



Frequency and Clinical Impact of Abusive Relationships among Female Patients with Obsessive Compulsive Disorder at Zagazig University Hospitals

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ABSTRACT

Background: Among all mental illnesses, obsessive compulsive disorder (OCD) is the leading cause of disability, thus it's critical to improve knowledge of the disorder's etiology and potential risk factors for future prevention. Preventing abusive relationships can improve the disease's symptomatology and prevent further consequences, particularly suicidal ideation or intent for a higher quality of life. Abusive relationships can also be a trigger for the onset of symptoms of the disorder or worsen preexisting symptoms and maintenance pathophysiology. Therefore, in order to prevent more abuse and its problems in society and improve people's quality of life, we sought to illustrate the effects of abusive relationships (both during childhood and maturity) on the clinical picture and severity of OCD among participants.

Methods: The study was carried out using a descriptive cross-sectional design. The sample had been collected randomly within 2 years (from January 2020 to January 2022) where all female patients diagnosed as OCD according to DSM IV Diagnostic criteria. The study was conducted in Psychiatry Department (inpatient ward and the outpatient clinic) Zagazig University hospitals, Sharkia, Egypt.

Results: 76(89.4%) participants had history of childhood trauma exposure; 36(42.4%) of them had also Intimate partner violence (IPV) exposure. There is a statistically significant relation between exposure to childhood trauma and compliance. All patients without violence had good compliance versus 53.9% of those exposed to childhood trauma.

Conclusion: High frequency of Childhood Trauma among our patients insure that it plays great role in psychopathology of Obsessive Compulsive Disorder.

Keywords: Abusive Relationships; Female; Obsessive Compulsive Disorder.

INTRODUCTION

The hallmarks of obsessive-compulsive disorder (OCD) include persistent, disruptive obsessions and/or compulsions. Usually regarded as unreasonable, obsessions are intrusive, upsetting ideas. Even though intrusive thoughts are nearly universal in the general population, OCD sufferers consider their intrusions to be more serious and distressing. In an attempt to control their obsessions and the detrimental consequences that go along with them, people either engage

in obsessive rituals or routinely avoid situations or stimuli that could trigger the intrusions. The American Psychiatric Association [1] states that OCD sufferers often feel the urge to perform repetitive compulsions, often under strict, strange restrictions; these behaviors are often irrational or performed excessively.

OCD is the leading cause of disability among all mental illnesses, although being relatively rare in the general population (estimates for

its 12-month and lifetime prevalence are 1.2% and 2.3%, respectively) [2].

Many people with obsessive-compulsive disorder attribute the origin of their symptoms to a difficult time in their lives or a specific traumatic event, and they frequently cite psychosocial stress as a contributing reason to their symptoms. Uncertainty surrounds whether stress or trauma is a trigger that exacerbates obsessive-compulsive disorder symptoms in conjunction with other psychiatric symptomatology, a triggering factor that interacts with a preexisting diathesis, or an independent cause of obsessive-compulsive disorder symptoms [3]. Because of this, little is known about the pathophysiological connection between stress and obsessive-compulsive disorder.

There are substantial costs associated with childhood maltreatment, which is defined as emotional, physical, and sexual abuse or emotional and physical neglect, for both the victim and society as a whole [4] and raises the risk of physical illness or mental disorders in adulthood [5].

Prior studies examining how childhood maltreatment contributes to the development of psychopathology have primarily examined mental illnesses like substance use disorder, posttraumatic stress disorder (PTSD), personality disorders, and affective disorders [6]. Additionally, there is some preliminary evidence that child abuse and neglect have an impact on obsessive-compulsive disorder (OCD), however it is conflicting and poor.

Children who witness their fathers harassing their mothers are more likely to use the same aggressive habit that their parents adopted and to pass on violent behavioral patterns to future generations. According to Korkmaz et al. [7], it even encourages "genocide" to be passed down through the generations. Women who grew up witnessing their parents' arguments and who embraced certain patriarchal ideologies are more likely to experience their spouses' violent, hazardous, and cruel actions as adults [8].

