also be a subcomponent that can directly affect this condition. Because chronic urticaria is often associated with psychiatric symptoms such as depression, anxiety and stress that can play a role in the development and evolution of the disease. Emotional factors such as stress and anxiety are also known to play an active role in some skin disorders. Data obtained by Hashiro and Okumura (1994) showed that chronic urticaria patients were more prone to anxious, depressive, and psychosomatic symptoms than normal patients (19-27-29).

Gupta et al. examined the relationship between itching and depression in patients with itchy skin disease, which is considered to have a psychosomatic component, such as psoriasis, atopic dermatitis, and chronic idiopathic urticaria. It was recognized that these diseases had a psychosomatic component, since it was observed that the emotional stress experienced by the patient due to this disorder worsened or affected the course of this disorder (30).

In Barbosa et al.'s study, a significant prevalence of anxiety symptoms was observed more than depressive symptoms in chronic urticaria patients. Besides, significant relationships were observed with personality dimensions, insecure attachment styles, alexithymia, and quality of life dimensions from a comprehensive study of anxiety symptoms. These results emphasize the importance of reaching psychosocial variables in order to better understand chronic urticaria patients. They stated the points that should be taken into account in clinical contact with chronic urticaria patients with anxiety symptoms. These are personality traits (neuroticism, extroversion), how they relate to their social networks (partner, family members, close friends), how they seek social support and how they seek help and how they deal with emotions and express them to others, especially to the physician (31). In our study, a significant positive relationship was found between depression, anxiety, negative ego, hostility, difficulty in emotion regulation and adverse childhood experience in patients with chronic urticaria.

Depressive symptoms play an important role in chronic urticaria and idiopathic itching. Itching can cause symptoms of both depression and anxiety, and can also be caused by stress, anxiety or depression. Famous dermatologist Arthur Rook had argued for years that if psychological factors were not taken into account in at least half of all skin-related cases, the outcome of the treatment would be insufficient. But he turned out to be true to his word after many years of work. In this case, due to the frequency of psychological symptoms, complementary psychological treatment of patients suffering from chronic urticaria disease is considered necessary. For example, a study examining the relationship between skin disease and depression found that 43% of patients were prone to anxiety and depression. Moreover, Kökçam and Dilek found that depression (48.1%) and generalized anxiety disorder (31.4%) were among the most common diagnoses in the dermatology clinic. In a study to determine the levels of anxiety and depression experienced by chronic urticaria patients by Engin et al., high values of anxiety and depression emerged, supporting studies in the literature. In our study, no statistically significant difference was found between the scores of the BSI scale and sub-dimensions (depression, anxiety) of chronic urticaria patients and those with and without a psychiatric diagnosis (32-36).

A positive relationship was found between somatization and emotional regulation difficulties. Individuals who have difficulties in expressing emotions in difficult times may experience their emotional difficulties as sensitivity to their physical health (37,38).

CONCLUSION

Young children with multiple adverse childhood experiences have a higher prevalence and more persistent chronic urticaria disease. The clinical significance of these findings should encourage health professionals to consider using screening tools that identify adverse childhood experiences in pediatric populations. Besides, interventions to prevent adverse childhood experiences or address existing problems can reduce the risk of chronic urticaria formation and persistence. Future research is needed to verify these relationships, determine their mechanisms, and determine optimal prevention and treatment strategies in this subset of chronic urticaria patients.

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