

Psychosocial Impacts And Quality of Life of Children With Atopic Dermatitis

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Abstract

This study was conducted on 100 children with atopic dermatitis (AD) attending Dermatology Clinic, Al-Hussein University Hospital and an equal number of children as controls. The aim of the study was to determine the psychosocial impacts of AD on children and their families, to define quality of life (QOL) of children and their families and to determine the relationship between these items and AD severity. A cross-section, analytical, clinic based study design was chosen to perform this research. Criteria for diagnosis of depression and anxiety were according to DSM IV. Also, we used The Children's Dermatology Life Quality Index and The Dermatitis Family Impact questionnaire to assess the impact of AD on the children's quality of life and to assess the impact of AD on the quality of family life, respectively. The most common behavioural and psychiatric impacts in children were dependence (33.0%) and anger (26.0%). Also, AD interfered with children's social life and recreation in 73.0% and 29.0% of them, respectively. While, mothers' psychiatric impacts and family disturbances were more in AD families; 43.0% and 70.0%, respectively. The impacts of AD were more in children and families with severe AD with statistically significant differences. Also, 86.0% of children with AD and 62.0% of their mothers had poor QOL.

Introduction

Atopic dermatitis (AD) is a common and important skin condition, which is most often arises in infants and children. It affects up to 21.0% of children in Northern Europe, United States and Japan (Sugiura *et al.*, 1998 and Williams *et al.*, 1999). Moreover, it has been estimated that patients with AD account for 30.0% of dermatology consultation in primary care and up to 20.0% of all referrals to dermatologists (Holden and Parish, 1998). Despite the frequency of AD, society and the medical community often view it as a

minor dermatological condition. Many believe that it does not present any major difficulties for the patient, family, or society. However, research demonstrates that AD can be a major skin disorder with very significant costs and morbidity. AD in children can have a major effect on their quality of life, disrupting family and social relationships as well as interfering with recreational activities and school (Lapidus, 2001).

AD has profound effects on many aspects of patients' lives and the lives of

their families. The disease is both uncomfortable and distressing to patients. When severe, AD can be extremely disabling, causing major psychological problems and, in the case of a young child, be overwhelming to the entire family (Schultz *et al.*, 1996 ; Barnetson and Rogers, 2002). Also, one of the most disturbing impacts of the disease is on sleep pattern. This can lead to behavioural difficulties in the most severely affected children (Finlay, 2001 ; Hallett, 2005). Further, persistent skin disease throughout infancy can cause personality changes and changes due to maternal rejection, which further aggravate AD. The habit of scratching may become an automatic reflex (Champion and Parish, 1992). Moreover, maladaptive family behaviour may contribute to chronicity of AD, while depression and anxiety may be an aggravating cause or complication of AD. Also, depression may reduce threshold for pruritus (Gupta *et al.*, 1994).

There is a large body of evidence demonstrating the psychosocial impact of AD (Wittkowski *et al.*, 2004). Anger is one of these psychosocial impacts (Jordan and Whitlock, 1972 ; Ginsburg *et al.*, 1993).

Anxiety, not always recognized or acknowledged by the patient, may be an essential driving force in some individuals (trait anxiety) (Speilberger, 1972). When this increases, as a result of extra stresses or presence of disease, it may become marked (state anxiety). The symptoms themselves, for example intensity of pruritus, may become part of a general stress response characterized by emotional over arousal (Lader and Peturrson, 1983). Pathological anxiety is more common in patients with a chronic medical problem (e.g. AD) than in those without (King and Wilson, 1991; House and Stark, 2002). Detecting and treating anxiety is an integral part of

dermatological management, leading to better QOL and less use of resources (Cotterill and Finlay, 2004).

Depression is common in dermatological patients especially with severe skin diseases (Cotterill and Finlay, 2004). Skin diseases, particularly those affecting the face and hand, may cause depression in body image, self-esteem, confidence and secondary depression (Hardy and cotterill, 1982). Patients with generalized pruritus, e.g. AD, are more likely to be depressed than controls (Sheehan-Dare and Cotterill, 1990 ; Hashiro and Okumura, 1997). Depression is a well-recognized risk factor for non-compliance with treatment so depressed patients are three times more likely to be non-compliant than non-depressed patients (DiMatteo *et al.*, 2000). Also, it is possible that having severe disease leads to poor life quality, which in turn leads to a degree of depression and a sense of “giving up”. This may result in poor concordance with therapy and in turn further deterioration in the disease (Cotterill and Finlay, 2004).