Comorbidity (depression and anxiety levels) may act as a mediator in studies that demonstrated a substantial association between CT and OCD severity [9].

Suicidality is a chronic and extremely common comorbidity of OCD, with a prevalence of between 13% to 47% in OCD patients [10]. Even after adjusting for the severity of OCD and/or depression, UOTs and/or RFH were found to be more linked to suicidal risk among OC symptoms [11].

According to Moasheri et al. [8], women who suffer from severe OCD are more likely to experience abuse from their spouses; hence, OCD is a good indicator of violence against women. Obsessive-compulsive disorder may result in low self-esteem, elevated anxiety, incompatibility (which diminishes decision-making power), difficulty resolving issues, and interruptions in women's social performance, all of which enhance their susceptibility to violence. However, the physical, mental, and social performance of women is negatively impacted by partner violence. Due to the high expense and lengthy treatment process, physical and mental issues may go untreated, which raises the possibility of psychiatric disorders and aggression. Women's OCD can both contribute to and result from abuse.

METHODS

A descriptive cross-sectional design was used to conduct the study. All of the female patients in this group, who were randomly selected between January 2020 and January 2022, have been diagnosed with obsessive compulsive disorder based on the DSM IV diagnostic criteria. This study included 85 female patients with obsessive compulsive disorder as their primary diagnosis (the reason for seeking medical advice). The study was carried out at Zagazig University Hospitals in Sharkia, Egypt, in the Psychiatry Department (inpatient ward and outpatient clinic). Each patient's assessment took roughly two hours.

Approval was obtained from the Institutional Review Board (IRB Number 5477-10/7/2019) and Psychiatry Department, Zagazig University. After discussing the purpose of the study with the participants, written informed consents were obtained.

Inclusion Criteria:

- The DSM-IV criteria for obsessive compulsive disorder should be met by the patients.
- Only female patients will be covered.

- The age will be between 18 and 60.
- When OCD was the primary disorder for which treatment was sought, participants with other comorbid mental diagnoses were also included.

Exclusion Criteria:

- Individuals having a history of mental retardation, bipolar disorder, personality disorders, alcohol/substance use problems, schizophrenia, or any psychotic disorder.
- Individuals having a history of neurological conditions, head injuries, or a major coexisting medical condition that may be related to psychiatric disorders or functional disabilities (e.g., cancer, renal failure, ischemic heart disease, cardiac failure, epilepsy, etc.) were not included.

A comprehensive psychiatric evaluation was conducted on each patient using semi-structured interviews, as well as the patient's medical history as HTN/DM, clinical characteristics of the disorder (age of onset, duration, course of OCD, history of prior hospitalization, history of suicide, history of previous psychological or psychopharmacological treatment, compliance on treatment, and family history of psychiatric disorders), and other factors. A comprehensive psychiatric sheet included in the semi-structured interview enabled each patient to acquire a psychiatric diagnosis by the end of the session, during which the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IV) criteria were used to confirm the diagnosis of OCD [12].

The following Psychometric Scales were administered:

A. The Structured Clinical Interview for DSM-IV (SCID-I) (Arabic version):

To ascertain whether particular symptoms are present that permit diagnosis in accordance with DSM-IV criteria, the SCID-I was used, which consists of a standard set of questions. The SCID is primarily used for research, diagnostic evaluation, and mental health professional training. According to First and Gibbon [13], it evaluates thirty-three of the more prevalent mental illnesses listed in the Diagnostic and Statistical Manual (DSM-IV), fourth edition, of the American Psychiatric Association's Axis I disorders.

Prior research at the Institute of Psychiatry, Ain Shams University, translated and validated the Arabic version of the SCID-I used in this study [14].

B. Yale–Brown Obsessive Compulsive Scale (YBOCS) (Arabic version)

It divided OCD symptoms into two categories: reactive (doubt, hoarding, and contamination) and autogenic (aggression, religion, and sexuality).

