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Comparison of Mental Health and Resilience among Patients with Acute and Chronic Urticaria and Healthy Individuals

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Abstract

Background & Objective: Urticaria is a common inflammatory skin disorder that, particularly in its chronic form, may result in substantial psychological and social consequences. Despite extensive evidence regarding mental health disturbances among affected individuals, the role of resilience as a psychological protective factor has remained insufficiently explored, particularly in comparative studies. This study aimed to compare mental health and resilience among patients with acute urticaria, patients with chronic urticaria, and healthy individuals.

Materials & Methods: This causal-comparative study was conducted in Arak, Iran, between 2019 and 2020. A total of 90 participants were recruited through convenience sampling and equally assigned to three groups: patients with acute urticaria (n = 30), patients with chronic urticaria (n = 30), and healthy individuals (n = 30). Mental health was assessed using the Symptom Checklist-25 (SCL-25), while resilience was measured using the Connor-Davidson Resilience Scale (2003). Data were analyzed using multivariate analysis of variance (MANOVA) and Tukey's post hoc test in SPSS version 20.

Results: The findings indicated that patients with chronic urticaria exhibited the highest levels of mental health disturbances and the lowest levels of resilience compared with patients with acute urticaria and healthy individuals. In addition, patients with acute urticaria demonstrated poorer psychological status than healthy individuals across most domains.

Conclusion: Chronic urticaria is associated with marked psychological vulnerability and diminished resilience. These findings underscore the importance of incorporating psychological screening, resilience-enhancing interventions, and patient education into the routine management of patients with chronic urticaria in order to improve long-term adaptation and quality of life.

Keywords: Mental health, Resilience, Chronic urticaria, Acute urticaria, Psychological well-being

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Introduction

Urticaria is among the most common inflammatory skin disorders and is characterized by swelling, erythema, and sudden, distressing pruritus. The condition may present in either acute form, lasting less than six weeks, or chronic form, persisting for more than six weeks (1). Although urticaria is primarily recognized as a dermatological condition, its effects, particularly in

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chronic cases, extend far beyond physical manifestations and substantially influence patients' emotional, social, and psychological well-being (2). Individuals with chronic urticaria frequently experience persistent itching, sleep disturbances (3), impaired ability to perform daily activities (4), recurrent stress (5), and emotions such as shame, anxiety, and social isolation (6). These psychosocial burdens not only exacerbate physical symptoms but may also contribute, over time, to more severe psychological complications, including depression (7), anxiety (8), diminished quality of life (9), negative thought patterns (10), and even social withdrawal from family and community life (11). Furthermore, the considerable financial burden associated with medical expenses, repeated physician visits, and reduced occupational functioning places additional strain on both patients and their families (12).

Mental health is a multidimensional construct that encompasses not merely the absence of psychiatric disorders but also an individual's capacity to cope effectively with stress, establish positive interpersonal relationships, experience meaning and satisfaction in life, and maintain appropriate psychosocial functioning (13). The adverse consequences of chronic urticaria can seriously compromise the mental health of affected individuals (14). Clinical studies have reported a higher prevalence of psychiatric disorders among patients with urticaria compared with healthy individuals, with overall psychological functioning found to be significantly poorer in this population (15). Persistent concerns regarding disease recurrence, uncontrollable itching, and negative social perceptions render these patients particularly vulnerable to psychological distress (16).

Within this context, resilience has emerged in recent years as one of the most significant concepts in mental health research, particularly in relation to chronic diseases (17). Resilience may be defined as the capacity or process through which individuals adapt successfully to stressful, threatening, or adverse circumstances; in other words, it reflects the ability to regain psychological equilibrium following exposure to crises or illness (18). It encompasses a combination of cognitive, emotional, and behavioral characteristics that enable individuals to cope effectively with challenges while preserving mental well-being (19). Resilience may develop naturally or be enhanced through psychotherapeutic interventions and skills training, thereby playing a crucial role in reducing the negative psychological consequences of chronic illnesses (20). Individuals with higher levels of resilience are generally less likely to experience severe distress, hopelessness, or social isolation when confronted with illness-related stressors and tend to demonstrate better adaptation to everyday challenges (21).

