Relationship between childhood trauma and suicide probability in obsessive-compulsive disorder

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ABSTRACT

The aim of this study is to assess the relationship between childhood trauma with the probability of suicide in obsessive compulsive disorders. Sixty-seven patients who were diagnosed with OCD were included in the study out of the patients who were admitted to Malatya Training and Research Hospital psychiatry outpatient clinic. The research data were collected using Yale Brawn Obsessive Compulsive Scale (YBOCS), Beck Depression (BDS) and Beck Anxiety Scales (BAS), Childhood Trauma Questionnaire-28 (CTQ-28), and Suicide Probability Scale (SPS). CTQ was detected as ≥ 35 in 36 of 67 patients who were included in the study. Aggression ($p = 0.003$), sexual ($p = 0.007$) and religious ($p = 0.023$) obsessions and rituelistic ($p = 0.000$) compulsions were significantly higher in the group with CTQ ≥ 35. Mild correlation was detected between the SPS score and the scores of CTQ. Correlation remained even when the effect of BAS and BDS scores were excluded. At the end of our study, childhood traumas were found to be associated with obsessive symptoms. In the group with childhood trauma, increased suicide probability was detected independently from depression and anxiety.

1. Introduction

In general, child neglect and abuse can be defined as suffering of the child from all kinds of physical, mental, sexual or social aspects and his/her health and safety getting into danger as a result of the actions taken or procrastinated by the people who are responsible for the care, health and protection of child and other adult persons, especially the parents. It is not necessary for the neglect or abuse to be perceived by the child nor is it necessary for the adult to commit it consciously (Turla, 2002).

Physical abuse is being exposed to brute force before 18 years of age by someone who is at least 5 years older or a family member who is 2 years older than him/herself. The person should not perceive this as a domestic conflict like sibling rivalry. Friendship conflicts that do not involve physical contact are not included in that definition (Brown and Anderson, 1991).

Sexual abuse is defined as being exposed to sexual exploitation, at any level from caressing to sexual intercourse, before 18 years of age by a person who is at least 5 years older or a family member who is 2 years older than him/herself (Brown and Anderson, 1991).

Emotional abuse is the exposure of children or adolescents to verbal threats, ridicule, or humiliating comments to the extent that it would threaten their emotional or mental health (Walker et al., 1988).

Neglect is the situation in which the physical care such as nutrition,

safety, education, medical treatment of a child is not taken or his/her emotional needs such as love, support, interest, emotionality, decency, attachment are not met (Walker et al., 1988). The most important point that distinguishes between exploitation and neglect is the fact that exploitation is active and neglect is a passive phenomenon.

It is known that living traumatic events during childhood, when the individual is vulnerable and needs to be protected, may be associated with neurobiological changes and is associated with an increased risk of developing psychiatric disorders in adulthood (Mathews et al., 2008). A positive relationship has been detected between the presence of many psychiatric disorders such as dissociative disorders, anxiety disorder, post-traumatic stress disorder, borderline personality disorder, somatization disorder, antisocial personality disorder, alcohol and substance dependence, depression, conversion disorder, inattentive personality disorder, psychotic disorders and trauma story in childhood (Kivilcim, 2015).

In addition to these disorders, it was shown in some studies that obsessive-compulsive disorder (OCD) which is characterized by ego-dystonic, disturbing, repetitive, anxiety-provoking thoughts (obsessions) that disrupt the social and occupational functioning of the person and repetitive behaviors or mental actions that are performed to reduce the anxiety (compulsions) may be associated with trauma in childhood (Lochner et al., 2002; Carpenter and Chung, 2011). Also, psychological

traumas in childhood may not only cause the emergence of obsessive-compulsive symptoms but also may influence them so that they progress, increase in intensity and/or frequency, and change in terms of content (Demirci, 2016). In the study by Murphy et al. (1988) in a nonclinical sample, they reported that more obsessive-compulsive symptoms were reported in adult women who were exposed to sexual assault during their childhood. In a study conducted on a non-clinical sample in our country, it was reported that there were significant relationships between childhood traumatic experiences, more pronouncedly with emotional traumas, and obsessive-compulsive symptoms (Demirci, 2016). In another study performed on 120 patients who were diagnosed with OCD in our country, it was determined that there was a positive correlation between childhood trauma and obsessive-compulsive symptoms. In the same study, trauma scores in treatment-resistant OCD patients were reported to be higher than those of the other OCD patients (Semiz et al., 2014).

There are also studies examining the relationship between childhood trauma and suicide. In a study on 55,299 people in 21 countries, it was determined that child abuse increased the risks of suicide thought and suicide attempt, and that sexual and physical abuse had the strongest effect on suicidal behavior. Significant correlations were found between childhood traumas and suicidal thoughts and behaviors in the diseases such as depressive disorder (Dias de Mattos Souza et al., 2016) schizophrenia (Hassan et al., 2016), substance abuse (Marshall et al., 2013), bulimia nervosa (Smith et al., 2016). Contrary to popular belief, suicide rates in OCD are increasing in recent years. Dell'Osso et al. (2017) found that the rate of lifelong suicide attempts in OCD was 14.6%. Therefore, it is important to determine the situations that will cause suicide tendency in OCD. In this study, it was aimed to evaluate the relationship between childhood trauma and sociodemographic and clinical features of patients with OCD and secondarily to determine the association of childhood trauma with the probability of suicide in OCD.