Severity rating scale is a test that rates the severity of obsessive-compulsive disorder (OCD) symptoms [15]. Each item on the 10-item self-rating scale is rated from 0 (no symptoms) to 4 (severe symptoms), for a total possible score range of 0 to 40. The scale asks about the patient's resistance and control over these ideas, how much time they spend on obsessions, and how much impairment or distress they experience. Compulsions are also subjected to the same kinds of questions (e.g., interference, time spent, etc.). Based on the overall score, the results can be interpreted as follows: sub-clinical for scores 0–7, mild for scores 8–15, moderate for scores 16–23, severe for scores 24–31, and extreme for scores 32–40.

Individuals with mild or higher scores are probably having a major detrimental effect on their quality of life and have to think about getting professional assistance to reduce their obsessive-compulsive symptoms.

C. The Hamilton Depression Rating Scale (HDRS) (Arabic version)

Using a clinician-rated scale, adults' depression symptoms are measured for intensity and change during a 20–30 minute period. The most popular depression diagnostic tool used by clinicians is the HDRS, sometimes referred to as the Ham-D. 17 items (HDRS17) related to depressive symptoms throughout the previous week are included in the original form. The HDRS's focus on depressing and physical symptoms of depression stems from its initial development for hospital inpatients. Each edition has a different scoring methodology. A score of 0–7 on the HDRS17 is generally seen as being within the normal range (or in clinical remission), while admittance to a clinical trial usually requires a score of 20 or

higher (indicating at least severe severity). [16].

D. The Conflict Tactics scale (CTS) (Arabic version):

The Revised Conflict Tactics Scale (CTS2), developed by Straus et al. [17], was used to measure IPV. The CTS2 is a 36-item self-report tool that assesses how much a couple who are dating, living together, or married attacks one another physically and psychologically, as well as how they resolve disagreements over the course of the last 12 months by using negotiation or reasoning.

The two components of relationship abuse—physical harm from attacks and sexual coercion—are also examined by the measure. There are minor and severe subscales for psychological hostility and physical assault.

The six-item negotiation scale describes the steps done to resolve a dispute amicably through dialogue. There are three emotional and cognitive components on this measure. Examples of conversation foci include cognitive elements, such as the proposal of a compromise in a dispute.

By requesting expressions of care and respect for the e.g., emotional items gauge the degree to which positive affect is conveyed. "Despite our disagreements, I showed my partner that I cared."

Psychological aggression is the employment of both spoken and unspoken actions that have the impact of controlling or criticizing the partner. A partner being insulted or cursed at are examples of light psychological aggression (4 items), while trashing a possession or threatening to strike a partner are examples of severe psychological aggression (4 things).

Physical assault explains the particular behaviors that fall under the category of physical violence. Pushing or slapping are examples of minor physical assault (5 items), whereas beating, kicking, burning, or using a gun or knife on a partner are examples of serious physical assault (7 items).

Physical injury consists of three sexual assault items and seven other items.

The CTS has been used previously in the Arabic culture [18]. Only slight variations between the two translations were found when the Arabic-translated version of the

instrument was employed after translation and back translation. To guarantee consistency between the Arabic and English versions of the tool, this Arabic version was then presented to a panel of four bilingual and bicultural Arabic researchers. The CTS2 is scored using the same guidelines as the CTS1 [17].

The reference period for each method is the preceding 12 months, and the response options vary from "0=never" to "6=more than 20 times." Prevalence is the proportion of people who report at least one instance of the behavior in question. A behavior's "chronicity" is the frequency with which it occurs among those who record at least one occurrence of it. The reliability of the scale used in this investigation was judged sufficient with a Cronbach's alpha coefficient of 0.95 [18].

E. The Columbia Suicide Severity Rating Scale (C-SSRS) (Arabic version):

The instrument has shown strong convergent, divergent, and predictive validity, sensitivity to change, and sensitivity and specificity. It was created to differentiate between suicidal ideation and behavior and measures suicidality through four constructs: lethality, suicidal behavior, severity of ideation, and intensity of ideation. The outcomes listed below fall within C-SSRS categories and have yes/no binary answers. To make it easier to define the composite and comparative endpoints and to present the results clearly, the categories have been rearranged from the original scale.