A review of the existing literature reveals a strong association between resilience (22) and mental health indicators (23) across a range of chronic medical conditions, including chronic dermatological disorders. In particular, patients with chronic skin diseases who exhibit low levels of resilience appear to be more susceptible to depression (24), anxiety (25), maladaptive coping strategies (26), and poorer quality of life (27). Nevertheless, despite the acknowledged importance of resilience in mental health research, previous studies on skin disorders have largely focused on the biological dimensions of disease or on traditional mental health outcomes. Comparative investigations examining resilience among patients with acute urticaria, chronic urticaria, and healthy individuals remain limited. Moreover, within the Iranian context, the literature demonstrates a notable gap concerning the simultaneous examination of resilience and mental health in individuals with urticaria.

Existing evidence highlights the need for greater attention to resilience as a protective psychological construct in dermatological disorders and underscores the importance of strengthening resilience in order to prevent and manage adverse psychological outcomes in affected patients. Given the relatively high prevalence of urticaria, its substantial psychosocial burden, and the scarcity of comprehensive comparative studies addressing mental health and resilience among individuals with different forms of urticaria and healthy populations, a thorough evaluation of these variables appears essential. Identifying potential differences in mental health and resilience among patients with acute urticaria, patients with chronic urticaria, and healthy individuals may facilitate more effective treatment planning and the development of tailored psychological interventions that address the specific needs of these populations. Furthermore, the findings of the present study may help bridge an important gap in both national and international research, offer new insights into the psychological status of patients with urticaria in Iran, and address the following key question: Do mental health and resilience differ significantly among individuals with chronic urticaria, acute urticaria, and those without the disease?

Materials and Methods

The present study employed a causal-comparative design using a field-based approach. The statistical population consisted of all individuals with acute and chronic urticaria who attended the Allergy, Asthma, and Immunology Clinic and the Dermatology, Cosmetic, and Laser Clinic in Arak, as well as healthy individuals, during the 2019–2020 period. The sample size was determined using Cohen's (1988) formula for analysis of variance, assuming a medium effect size (f = 0.25), a statistical power of 0.80, and a significance level of 0.05. Based on this calculation, the minimum required sample size for each group was estimated to be 30 participants, yielding a total sample of 90 individuals, including 30 patients with acute urticaria, 30 patients with chronic urticaria, and 30 healthy individuals without urticaria (28).

Participants were recruited through convenience sampling and enrolled voluntarily after providing informed consent. Although convenience sampling was adopted because of practical considerations and ease of participant access, this sampling method may limit the generalizability of the findings to the broader population of patients with urticaria. The inclusion criteria were as follows: possession of at least a high school diploma, middle socioeconomic status as determined by occupational and educational indicators, absence of any chronic medical or psychiatric disorder other than urticaria, and willingness to participate in the study. The exclusion criteria included failure to respond to more than 25% of the questionnaire items, the presence of acute social problems such as recent divorce or active substance addiction, and unwillingness to continue participation at any stage of the study.

After the study procedures and required concepts had been fully explained, participants were asked to complete the Symptom Checklist-25 (SCL-25) and the Connor-Davidson Resilience Scale (2003) in order to assess mental health and resilience, respectively. Participants were assured that all personal information would remain confidential and that their privacy would be fully protected; therefore, they were instructed not to record their names or surnames on the questionnaires.

Symptom Checklist-25 (SCL-25):

The SCL-25 is a shortened form of the revised SCL-90-R developed by Derogatis (1977) and consists of 25 items designed to assess general psychological distress. The instrument evaluates eight dimensions of psychiatric symptoms, including somatization,

obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, phobic anxiety, paranoid ideation, and psychoticism. Responses are rated on a five-point Likert scale ranging from 0 to 4. Higher scores indicate poorer mental health, whereas lower scores reflect better psychological functioning. Derogatis (2004) confirmed the convergent validity of the instrument (29). In Iran, Najarian and Davoudi (2001) established its validity through factor analysis as well as convergent and divergent validity assessments, reporting a Cronbach's alpha coefficient of 0.97 and a test-retest reliability coefficient of 0.78 (30).