Many reports have illustrated the impact of AD on patients’ QOL (Badia *et al.*, 1999 ; Linnet and Jemec, 1999). But, the assessment of children quality of life (QOL) impairment is difficult because of issues relating to communication, rapid change in lifestyle at different ages and differing rates of maturing. The affected children may not be able to explain their distress, or have the insight to know that they are experiencing is abnormal (Cotterill and Finlay, 2004). Although, being able to assess the impact of skin disease on patients is essential in order to understand and meet what patients really need (Finlay, 2000). However, there is a controversy about the definition of QOL and whether it can be meaningfully assessed (Koller and Lorenz,

2002). Reasons for why health related QOL measurement may be helpful include clinical therapeutic research, health service research and audit research into psychological aspects of dermatology and patient behaviour, political/resource allocation, and informing clinical decisions (Cotterill and Finlay, 2004).

The aim of the present study is to determine the psychosocial impacts of AD on children and their families, to define QOL of these children with AD and their families and to determine the relationship between AD impacts and AD severity.

Subjects And Methods

One hundred children with clinical diagnosis of AD attending Dermatology Clinic, Al-Hussein University Hospital and an equal number of free children as controls, were enrolled in this study. Both AD patients and controls were matched in age and sex; their ages were 10-15 years. A cross-section, analytical, clinic-based study design was chosen to perform this study. The purpose of the study was explained to the mothers and young people of AD patients and controls. Verbal consent of both of them was given. AD severity was determined by using the SCORAD index (European Task Force on Atopic Dermatitis, 1993). Also, AD patients, controls and mothers of both were interviewed.

Criteria for diagnosis of depression and anxiety were according to DSM IV (First *et al.*, 1994).

In this study we used The Children's Dermatology Life Quality Index (CDLQI) (Lewis-Jones and Finlay, 1995), with some modification, to assess the impact of AD on the children's QOL. We helped the children in completing the CDLQI. The mothers not

help their children because: a) the responses would be more likely to reflect the child's own view of the disease, b) the data would be of a consistent quality. The aim of this questionnaire is to measure how much the skin problem has affected child's life over the last week. The questionnaire is consisting of 10 questions, each one is answered either "very much" (score 3), "a lot" (score 2), "a little" (score 1) or "not at all" (score 0). The maximum score (indicating highest possible impairment of quality of life) is 30 and the minimum (indicating lowest possible impairment of quality of life) is 0.

Also, we used The Dermatitis Family Impact (DFI) questionnaire (Lawson *et al.*, 1998) to assess the impact of AD on the quality of family life. The aim of this questionnaire is to measure how much the skin problem has affected family quality of life over the last week. The questionnaire is consisting of 10 questions, each one is answered either "very much" (score 3), "a lot" (score 2), "a little" (score 1) or "not at all" (score 0). The maximum score (indicating highest possible impairment of quality of life) is 30 and the minimum (indicating lowest possible impairment of quality of life) is 0.

We used the mean \pm standard deviation to represent results of CDLQI and DFI. Chi-square (χ^2) was used as test of significance, the significance level for χ^2 was accepted if the P-value ≤ 0.05 .

Results And Discussion

Regarding distribution of AD patients and controls according to child and family impacts, medical care and social class (table 1), we reported that 27.0%, 33.0%, 28.0% and 9.0%, 12.0%, 8.0% of our AD patients and controls respectively had clingy,