Wishing to die is Category 1; non-specific active suicidal thoughts are Category 2; and active suicidal ideation using any method (not planned) without intending to act is Category 3. Active suicidal ideation with some intent to act, without a specific plan, falls under category four. Active suicidal ideation with a specific plan and intent falls under category five. Preparatory acts or behavior falls under category six. Aborted attempts, interrupted attempts, actual attempts (non-fatal), and completed suicide fall under category nine.

Although unrelated to suicide, self-harming activity without suicidal intent is also a C-SSRS outcome with a yes/no binary response. A numerical score obtained from the C-SSRS

categories is the result that follows. The score, which is used to determine therapy emergence, is generated for each patient at each evaluation. The highest suicidal ideation category (1–5 on the CSSRS) that was present during the evaluation is known as the Suicidal Ideation Score. If there is no ideation, give it a score of 0.

Endpoints:

Composite endpoints based on the above categories are defined below:

- Suicidal ideation: A "yes" response to any one of the five C-SSRS suicidal ideation items (Categories 1–5) at any point during therapy.

- Suicidal behavior: A "yes" response to any one of the five C-SSRS suicidal behavior questions (Categories 6-10) at any point during treatment.

- Suicidal ideation or behavior: A "yes" response to any one of the C-SSRS's ten suicidal ideation and behavior items (Categories 1–10) at any point during treatment.

F. Adverse Childhood Experiences International Questionnaire (ACE-IQ) (Arabic version):

The ACE-IQ, an international questionnaire for adverse childhood experience, was created to gauge adverse childhood experiences. The scale has forty-three items. The World Health Organization's (2009) model of adverse childhood experiences served as the basis for the scale's development.

The questionnaire is divided into seven sections.

- Section A (0) asked about demographics, including age, sex, education level, marital status, civic engagement, and employment status during the previous 12 months.
- Section B (1) was a five-item survey with a yes-or-no response format that asked questions about marriage.
- Section C: (2) The five items asked about the relationship with parents or guardians. The first two items had five likert response formats, ranging from never (1) to always (5), while the latter three items had four progressing

response formats, ranging from never (1) to many times (4).

- Section D: The 16 items asked questions on the family environment. The first five items had a yes-or-no response format, while the remaining eleven had a 4-point Likert scale that ranged from never (1) to many times (4).
- Section E (6) included three items on peer aggression, the first two of which had a seven-point Likert scale and the third question had a four-point graduated response structure.
- Section F (7): used a 3-item, 4-likert response structure with responses ranging from never (1) to many times (4) to measure seeing community violence.
- Section G (8): Four items in asked about exposure to war and collective violence, with response styles ranging from never (1) to many times (4) [19].

One or no parents, parental separation or divorce, emotional neglect, physical neglect, bullying, community violence, collective violence, living with substance-abusing household members, living with mentally ill or suicidal household members, living with imprisoned household members, emotional abuse, physical abuse, sexual abuse, and bullying are the 13 categories into which the ACE-IQ questions about childhood experiences have been divided.

Verify the participant's responses to determine the ACE score using the binary version: A yes response should be circled and a 1 should be entered in the last column if the participant gave an affirmative response, whether once, many times, or numerous times. After finishing, you will receive a response from 0 to 13.

This is that person's ACE (binary) score. After that, the ACE score was divided into exposure categories of 0, 1, 2, and ≥ 3 . It took about 20 to 30 minutes for each participant to finish the surveys. In order to accommodate cultural differences in the Kingdom of Saudi Arabia (KSA), the questionnaire was translated into Arabic, then back translated into English [20].

Statistical analysis

The data was analyzed using SPSS version 26, known as the statistical tool for the social sciences. Based on their absolute frequencies, categorical variables were compared and described using the chi square test. Ordinal data between two groups was examined using the chi square trend test.

RESULTS

The mean age of the 85 female OCD patients in this study was 32 ± 18 years, and their ages ranged from 18 to 60. 42.4% were housewives, and almost 55% had a modest degree of education. 54.1% were from rural areas, 96.5% were Muslims, and almost 53% were married. 51.8% of them had a positive family history of mental illnesses, and none of them smoked or used drugs (Table 1).