Connor-Davidson Resilience Scale (2003):

The Connor-Davidson Resilience Scale was developed by Connor and Davidson in 2003 to assess resilience in the face of stress and adversity. The instrument comprises 25 items distributed across five subscales: personal competence (8 items), tolerance of negative affect and stress (7 items), positive acceptance of change (5 items), self-control (3 items), and spiritual influences (2 items). Items are scored on a five-point Likert scale ranging from 0 to 4. Total scores range from 0 to 100, with higher scores indicating greater resilience. Connor and Davidson (2003) confirmed the construct validity of the scale through factor analysis (31). In Iran, Samani et al. (2008) verified the validity of the instrument using construct, convergent, and divergent validity methods (32). Furthermore, Mohammadi et al., through the standardization of the scale in the Iranian population, reported a Cronbach's alpha coefficient of 0.89 and a test-retest reliability coefficient of 0.79 (33).

Data analysis was performed at both descriptive and inferential levels using SPSS version 20. Descriptive statistics included means and standard deviations, whereas inferential analyses consisted of multivariate analysis of variance (MANOVA) and Tukey's post hoc test. The level of statistical significance was set at $p < 0.05$.

Results

The distribution of participants across age groups was as follows: 16.6% were younger than 20 years, 33.4% were between 20 and 30 years, 33.4% were between 30 and 40 years, and 16.6% were older than 40 years. Gender, marital status, and educational level were distributed equally across the study groups. No statistically significant differences were observed among the acute urticaria, chronic urticaria, and healthy control groups with respect to gender, marital status, or educational level ($p > 0.05$) (Table 1).

The mean mental health disorder scores were highest in the chronic urticaria group, indicating greater psychological distress in this

Table 1. Frequency and Percentage Distribution of Demographic Characteristics of Study Participants.

Variable	Category	Frequency	Percentage
Age	Under 20 years	15	16.6%
	20–30 years	30	33.4%
	30–40 years	30	33.4%
	Over 40 years	15	16.6%
Gender	Male	45	50%
	Female	45	50%
Education	Diploma	30	33.4%
	Associate's	15	16.6%
	Bachelor's	30	33.4%
	Master's+	15	16.6%
Marital Status	Single	45	50%
	Married	45	50%

population compared with the other groups. With the exception of anxiety, which showed approximately similar mean scores in the acute urticaria and healthy groups, all other mental health dimensions yielded higher scores in the acute urticaria group than in the healthy control group. Regarding resilience, the chronic urticaria group demonstrated lower mean scores across all resilience dimensions than both the acute urticaria and healthy control groups, reflecting reduced resilience in these patients. Moreover, participants in the acute urticaria group also obtained lower resilience scores than healthy individuals across all components, descriptively indicating comparatively lower resilience levels (Table 2).

Table 3 shows that, for all mental health components except paranoia and for all resilience components except tolerance of negative affect, positive acceptance of change, and control, there were significant differences among the groups ($p<0.05$).

Table 2. Descriptive Indexes (Mean and SD) of Mental Health and Resilience Components in Acute Urticaria, Chronic Urticaria, and Healthy Individuals.

Mental Health Components	Group	Mean (SD)	Resilience Components	Group	Mean (SD)
Somatization	Healthy	5.56 (3.87)	Personal Competence	Healthy	22.46(5.89)
	Acute	7.12 (3.21)		Acute	(4.47) 19.47
	Chronic	12.27 (5.51)		Chronic	18.79(6.39)
Obsessive-Compulsive	Healthy	1.86 (1.55)	Trust & Tolerance	Healthy	16.36(4.88)
	Acute	2.60 (1.81)		Acute	15.26(4.21)
	Chronic	4.23 (2.88)		Chronic	14.13(4.85)
Interpersonal Sensitivity	Healthy	(1.84)2.93	Acceptance/Safe Relations	Healthy	13.74(3.36)
	Acute	(1.86)3.33		Acute	(3.30) 12.40
	Chronic	(2.81)5.66		Chronic	11.57(4.21)
Depression	Healthy	(1.31)1.16	Control	Healthy	7.80(2.52)
	Acute	(1.66)1.73		Acute	6.96(2.11)
	Chronic	(2.19)2.96		Chronic	6.61(2.90)
Anxiety	Healthy	(2.85)3.53	Spiritual Influences	Healthy	6.60(1.54)
	Acute	(2.28)3.20		Acute	5.33(1.69)
	Chronic	(3.20)5.73		Chronic	5.23(2.31)
Phobic Anxiety	Healthy	(1.71)2.50	Resilience (total)	Healthy	67.09(14.05)
	Acute	(1.75) 3.50		Acute	59.47(12.68)
	Chronic	(2.76)4.66		Chronic	56.33(16.56)
Paranoid Thoughts	Healthy	1.00 (0.83)			
	Acute	1.03(0.96)			
	Chronic	1.50(1.20)			
Psychoticism	Healthy	2.06(1.23)			
	Acute	2.23(1.36)			
	Chronic	(2.63) 3.83			
Other	Healthy	0.63(0.76)			
	Acute	1.16(0.87)			
	Chronic	(1.10) 1.86			
Mental Health (Disorder)	Healthy	21.22(11.45)			
	Acute	(9.26) 25.93			
	Chronic	42.75(19.50)			