2. Method

Sixty-seven patients who met the study criteria out of the patients who were admitted to the Psychiatric Clinic of Malatya Training and Research Hospital between August 2016 and February 2017 and who were diagnosed with OCD according to the DSM-5 criteria and were under follow-up and treatment were included in the study. The research project was approved by the Malatya Clinical Practice Ethics Board and the written informed consents were obtained from the participants. Of the followed up OCD patients, the patients in the age range of 18–65 years who were literate, who were a volunteer to participate in the study were included in the study while the patients with mental retardation, neurological or systemic disease that would affect cognitive function were not included.

2.1. Assessment tools

2.1.1. Sociodemographic data form
It is the question form developed by the researchers to be used in this study to determine the sociodemographic characteristics of the participants.

2.1.2. Yale-Brown Obsessive-Compulsive Scale: Y-BOCS
The Turkish validity and reliability studies of the scale, which was originally developed by Goodman et al. (1989), was conducted in 1993 by Karamustafalioglu et al. (1993) It is a scale which was developed to measure the type and severity of obsessive-compulsive symptoms and it was assessed by the interviewer. It consists of a total of 19 items, but the first 10 items are used to determine the total score. The Y-BOCS total score is the sum of these first 10 items. The first five items indicate us the score of obsessions and the second five items indicates the score of compulsions.

2.1.3. Childhood Trauma Questionnaire (CTQ-28)
It is a five-point Likert-type self-report scale which was developed by Bernstein et al. (1994). The scale which includes 5 subscales namely, emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect are scored from 1 to 5. In the adaptation, validity and reliability studies of the 28-question form of the scale, it was offered as following; for sexual and physical abuse > 5 points, for physical neglect and emotional abuse > 7 points, for emotional neglect > 12 points and as the cut-off score of the total score > 35 points (Sar et al., 2012).

2.1.4. Beck Depression Scale (BDS)
It is a four-point Likert-type self-reporting scale that was developed by Beck (1961) and includes 21 self-assessment sentences. The items are scored from 0 to 3 and the total score ranges between 0 and 63. The validity and reliability studies in our country were carried out by Hisli (1989) and the cut-off score the scale which was adapted to Turkish was determined as 17.

2.1.5. Suicide Probability Scale (SPS)
It is a four-point Likert-type self-assessment scale with 36 items and it was developed by Cull and Gill (1990). Adaptation to Turkish, validity and reliability studies were carried out by Atli et al. (2009). The aim of the scale is to assess suicide risk in adolescents and adults. It includes four subscales namely hopelessness, suicidal ideation, negative self-evaluation and hostility. A different score sum is obtained for each subscale while the sum of all the scores gives the score of general suicide probability. The higher scores obtained from the scale indicate a higher probability of suicide.

2.1.6. Beck anxiety scale (BAS)
It measures the frequency of anxiety symptoms that are experienced by the individual. It is a Likert-type self-assessment scale consisting of 21 items and scored in the range of 0–3. The higher total score indicates the higher anxiety level that is experienced by the person. It was developed by Beck et al. (1988) and its validity and reliability studies were conducted by Ulusoy (1993) in our country.

2.1.7. The methods of measurement, assessment and statistical analysis
The analysis of the data obtained from the patient groups was performed using the "SPSS for Windows 22" statistical package program. The data obtained by counting were expressed as a percentage and the data obtained by measurement were expressed as the arithmetic mean standard deviation. Chi-square test was used to compare categorical data, the independent T-test from the parametric tests was used to compare numerical variables of groups and the relations between parametric numerical variables were examined by Pearson correlation test. In all analyses, the significance level was accepted as 0.95 $(0 < 0.05)$.

3. Results

Out of 67 OCD patients which were included in the study, 31 (46.3%) had CTQ < 35 and 36 (53.7%) patients had CTQ $\geq$ 35 according to CTQ total scores. There was no statistically significant difference between two groups in terms of age, gender, duration of education, age at onset of the disease, BDS, BAS scores. The suicide attempt history $(p = 0.017)$ and the YBOCS Score $(p = 0.034)$ were significantly higher in the group with CTQ $\geq$ 35 compared to the group with CTQ < 35 (Table 1).

Two groups were compared in terms of obsessive-compulsive symptoms. Aggression $(p = 0.003)$, sexual $(p = 0.007)$ and religious $(p = 0.023)$ obsessions (Table 2) and ritualistic $(p = 0.000)$ compulsions (Table 3) were significantly higher in the group with CTQ $\geq$ 35 (Table 3). Two groups were also compared in terms of suicide probability total scores and its subscales' scores. Scores of suicide probability scale $(p = 0.000)$ and the subscales of hopelessness $(p = 0.000)$,