Our patients' OCD began between the ages of 8 and 35 and persisted for one to twenty years. Only 15.3% of our patients had a history of hospitalization, 21% had a positive medical history (such as HTN, DM, etc.), and the majority of patients (75.3%) had chronic courses, while more than half (58.8%) had high compliance with therapy. (Table 2).

When asked if they had ever been exposed to violence, 76 (89.4%) of the individuals reported having experienced childhood trauma, and 36 (42.4%) also reported having experienced intimate partner abuse. Of our female OCD patients exposed to IPV, 39 (45.95%) had no prior experience of childhood trauma, while just 3 (3.5%) did. (Table 3).

Eighty-nine percent of the 76 female OCD patients had previously been exposed to childhood trauma. Patients most frequently reported experiencing physical abuse, emotional neglect, or witnessing aggressive treatment of a household member (51.3%), 46.1%, and 43.4%, respectively. Sexual contact, bullying, mental and physical abuse,

and community and collective violence were recorded in 19.7%, 39.5%, 27.6%, 32.9%, 35.5%, and 11.8% of cases, respectively. Among the instances of collective violence were: parental divorce or separation; incarcerated family members; drug or alcohol abusers; and members who were mentally ill or chronically unhappy. The majority of our patients have experienced multiple forms of childhood trauma (Table 4).

Negotiation, physical abuse and psychological abuse, were very high—84.6%, 76.9%, and 69.2%, in that order. Sexual and physical injuries were recorded in 7.7% and 30.8% of cases, respectively. Some patients have experienced multiple forms of violence from intimate partners (Table 5). Severe HDRS was reported in 82.4% of studied patients (Table 6).

The relationship between compliance and exposure to childhood trauma is statistically significant. Compared to 53.9% of patients who had childhood trauma, all patients who did not experience violence exhibited good compliance. The age at which OCD first appears, the length of the illness, a patient's medical history, or the progression of OCD are all statistically unrelated to exposure to childhood trauma (Table 7).

Among all patients, the most often reported symptoms were doubt and aggression (79.2% and 72.9% respectively). Religious, sexual, symmetry, hoarding and contamination were reported in 40%, 20%, 10.6%, 17.6%, and 44.7% respectively. Severe YBOCS was reported in 68.2% of patients (Table 1S).

According to Table 2S, approximately 42.3% of people had no concept or desire to commit suicide, 30.6% had death wishes, 17.6% had nonspecific active thoughts, and 3.5% actually attempted suicide.

Table (1): Distribution of studied patients according to socio-demographic data

Items	n=85	%
Age (year) (Mean± SD)	32.18 ± 9.24	18 – 60 (Range)
≤40 years	73	85.9%
>40 years	12	14.1%
Education:		
Illiterate	0	0%
primary/middle	9	10.6%
High school(secondary/deplom)	47	55.3%
Higher	29	34.1%
Occupation:		
Housewife	36	42.4%
Worker	9	10.6%
Student	17	20%
Employee	15	17.6%
Specialist (high education)	8	9.4%
Marital status:		
Single	31	36.5%
Married	45	52.9%
Divorced	6	7.1%
Widowed	3	3.5%
Religions		
Muslim	82	96.5%
Christian	3	3.5%
Residence:		
Rural	46	54.1%
Urban	39	45.9%
Family history of psychiatric disorders:		
Negative	41	48.2%
Positive	44	51.8%
Smoking/substance		
No	85	100%
Yes	0	0%

Table (2): Distribution of studied patients according to Obsessive compulsive disorder-specific data

Items	n =85	
Age of onset (year)		
Mean ±SD	20.6 ± 6.93	8 – 35 (Range)
Duration (year)		
Mean ±SD	11.93 ± 6.73	1 – 20 (Range)
Course		
Episodic	21	24.7%
Chronic	64	75.3%
Compliance:		
Poor	35	41.2%
Good	50	58.8%
Hospitalization:		

Items	n =85	
No	72	84.7%
Yes	13	15.3%
Medical history:		
Negative	67	78.8%
Positive	18	21.2%