Table 3. ANOVA Results for Mental Health and Resilience Components among Chronic Urticaria, Acute Urticaria, and Healthy Groups.

Source	Variable	SS	df	MS	F	p
Group	Somatization	739.012	2	369.506	19.178	.001
	OCD	88.067	2	44.033	9.435	.001
	Interp. Sens.	130.756	2	65.378	13.314	.001
	Depression	50.822	2	25.411	8.218	.001
	Anxiety	113.689	2	56.844	7.229	.001
	Phobic	70.556	2	35.278	7.757	.001
	Paranoia	4.689	2	2.344	2.306	.106
	Psychoticism	57.089	2	28.544	8.350	.001
	Others	22.956	2	11.478	13.386	.001
Error	Somatization	1676.244	87	19.267		
	OCD	406.033	87	4.667		
	Interp. Sens.	427.200	87	4.910		
	Depression	269.000	87	3.092		
	Anxiety	684.133	87	7.864		
	Phobic	395.667	87	4.548		
	Paranoia	88.467	87	1.017		
	Psychoticism	297.400	87	3.418		
	Others	74.600	87	0.857		
Group	Pers. Competence	229.081	2	31.861	3.595	.032
	Tolerance	74.449	2	21.701	1.715	.186
	Acceptance	71.751	2	13.281	2.701	.073
	Control	22.172	2	6.421	1.727	.184
	Spiritual	34.822	2	3.531	4.930	.009
Error	Pers. Competence	2771.868	87			
	Tolerance	1888.005	87			
	Acceptance	1155.404	87			
	Control	558.608	87			
	Spiritual	307.233	87			

Table 4 demonstrates that no significant differences were observed between the healthy control group and the acute urticaria group with respect to mental health and the "personal competence" dimension of resilience. In contrast, significant differences were identified between the healthy control group and the chronic urticaria group across all mental health dimensions and the personal competence component of resilience ($p < 0.05$). Regarding the spiritual influences subscale, significant differences were found between the healthy and chronic urticaria groups, as well as between the healthy and acute urticaria groups; however, no significant difference was observed between the acute and chronic urticaria groups.

Discussion

The present study was conducted to evaluate mental health and resilience among individuals with chronic urticaria, individuals with acute urticaria, and healthy controls. The findings revealed significant differences among the study groups across all dimensions of mental health, with the exception of paranoid ideation. Mental health disturbances were significantly greater in the chronic urticaria group than in the healthy control group, whereas the acute

Table 4. Tukey's Pairwise Comparison Results for Health and Resilience Components among Chronic Urticaria, Acute Urticaria, and Healthy Groups.