dependent and fearful behaviours, with statistically significant differences. These results were in accordance with Daud *et al.* (1993), as cleared those children with AD being more clingy, dependent and fearful. As regard psychiatric impacts, 26.0%, 16.0%, 9.0% and 7.0%, 5.0%, 3.0% of our AD patients and controls respectively had anger, depression and anxiety, respectively. The differences were statistically significant for anger and depression only. Results regarding anger were in accordance with Jordan and Whitlock (1972) and Ginsburg *et al.* (1993). While, results regarding depression were in accordance with Hardy and Cotterill 1982, Sheehan-Dare and Cotterill, 1990; Hashiro and Okumura, 1997 and Cotterill and Finlay (2004). Patients with generalized pruritus, e.g. AD, are more likely to be depressed than controls (Sheehan-Dare and Cotterill, 1990 ; Hashiro and Okumura, 1997). Also, our results regarding anxiety were in accordance with King and Wilson (1991) ; House and Stark (2002). They reported that pathological anxiety is more common in patients with chronic medical problem, e.g. AD, than in those without. Regarding interference of AD with child's social life, we noticed that there was interference in 73.0% and 17.0% of our patients and controls, respectively, with statistically significant difference. This result was in accordance with Lapidus and Honig (1994), Lapidus (2001), Wittkowski *et al.* (2004) and Hallett (2005). As regard interference with recreation and/or sport, we showed that there was interference in 29.0% and 11.0% of our patients and controls, respectively, with a statistically significant difference. This result was in accordance with Daud *et al.* (1993) and Lapidus (2001). The atopic child's participation in sports may be limited (Lapidus and Honig, 1994

and Hallett, 2005). As respect interference with school, 14.0% and 9.0% of our AD patients and controls respectively had absenteeism >5 days/month, respectively. This difference was statistically non-significant. Also, <50.0% achievement in mid-year exam was found in 26.0% and 16.0% of our patients and controls respectively, with statistically significant difference. Delayed academic achievement often results because of school missed for hospitalization or physician visit, sedation from medications, poor sleep due to intense pruritus and distractions from physical discomfort (Lapidus and Honig, 1994; Lapidus, 2001; Hallett, 2005). As regard interference with mother's work (table 1), we reported that 61.0% and 29.0% of mothers of AD children and controls had work interference, respectively, with statistically significant difference. In details, homework had a statistically significant difference (P=0.000), while employment had not (P=0.241). Daud *et al.* (1993) cleared that mothers of the children with AD are less frequently in outside employment. Also, Su *et al.* (1997) demonstrated that mothers missed time from work for their child's hospital visits and care at home and lost wages due to interruption of employment, and in the moderate to severe AD groups, potential parental unemployability. As respect psychiatric problems and/or stress in the family, 43.0% and 21.0% of families of our AD patients and controls, respectively had. The difference was statistically significant (P= 0.001). Regarding family disturbances, we noticed that there were disturbances in 70.0% and 53.0% of families of our patients and controls respectively, with statistically significant difference (P=0.01). In details, 32.0% and 22.0% of families of our patients and controls respectively, had social

disturbances with statistically non-significant difference ($P=0.151$). Also, 38.0% and 31.0% of families of our patients and controls respectively, had economic disturbances with statistically non-significant difference ($P=0.372$). It has been shown that parents find it stressful to care for a child with AD (Daud *et al.*, 1993; LaGreca & Schuman, 1995 and Su *et al.*, 1997). AD in children can have a major effect on disrupting family and social relationships (Lapidus, 2001). Also, Daud *et al.* (1993) cleared that having a child with AD may markedly disrupt family life and parenting. The added burden of caring for an atopic child can affect the spousal relationship. The parent, who is not the primary caretaker, as well as other children in the family, may resent the time the care-taking parent spends with the atopic child. These problems may lead to dysfunctional family relationships (Lapidus and Honig, 1994; La Greca and Schuman, 1995). Moreover, Daud *et al.* (1993) described other factors that contribute to the stress of caring for a child with AD. Mothers of the children with AD are report less support in their social life. Friends are reluctant to baby-sit for their atopic children, thereby causing a negative effect on parental social functioning. Parents feel an increased burden of care. Mothers of children with AD are less effective at discipline and give in more often. Families are often restricted on where they can eat or take vacation. Also, Su *et al.* (1997) looked at the impact on parents and families of caring for a child with AD. They demonstrated that caring for a child with moderate or severe AD is more stressful than taking care of a child with insulin-dependent diabetes. In addition to the direct financial costs, they attribute this parental stress to several factors: nightly sleep interruption and deprivation of 1-2

