



Childhood maltreatment is associated with depression but not with hypochondriasis in later life



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ABSTRACT

Objective: Previous studies demonstrated that a history of childhood trauma is linked to mental disorders in adulthood, particularly to depression. Adverse childhood experiences are also considered to contribute to the risk of hypochondriasis, but the results of previous studies have not been conclusive with respect to the strength and specificity of this association. Therefore, we compared the association of adverse childhood experiences with both hypochondriasis and depression.

Methods: Fifty-eight patients with hypochondriasis, 52 patients with depression, and 52 healthy control participants completed the Childhood Trauma Questionnaire (CTQ) which assesses 5 varieties of abuse and neglect. A clinical interview (SCID-I) was used to establish DSM-IV diagnoses. Associations between childhood maltreatment, hypochondriasis and depression were estimated by means of analyses of variance and multiple linear regression analyses.

Results: In comparison to hypochondriacal and healthy participants, patients with a current depressive disorder reported more emotional abuse as well as more emotional and physical neglect during childhood. Patients with hypochondriasis reported more emotional neglect than healthy individuals. However, when predicting the CTQ trauma types by diagnostic category adjusting for sex and comorbid DSM-IV diagnoses, emotional abuse, emotional neglect, physical abuse, physical neglect, as well as the CTQ total score were significantly associated with depression, but none of the CTQ scores was significantly related to hypochondriasis.

Conclusions: The findings suggest a robust association of childhood maltreatment with depression but not with hypochondriasis. This result does not support etiological models of hypochondriasis which rely on childhood maltreatment as a risk factor for the development of this disorder.

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Introduction

Numerous studies found evidence for a link between various forms of childhood maltreatment (i.e., sexual abuse, physical abuse, emotional abuse, physical neglect, and emotional neglect) and mental disorders in adulthood, particularly for anxiety and depressive disorders [1–5]. Furthermore, there is some support of Rose and Abramson's [6] hypothesis that certain forms of childhood maltreatment, primarily emotional abuse, may specifically contribute to the development of depressive disorders [7–9], whereas sexual abuse may serve as a non-specific risk for psychopathology in general [10]. Consistent with this view, Gibb et al.

[8] found that childhood emotional abuse was more strongly related to depressive disorders than anxiety disorders, whereas physical and sexual abuse were equally strongly related to both mental disorders. However, in a subsequent study Gibb et al. [9] observed this association not only in patients with major depression, but also in patients with social phobia. Therefore, additional research is needed to demonstrate the relative specificity of emotional abuse for the development of depression compared to other mental disorders.

Patients with hypochondriasis might constitute a potential comparison group to test this specificity hypothesis, because adverse childhood experiences are also considered to contribute to the risk of hypochondriasis [11,12]. The interpersonal model of hypochondriasis proposes that childhood adversities like the experience of early childhood illness and lack of parental care, which interfere with secure attachment and identity formation, make individuals prone to hypochondriasis [12–14]. However, only few clinical studies focused on this proposed association between childhood trauma and hypochondriasis: Barsky et al. [11]

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compared self-reports of six childhood traumas in 56 outpatients with DSM-III-R hypochondriasis and 55 non-hypochondriacal outpatients from a general medical clinic. The authors observed significantly higher rates of traumatic sexual contact, physical violence, and major parental upheaval among patients with hypochondriasis. However, hypochondriacal patients did not rate these traumatic experiences as more severe than the non-hypochondriacal patients. In a study by Noyes and et al. [12], the 47 patients with DSM-III-R hypochondriasis reported only one event (extreme illness or injury) more frequently than the 108 non-hypochondriacal general practice patients. Most important, no significant group difference was found in regard to traumatic sexual experience, sexual abuse, and physical abuse. Nevertheless, the authors conclude that their findings are consistent with the literature that links childhood adversity to hypochondriasis in adulthood.

Findings from studies of other forms of somatoform and related disorders are more consistent with this view. For example, a history of traumatic childhood experiences (especially sexual and physical abuse) has been linked to somatization disorder [15–18], conversion disorder [19], and functional somatic syndromes [20], including irritable bowel syndrome [21], fibromyalgia [22,23], and chronic fatigue syndrome [24,25].

In sum, the results regarding a possible link between childhood maltreatment and mental disorders are not conclusive with respect to the strength and the specificity of this association. Moreover, many of the previous studies did not control statistically for comorbid mental disorders. To specifically address these limitations of previous studies, we investigated childhood maltreatment amongst cases with a current depressive disorder, cases with hypochondriasis and healthy control participants. We used the well-validated and reliable Childhood Trauma Questionnaire (CTQ) [26–31] to assess different forms of childhood abuse and neglect, and a comprehensive clinical interview to control for comorbid DSM-IV diagnoses, because hypochondriasis frequently co-occurs with other mental disorders, especially with anxiety and depressive disorders [32]. In light of previous investigations we expected that both clinical groups would report higher levels of childhood abuse and neglect than the healthy individuals. In addition, we hypothesized depression but not hypochondriasis to be specifically related to high levels of childhood emotional abuse after controlling for comorbid DSM-IV diagnoses.