Component	Groups compared	Mean Difference	Std. Error	p-value
Somatization	Healthy - Acute	-1.56	1.13	.356
	Healthy - Chronic	-6.70	1.13	.001
	Acute - Chronic	-5.14	1.13	.001
OCD	Healthy - Acute	-0.73	0.55	.391
	Healthy - Chronic	-2.36	0.55	.001
	Acute - Chronic	-1.63	0.55	.012
Interp. Sens.	Healthy - Acute	-0.40	0.57	.765
	Healthy - Chronic	-2.73	0.57	.001
	Acute - Chronic	-2.33	0.57	.001
Depression	Healthy - Acute	-0.56	0.45	.428
	Healthy - Chronic	-1.80	0.45	.001
	Acute - Chronic	-1.23	0.45	.021
Anxiety	Healthy - Acute	0.33	0.72	.890
	Healthy - Chronic	-2.20	0.72	.009
	Acute - Chronic	-2.53	0.72	.002
Phobic	Healthy - Acute	-1.00	0.55	.170
	Healthy - Chronic	-2.16	0.55	.001
	Acute - Chronic	-1.16	0.55	.092
Psychoticism	Healthy - Acute	-0.16	0.47	.935
	Healthy - Chronic	-1.76	0.47	.001
	Acute - Chronic	-1.60	0.47	.003
Others	Healthy - Acute	-0.53	0.23	.072
	Healthy - Chronic	-1.23	0.23	.001
	Acute - Chronic	-0.70	0.23	.012
Pers. Competence	Healthy - Acute	2.99	1.45	.105
	Healthy - Chronic	3.67	1.45	.036
	Acute - Chronic	0.67	1.45	.888
Spiritual Influences	Healthy - Acute	1.26	0.48	.028
	Healthy - Chronic	1.36	0.48	.016
	Acute - Chronic	0.10	0.48	.977

urticaria group did not differ significantly from healthy individuals. These findings are consistent with those reported in previous studies (1–7, 9, 13, 16).

The principal implication of the present research is that individuals with chronic urticaria experience substantially greater impairment across nearly all domains of mental health, except paranoid ideation, compared with healthy individuals, while patients with acute urticaria do not exhibit comparable psychological impairment. This distinction may largely be attributed to the prolonged and persistent nature of chronic disease. Chronic disorders, including chronic urticaria, are typically characterized by an enduring, unpredictable, and relapsing course that continuously affects patients' self-perception, long-term expectations, social relationships, and daily functioning (1,2,6). Previous studies have demonstrated that the persistence of symptoms and ongoing uncertainty regarding disease prognosis in chronic urticaria are major contributors to depressive symptoms, anxiety, insomnia, concentration difficulties, and diminished quality of life (1).

Furthermore, a considerable proportion of patients with chronic urticaria experience

clinically significant psychological distress, which has been associated with an increased likelihood of disease exacerbation, whereas psychological symptoms in acute urticaria are generally reported to be substantially less severe (2). In fact, the transient and episodic nature of acute urticaria allows individuals to resume their normal lives without experiencing profound disruptions in their psychological outlook, interpersonal functioning, or sense of hopefulness. By contrast, the persistent manifestations of chronic skin disorders such as urticaria gradually deplete psychological coping resources and foster persistent feelings of anxiety, hopelessness, and emotional distress (6). It therefore appears that the temporary nature of acute urticaria allows coping mechanisms to remain relatively intact, whereas the chronic persistence of symptoms in chronic urticaria may contribute to the gradual exhaustion of these psychological capacities.

Sleep disturbance resulting from persistent nocturnal pruritus and discomfort appears to represent another key finding of the present study. Sleep disruption is highly prevalent among patients with chronic urticaria and has been identified not merely as a secondary symptom but also as a critical mediating factor linking physical illness to psychological distress, a relationship emphasized in numerous previous investigations (3,9). Persistent sleep disturbance can markedly reduce quality of life and contribute to chronic fatigue, impaired emotional regulation, heightened anxiety, and ongoing stress related to fears of disease recurrence, thereby exacerbating psychological dysfunction. In contrast, the temporary nature of sleep disruption in acute urticaria generally prevents the establishment of this maladaptive cycle (9).

From a social and occupational perspective, the burden imposed by a long-term illness further aggravates psychological vulnerability and diminished resilience in patients with chronic urticaria. Previous studies have documented persistent concerns regarding physical appearance, fear of negative judgment, avoidance of social and occupational situations, social withdrawal, impaired functioning, recurrent work absenteeism, reduced social support, depressive symptoms, anxiety, and feelings of inadequacy among individuals with chronic urticaria (4,6). Such complications are considerably less evident in patients with acute urticaria because of the temporary nature of the condition. This observation is consistent with the findings of the present study, in which the personal competence dimension of resilience was significantly impaired only in the chronic urticaria group.