hours; time missed from work, lost wages due to interruption of employment, and in the moderate to severe AD groups, potential parental unemployability. Regarding source of medical care (table 1), we showed that 23.0% and 34.0% of our patients and controls respectively had private medical care. On the other hand, 77.0% and 66.0% of our patients and controls respectively, had public medical care. These differences were statistically non-significant ($P=0.084$). In details, 56.0% and 53.0% of our patients and controls respectively, had outpatient clinic care, with statistically non-significant difference ($P=0.776$). Moreover, 21.0% and 13.0% of our patients and controls respectively, had emergency room care, with statistically non-significant difference ($P=0.187$). Witkowski (1988) stated that many studies on chronic disease suggested that the emergency department is an inappropriate setting in which to treat AD or, for that matter, most chronic non-life-threatening conditions. The use of the emergency department for treatment of AD is neither desirable nor optimal for the child, hospital, or society. Given the high prevalence of AD, its associated morbidity, its cost and the pressing need to cut health care expenditures, attention must be focused on improving the organization of treatment for AD. Innovations such as home visits and increasing visits to dermatology clinics can significantly improve the care received by children with AD while reducing cost (Lapidus *et al.*, 1993). Starfield (1990) showed the poor access to care by low-income families and their noncompliance with treatment regimens. As regard compliance with therapy, we observed that 64.0% and 59.0% of our patients and controls respectively had no compliance with medical treatment. This difference was statistically non-

significant ($P= 0.561$). The problems of caring for an atopic child may lead to dysfunctional family relationships. So, these families have been shown to exhibit poor treatment compliance and, therefore, inadequate control of symptoms (Lapidus and Honig, 1994 ; La Greca and Schuman, 1995). Also, depression is a well-recognized risk factor for non-compliance with treatment so depressed patients are three times more likely to be non-compliant than non-depressed patients (DiMatteo *et al.*, 2000). Lastly, low social class, including low-income families, was found among 58.0% and 48.0% of our patients and controls respectively, with statistically non-significant difference ($P=0.202$). Children who have AD may be an even greater challenge for low-income families. Mothers' caretakers, of families below the poverty level in the United States, have fewer personal, social and economic resources to devote to the care of a child who has a chronic illness. Poverty has been shown to be associated with ill health and poor access to care (Lapidus, 2001). Also, Lapidus *et al.* (1993) stated that a large fraction of the cost of care for children with AD was for emergency room visits. The study demonstrated that the large majority of patients seen in the emergency department for AD were government-insured, low-income patients and they were also the more severe cases. They concluded that low-income families with atopic children are at high risk and need alternative ways to provide treatment for their disease. Also, all the problems of AD can lead to environmental, social and emotional deprivations, which negatively affect the course of the disease (Lapidus and Honig, 1994 ; Hallett, 2005).

As regard distribution of atopic dermatitis patients' severity status by child

and family impacts, medical care and social class (table 2), we showed that most of the children with severe form of the disease were clingy (50.0%), dependent (59.1%) and fearful (54.5%). The differences between the three forms of the disease were statistically significant. Also, we observed that most of the children with severe form of disease were anger (54.5%), depressed (31.8%) and felt anxieties (22.7%). Also, the differences between the three forms of the disease were statistically significant. Moreover, the disease had interfered with social life among 100.0% of the children with severe form of AD. Also, the disease had interfered with recreation and/or sport in 63.6% of the children with severe form of disease. The atopic child's participation in sports may be limited (Lapidus and Honig, 1994 ; Hallett, 2005). At the same time, most of the children with severe form of disease had interference with school absenteeism (31.8%) and scholastic achievement (54.5%). These results are expected and accepted as it is possible that having severe disease leads to poor life quality, which in turn leads to a degree of depression and a sense of "giving up" (Cotterill and Finlay, 2004). Also, delayed academic achievement often results-according to school missed for hospitalizations or physician visits, sedation from medications, poor sleep due to intense pruritus and distractions from physical discomfort. Peers and teachers acceptance may be affected by the appearance of the child and concerns about infectivity (Lewis-Jones and Finlay, 1995). Regarding interference of the disease with mother's work, 100.0% of the children with severe form of disease their mothers had interference. In details, 40.9% and 59.1% of them had interference with employment and homework, respectively. Also, 100.0% of