Methods

Participants

A total of 162 participants from a larger multi-level case–control-study on health anxiety were included in this investigation: 58 participants with hypochondriasis, 52 participants with depression and 52 healthy controls. Members of the two clinical groups were recruited from a Cognitive Behavior Therapy outpatient unit specialized in the treatment of somatoform and affective disorders at the Central Institute of Mental Health (CIMH), Mannheim, Germany. The healthy participants were recruited by advertisements published in local newspapers and on the web page of the CIMH.

Prior to enrollment in the study, participants were informed about study procedure and purposes and gave written informed consent. The study was approved by the Medical Ethics Committee of the Medical Faculty Mannheim at the University of Heidelberg, Germany. All patients completed a set of screening questionnaires related to health anxiety and depression, and a checklist for diseases and current medication, before study inclusion [33]. Diagnosis of hypochondriasis as well as all other current axis I diagnoses were made according to the DSM-IV criteria [34], using a comprehensive clinical interview for mental disorders (SCID-I) [35]. General exclusion criteria were: age below 18 and above 65 years, lifetime diagnoses of psychotic disorders, substance use disorders, organic brain disease or organic mental disorders, presence of a current somatic illness that could account for the hypochondriacal complaints, and inadequate command of German. Additional exclusion

criteria for depressive patients, who had to fulfill the criteria for either a major depressive episode or dysthymia, were: suffering from severe health anxiety, or co-morbid panic disorder, obsessive compulsive disorder, generalized anxiety disorder, or any somatoform disorder. The same was true for the healthy controls, but with affective disorders as additional exclusion criteria.

Measures

As screening measures, the well-validated Patient Health Questionnaire (PHQ) [36,37] was used to assess depressive (PHQ-9) and somatic (PHQ-13) symptoms, and the Short Health Anxiety Inventory (SHAI) [38] to assess the level of health anxiety. The SHAI contains 14 items in multiple-choice format which probe the range of health anxiety irrespective of physical health status. These screening scales had demonstrated good validity and reliability (SHAI: $\alpha = .97$, PHQ-9: $\alpha = .91$, PHQ-13: $\alpha = .83$) in the present study [33].

Mental disorders were assessed in face to face interviews with the Structured Interview for DSM-IV disorders (SCID-I) [35]. The clinical interviews were conducted by clinical psychologists. Although all interviewers had extensive experience (2–10 years) in the use of the SCID already at study onset, they received an additional one-week training by a SCID expert and subsequently were closely supervised by one of the senior researchers (JB). The interviewers were encouraged to use all available sources of information (i.e., self-report, medical records, attending doctors) when they needed clarification of interview results, especially for the evaluation of the somatoform and health anxiety items.

In addition to the clinical interview, questionnaire measures were applied to assess health anxiety, somatic symptoms, and the experience of childhood traumas. The Multidimensional Inventory of Hypochondriacal Traits (MIHT) [39] was used to assess the various aspects of health anxiety (i.e., disease conviction, reassurance-seeking, somatic awareness, illness worries). The MIHT is a 31-item scale with good reliability and validity for both the original and the German version [40]. Cronbach's α coefficient for the total score was .96 in this study.

Somatoform symptoms were covered with the Screening for Somatoform Symptoms (SOMS) [41]. The SOMS lists 53 somatic symptoms relevant for the diagnosis of somatization disorder according to DSM-IV. Participants had to mark all those symptoms that had been present within the last 2 years and that produced suffering but could not be attributed to a medical cause by a physician. Reported symptoms were added to yield a DSM-IV symptom total score.

The German 28-item version of the Childhood Trauma Questionnaire (CTQ) was used to assess the participants' levels of childhood emotional, physical and sexual abuse as well as emotional and physical neglect [29,31]. Each CTQ item is rated on a 5-point Likert scale ranging from "never true" to "very often true". Subscale scores are calculated by summing up responses within each type of childhood trauma, with higher scores indicating higher levels of childhood maltreatment. The CTQ is a brief, reliable and well validated self-report scale with good psychometric properties [28–31]. In this study Cronbach's α coefficient for the total CTQ score was .93, and .67–.93 for the five subscales.

Statistical analyses

All data were analyzed with SPSS Version 20.0 (SPSS Inc., Chicago, Ill., USA). Groups were compared using analyses of variance (ANOVA) and a multivariate analysis of variance (MANOVA) for continuous variables, followed by post-hoc comparisons between specific groups using the Tukey test. For categorical variables, the χ^2 -test was used. Multiple linear regression analyses were performed to predict continuous criterion variables (CTQ scores). The variance inflation factor (VIF) was calculated to test for multicollinearity among the predictor variables and was within normal ranges for all predictors ($VIF = 1.02$ – 2.86).

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