Recent studies have further demonstrated that both the severity and persistence of chronic urticaria are associated with substantial increases in psychological dysfunction, particularly in the domains of depression, anxiety, and stress. Research has indicated a direct relationship between frequent disease recurrence, treatment resistance, and elevated levels of emotional distress and psychological burden in these patients (5). Conversely, because of its transient course, acute urticaria does not appear to produce marked psychological differences compared with the healthy population (7,8).

In addition, psychological and cognitive factors such as fear of stigmatization, reduced self-esteem, perceived helplessness, and loss of control may function as mediating mechanisms within this relationship. These factors may intensify a vicious cycle that ultimately contributes to worsening mood-related symptoms (6,27). Nevertheless, previous evidence suggests that the psychological burden associated with chronic urticaria primarily manifests in affective disturbances such as depression and anxiety rather than in severe psychotic symptoms, including paranoid ideation. In other words, the primary

psychological vulnerability among patients with chronic urticaria appears to be concentrated within emotional and affective domains (9).

Recent evidence has also revealed a bidirectional relationship between inflammatory processes, cytokine alterations, and psychological disorders in chronic urticaria. This interaction appears to influence both the physical severity of the disease and the extent of psychological impairment, particularly among individuals predisposed to mental health disorders (13). These findings underscore the complexity of psychological complications in chronic urticaria and highlight the necessity for integrated physical and psychological treatment approaches (13,14). Moreover, neglecting the psychological dimensions of chronic urticaria management may result in reduced quality of life and poorer disease control. Consequently, routine mental health screening and psychological interventions appear essential for patients with chronic urticaria. Failure to address these issues may contribute to the progression of psychological disorders and reduce the effectiveness of pharmacological treatment (16). Unlike healthy individuals and patients with acute urticaria, who generally do not require immediate psychological intervention, patients with chronic urticaria are likely to benefit from multidimensional treatment programs that incorporate psychological therapies alongside medical management (1–7, 13, 14, 16).

With regard to the perceived personal competence dimension of resilience, no significant difference was identified between the healthy control group and the acute urticaria group. However, a significant difference in perceived personal competence was observed between the healthy control group and the chronic urticaria group. This finding is consistent with previous studies (17–22). Existing evidence has demonstrated the detrimental impact of long-term chronic illnesses, particularly chronic dermatological disorders, on resilience and, more specifically, on perceptions of personal competence. The chronic nature of illness tends to adversely affect multiple dimensions of resilience, including self-efficacy, purposefulness, and hopefulness (17). In the study conducted by Yi, it was reported that prolonged illness duration was associated with substantial declines in these dimensions. Persistent disease symptoms and uncertainty regarding the future may gradually undermine self-esteem and increase dependence on external sources of support, thereby weakening resilience, particularly in relation to perceived personal competence. This process may help explain the significant reduction in perceived personal competence observed in the present study among patients with chronic urticaria compared with healthy individuals (17,18).

The consequences of diminished resilience, particularly in the domains of self-care and social functioning, are also substantial. Jin and colleagues reported that low levels of resilience and reduced perceived personal competence directly impair self-care behaviors among patients with chronic illnesses, including adherence to treatment and effective stress management (19). In contrast, among patients with acute conditions, the temporary nature of the illness generally prevents significant disruption to self-concept and perceived competence. From a social perspective, research conducted by Shi and colleagues demonstrated that patients with chronic illnesses typically exhibit lower overall resilience, reduced self-confidence, and greater hopelessness, while diminished social support further weakens resilience by undermining perceived personal competence (20). Collectively, these findings help explain why, in chronic conditions such as urticaria, the personal competence dimension of resilience declines considerably compared with both healthy individuals and patients with acute disease.

Additional studies have highlighted the influence of demographic and environmental factors, including age, sex, living conditions, and treatment environments, on the reduction of resilience among patients with chronic urticaria. Research conducted by Andas et al. among older adults demonstrated that chronic diseases, including chronic dermatological conditions, intensify feelings of social isolation, reduce perceived social support, and contribute to psychological exhaustion, ultimately resulting in lower resilience and a diminished sense of personal worth and competence (21). Indeed, the persistent exposure to stress, withdrawal from active social engagement, and gradual erosion of positive psychological resources place individuals with chronic illnesses at a markedly lower level of resilience than those with acute conditions or healthy individuals.