the children with severe form of disease their families had psychological problems and/or stress. Moreover, 100.0% of the children with severe form of disease their families had disturbances. In details, 59.1% and 40.9% of them had social and economic disturbances, respectively. All differences regarding familial impacts were statistically significant. As respect source of medical care, 50.0% of the children with severe form of disease their sources of medical care were private and public, respectively. In details, 9.1% and 40.9% of them had mainly outpatient clinic and emergency room care, respectively. Regarding compliance with therapy, 100.0% of the children with severe form of disease had no compliance with therapy, with a statistically significant difference ($P=0.0000$). Lastly, 100.0% of the children with severe form of disease were of low social class. Su *et al.* (1997) suggested that the direct financial cost to a family for the care of a child with moderate or severe AD was substantially higher than for the child with asthma and that the direct financial cost to a family for the care of a child with severe AD was also substantially higher than for the child who required hospitalization for asthma in the preceding year. They also demonstrated that the direct financial cost to a family for the care of a child with diabetes was similar to that of AD (Lapidus, 2001).

Regarding distribution of AD patients according to CDLQI (table 3), we revealed that results of the present study confirmed that AD children had poor QOL. Psychosocial aspects associated with AD extend beyond the home. Lewis-Jones and Finlay (1995) have shown that, of all children's skin conditions, AD has one of the greatest effects on the child's quality of life. In general, AD affected QOL among

86.0% of the children scored more than zero. This was expected, as all the children were diseased at that time and AD is a chronic relapsing disease. At the same time, this result was in consistent with Ben-Gashir *et al.* (2004) who reported 77.0% and 92.0% affection of QOL at two occasions. Also, in this study, itching had the highest impacts on the children's QOL as it produced the highest mean score (1.7 ± 1.1) for items of CDLQI. Also, it represented 73.0% of the children scored more than zero. Regarding sleep, it had the second highest mean score (1.5 ± 1.2) and the second percent of the children scored more than zero, 46.0%. These results were in accordance with Lewis-Jones and Finlay (1995); Ben-Gashir *et al.* (2004) and Cotterill and Finlay (2004). Itching score represented the highest percent and mean score. This illustrating how itchy AD is and the discomfort to the child from having this disease (Ben-Gashir *et al.*, 2004).

As regard distribution of AD children according to DFI (table 4), we cleared that results of our study supported that mothers of AD children had poor QOL. In general, AD affected family QOL among 62.0% of the affected children who their mothers scored more than zero in DFI. This was expected, as all the children were diseased at that time and AD is a chronic relapsing disease, which its effects extend to other family members. At the same time, this result was higher than that of Ben-Gashir *et al.* (2002) who reported 51.0%. This might be attributed to that psycho-socio-economic conditions of our children's families were already affected as they belong to low social class. Also, in the present study, AD affected sleep of others in the family among 39.0% and had the highest impacts on the families' QOL as it produced the highest mean score (1.7 ± 1.2)

for all items of CDLQI. Regarding food preparation, it had the second highest mean score (1.6 ± 1.4) and the second percent of the children scored more than zero, 37.0%. These results were in accordance with Lawson *et al.* (1998) and Ben-Gashir *et al.* (2002). On the other hand, time spent in shopping for the family had the lowest mean score (0.3 ± 0.2) and the lowest percent of the mothers scored more than zero, 9.0%. This was expected, as most of our studied group were belonging to low socioeconomic class.

Conclusion

It could be concluded that AD is an important skin condition, which most often arises in children. It can have a great effect

on the quality of life, disrupting family and/or social relationships and interfering with play, sports and school. Caring for a child with AD can be very stressful for a mother. Problems associated with AD can extend beyond the home into delayed academic achievement and poor participation in sports. The challenges become even greater with low-income families. Country-specific programs to make the health care system, families and schools more aware of AD and its associated problems and possible solutions, including psychosocial intervention are needed. So, it could be recommended that more research should be carried out to understand AD and its associated problems among children in Egypt.

Table (1): Distribution of atopic dermatitis (AD) patients and controls according to child and familial impacts, medical care and social class.

Child& Familial Impacts, Medical Care and Social class	AD patients (n=100)		Controls (n=100)		χ^2	P-Value
	No.	%	No.	%		
Impacts on the child						
Behavioural aspect:						
Clingy	27	27.0	9	9.0	9.79	0.0017
Dependant	33	33.0	12	12.0	11.47	0.0007
Fearful	28	28.0	8	8.0	12.23	0.0004
Psychiatric impacts:						
Anger	26	26.0	7	7.0	11.76	0.0006
Depression	16	16.0	5	5.0	5.32	0.0210
Anxiety	9	9.0	3	3.0	2.22	0.1365
Interference with social life:						
Yes	73	73.0	17	17.0	61.35	0.0000
Interference with recreation/sport:						
Yes	29	29.0	11	11.0	9.03	0.0026
Interference with school: (yes)						
Absenteesm: >5 days/month	14	14.0	9	9.0	0.79	0.3752
Achievement: <50% mid-year exam	26	26.0	16	16.0	2.44	0.1181
Familial impacts						
Interference with mother's work:						
Yes:	61	61.0	29	29.0	19.41	0.0000
Employment	19	31.2	12	41.4	1.37	0.2410
Homework	42	68.8	17	58.6	13.85	0.0001
Psychiatric problems/stress:						
Yes	43	43.0	21	21.0	10.13	0.0014
Family disturbances:						
Yes:	70	70.0	53	53.0	5.41	0.0134
Social	32	45.7	22	41.5	2.05	0.1517
Economic	38	54.3	31	58.5	0.80	0.3721
Medical care						
Source of medical care: (mainly)						
Private	23	23.0	34	34.0		
Public:	77	77.0	66	66.0	2.45	0.0848
Outpatient clinic	56	72.7	53	80.3	0.08	0.7764
Emergency room	21	27.3	13	19.7	1.74	0.1876
Compliance with therapy:						
No	64	64.0	59	59.0	0.34	0.5610
Social class						
Low social class	58	58.0	48	48.0	1.63	0.2022

Table (2): Distribution of atopic dermatitis (AD) patients' severity status by child and familial impacts, medical care and social class.

Child & Familial impacts, Medical Care and Social Class	AD severity (n=100)						χ^2	P- Value
	Mild (n=47)		Moderate(n=31)		Severe (n=22)			
	No.	%	No.	%	No.	%		
Impacts on the child								
Behavioural aspect:								
Clingy	4	8.5	12	38.7	11	50.0	16.21	0.0003
Dependant	6	12.8	14	45.2	13	59.1	17.55	0.0001
Fearful	5	10.6	11	35.5	12	54.5	15.58	0.0004
Psychiatric impacts:								
Anger	6	12.8	8	29.8	12	54.5	13.60	0.0011
Depression	3	6.4	6	19.4	7	31.8	7.59	0.0224
Anxiety	1	2.1	3	9.7	5	22.7	7.79	0.0203
Interfer with social life:								
Yes	25	53.2	26	83.9	22	100.0	19.35	0.0000
Interfer with recriation:								
Yes	5	10.6	10	32.3	14	63.6	20.67	0.0000
Interfer with school:								
Absenteesm	2	4.3	5	16.1	7	31.8	9.62	0.0081
Achievement	5	10.6	9	29.1	12	54.5	15.23	0.0004
Familial impacts								
Interfer with work:								
Yes:	13	27.7	26	83.9	22	100.0	42.84	0.0000
Employment	6	12.8	8	25.8	9	40.9	6.90	0.0317
Homework	7	14.9	18	58.1	13	59.1	20.10	0.0000
Psych. problem/stress:								
Yes	7	14.9	14	45.2	22	100.0	44.37	0.0000
Family disturbances:								
Yes:	22	46.8	26	83.9	22	100.0	24.31	0.0000
Social	10	21.3	9	29.1	13	59.1	10.03	0.0066
Economic	12	25.5	17	54.8	9	40.9	6.91	0.0315
Medical care								
Source of medical care:								
Private	4	8.5	8	25.8	11	50.0	14.77	0.0006
Public:	43	91.5	23	74.2	11	50.0	14.77	0.0006
Outpatient clinic	30	63.8	15	48.4	2	9.1	18.06	0.0001
Emergency room	13	27.7	8	25.8	9	40.9	1.63	0.4428
Therapy compliance:								
No	14	29.8	28	90.3	22	100.0	45.58	0.0000
Social class								
Low social class	12	25.3	24	77.4	22	100.0	41.07	0.0000