Similarly, the study by Wan and Lan et al. emphasized the pivotal role of perceived personal competence, demonstrating that prolonged illness duration, continuous exposure to physical limitations, and persistent feelings of helplessness contribute to increasingly negative self-perceptions and diminished confidence in one's ability to cope with adversity (22). Even when adequate social support and primary care are available, the chronic nature of disease itself may profoundly undermine self-confidence and perceptions of personal competence. This negative effect has been observed primarily among children and adults living with chronic illnesses rather than acute conditions. Such differences may be attributable to prolonged psychological strain, reduced optimism regarding treatment outcomes, gradual erosion of social support, and the persistence of stigma and negative self-perceptions, all of which are experienced more deeply and enduringly by patients with chronic diseases. By contrast, individuals with acute urticaria generally retain a stronger sense of personal capability and psychological efficacy (17–22).

The findings of the present study further demonstrated significant differences in the spiritual dimension between healthy individuals and both patient groups, including those with acute and chronic urticaria. Chronic skin disorders such as urticaria, because of their persistent and debilitating nature, may exert profound effects on the spiritual dimensions of patients' lives. Continuous exposure to disease symptoms, chronic stress, and social limitations may contribute to diminished hopefulness, weakened meaning and purpose in life, and, consequently, reduced spiritual resilience and perceived personal competence. These findings suggest that medical interventions alone may be insufficient for the effective management of chronic illnesses and that a comprehensive multidimensional approach addressing psychological and spiritual dimensions is required. Previous studies have demonstrated that strengthening patients' interpretation of illness and supporting their sense of competence and hopefulness can substantially improve adaptation and health-related quality of life (17–22). Accordingly, integrating psychosocial and spiritual support with conventional medical treatment may represent an essential principle in the comprehensive care of these patients.

The present study underscores the importance of paying particular attention to psychological and spiritual dimensions in the assessment and management of patients with chronic urticaria and highlights the need for multidimensional interventions aimed at improving patients' quality of life. From both educational and clinical perspectives, regular screening for mental health problems and sleep disturbances among patients with chronic urticaria, together with the incorporation of supportive psychological interventions such as resilience training and stress-management programs into treatment plans, appears warranted. At the health policy level, the development and implementation of integrated psychosomatic

care models within dermatology centers may constitute an important step toward improving the quality of comprehensive patient care.

Conclusion

In light of the findings of the present study, and considering limitations such as convenience sampling, the relatively small sample size, and the absence of control for potential demographic confounding variables, future research should employ larger samples and randomized sampling methods while applying more rigorous control of intervening factors. Furthermore, the design and evaluation of integrated psychosocial intervention programs are strongly recommended. Qualitative investigations exploring individual and environmental factors influencing mental health and resilience among patients with urticaria may also provide deeper insights into previously unexplored dimensions of the disease and contribute to the development of more effective intervention strategies. In addition, future studies may examine the comparative effectiveness of psychological, supportive, and spiritual interventions in improving the psychological well-being of these patients. Investigating variables such as family relationship quality, social support, and cultural and economic factors as potential mediators or moderators of mental health and resilience in patients with urticaria is likewise recommended.

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Conflict of Interest

The authors declare no conflict of interest.

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Ethical Considerations

This study employed a causal-comparative design and involved neither manipulation of variables nor therapeutic intervention. Data were collected anonymously using standardized psychological questionnaires. Participation was entirely voluntary, and all participants were provided with clear information regarding the objectives of the study, study procedures, and their right to withdraw at any time without any adverse consequences. Written informed consent was obtained prior to questionnaire completion. To ensure confidentiality, all responses were kept strictly confidential and used solely for academic purposes. No personally identifiable information was collected. Because the study involved only the completion of self-report questionnaires, it posed no more than minimal risk to participants. Overall, all ethical principles governing research involving human participants, including respect for autonomy, informed consent, confidentiality, and non-maleficence, were fully observed throughout the study.

Code of Ethics

The present article was derived from the thesis of Sahar Bahmanyar (Thesis Code: 12120057171742139811 3701).

Authors' Contributions

All authors contributed to the study design, data analysis, and manuscript preparation

equally. All authors read and approved the final version of the manuscript.

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