Table (3): Distribution of atopic dermatitis (AD) patients according to child's dermatitis life quality index (CDLQI).

CDLQI items	Percent	Mean ± SD
Total CDLQI percent: 86.0%		
Scratching	73	1.7 ± 1.1
Embarrassed	19	0.7 ± 0.5
Friendships	16	0.6 ± 0.4
Change clothes	14	0.4 ± 0.3
Playing / sport	18	0.7 ± 0.5
School time	17	0.7 ± 0.4
Holiday time	21	0.9 ± 0.7
Teasing	43	1.1 ± 1.1
Child sleep	46	1.5 ± 1.2
Treatment	23	1.1 ± 0.8

Table (4): Distribution of atopic dermatitis (AD) patients according to dermatitis family impact (DFI).

DFI items	Percent	Mean ± SD
Total DFI percent: 62.0%		
House work	34	1.4 ± 1.3
Food preparation	37	1.6 ± 1.4
Sleep of others in family	39	1.7 ± 1.2
Family leisure activities	26	0.3 ± 0.2
Time of shopping for family	9	0.3 ± 0.2
Costs related to AD	35	0.7 ± 0.4
Cause tiredness/exhaustion	31	0.5 ± 0.4
Cause emotional distress	28	0.6 ± 0.4
Relationships within family	13	0.2 ± 0.1
Help in treatment	17	0.6 ± 0.3

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التأثيرات النفسية و الاجتماعية و نوعية الحياة فى الأطفال المصابين بالتهاب الجلد الاستشرائى

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أجريت هذه الدراسة على 100 طفل مصابين بالتهاب الجلد الاستشرائى من المترددين على عيادة الأمراض الجلدية بمستشفى الحسين الجامعى وكذلك على عدد مساو من الأطفال السالمين من هذا المرض كمجموعة ضابطة. وتهدف هذه الدراسة إلى تحديد التأثيرات النفسية و الاجتماعية على الأطفال المصابين بهذا المرض و عائلاتهم و تحديد نوعيه الحياة لهؤلاء الأطفال و عائلاتهم وكذلك تحديد العلاقة بين هذه التأثيرات و شدة المرض. وقد أختير نمط الدراسة المقطعية التحليلية بالعيادة لإجراء هذا البحث. وقد حددت مواصفات خاصة لتشخيص القلق و الاكتئاب عند الأطفال. وكذلك استخدمنا دليل نوعية الحياة للأطفال المصابين بأمراض جلدية و استبيان تأثير المرض الجلدى على أسرة الطفل المصاب لتقييم تأثير الإصابة بالتهاب الجلد الاستشرائى على نوعية الحياة للأطفال و تقييم تأثير الإصابة بهذا المرض على نوعية حياة الأسرة. وقد بينت الدراسة أن أكثر التأثيرات السلوكية و النفسية عند الأطفال هى الاعتمادية (33%) و الغضب (26%). وقد تعارض المرض مع الحياة الاجتماعية و الترفيه عند الأطفال فى 73%، 29% منهم على الترتيب. بينما كانت التأثيرات النفسية عند الأمهات و الاضطرابات العائلية أكثر فى عائلات الأطفال المصابين بالمرض: 43%، 70% على الترتيب. وكذلك كانت تأثيرات المرض أكثر فى الأطفال و العائلات ذات درجة المرض الشديدة و ذلك بدلالة إحصائية. و قد تأثرت نوعية الحياة عند 86% من الأطفال المصابين بالمرض و كذلك عند 62% من أمهاتهم.