Table (3): Distribution of studied patients according to history of violence exposure

Violence	n =85	%
No	6	7.1%
Childhood trauma (CT)	76	89.4%
Intimate Partner Violence (IPV)	39	45.9%
Combined CT and IPV	36	42.3%

Table (4): Distribution of studied patients according to childhood trauma questionnaire (n =76)

Subtypes	No		Yes	
	n	%	n	%
Emotional neglect	31	(53.9%)	35	(46.1%)
Physical neglect	61	(80.3%)	15	(19.7%)
Household member treated violently	40	(56.6%)	36	(43.4%)
Emotional abuse	46	(60.5%)	30	(39.5%)
Physical abuse	37	(48.7%)	39	(51.3%)
Sexual contact	55	(72.4%)	21	(27.6%)
Bullying	51	(67.1%)	25	(32.9%)
Community violence	49	(64.5%)	27	(35.5%)
Collective violence	68	(88.2%)	9	(11.8%)

Table (5): Distribution of studied patients according to Straus’s Conflict Tactics Scale (intimate partner violence) (n =39)

Subtypes	No	Yes
Negotiation	6 (15.4%)	33 (84.6%)
Psychological abuse	12 (30.8%)	27 (69.2%)
Physical abuse	9 (23.1%)	30 (76.9%)
Physical injury	27 (69.2%)	12 (30.8%)
Sexual injury	36 (92.3%)	3 (7.7%)

Table (6): Distribution of studied patients according to severity of associated depression: (n =85)

HDR-S total score	n	%
No	0	0%
Mild	0	0%
Moderate	15	17.6%
Severe	70	82.4%

HDRS: Hamilton depression rating scale

Table (7): Relation between exposure to childhood trauma and obsessive compulsive disorder-specific data

Items	No	Childhood trauma	χ^2	p
	n =6	n =76		

Items	No	Childhood trauma	χ^2	p
Age of onset (year) Mean \pm SD	25 \pm 5.48	20.12 \pm 7.04	1.656	0.102
Duration (year) Mean \pm SD	12 \pm 3.46	12.08 \pm 7.02	-0.027	0.978
Medical history: Negative Positive	6(100%) 0(0%)	61 (80.3%) 15 (19.7%)	Fisher	0.356
Course Episodic Chronic	3(50%) 3(50%)	18 (23.7%) 58 (76.3%)	Fisher	0.33
Compliance: Poor Good	0(0%) 6(100%)	35 (46.1%) 41 (53.9%)	Fisher	0.035*
Hospitalization: No Yes	6(100%) 0 (0%)	65 (85.5%) 11 (14.5%)	Fisher	0.591

χ^2 Chi square test **p \leq 0.001 is statistically highly significant *p<0.05 is statistically significant

DISCUSSION

In addition to raising the risk of physical illness [5] or mental disorders in adulthood, childhood maltreatment—which includes emotional, physical, and sexual abuse as well as emotional and physical neglect—is associated with substantial costs for the individual and society [4].

Additionally, there is some preliminary evidence that obsessive-compulsive disorder (OCD) is influenced by child abuse and neglect, however this evidence is conflicting and restricted [6].

85 female patients with an OCD diagnosis based on the Structured Clinical Interview for DSM-IV were chosen at random from the inpatient ward and outpatient clinic at Zagazig University Hospitals over the course of two years to participate in our study. Prevalence rates of childhood abuse were greater among OCD patients than among controls in most previous research [21, 22]. and our findings are consistent with the high prevalence of childhood trauma among participants (76 female OCD patients, or 89%), many of whom experienced multiple forms of trauma.

Additionally, according to a 2020 study by Boger et al. [23] Most people who had experienced childhood trauma reported many subtypes, and almost two thirds of the OCD group reported experiencing abuse and neglect of some kind. 60% of adults have been shown

to have experienced childhood trauma, and rates in clinical samples can reach 80% to 90%. [24].

However, other research with large sample sizes and sufficient power [25] did not discover increased prevalence rates for childhood trauma of any kind in OCD patients. 210 OCD cases from university treatment centers made up Grabe et al. [26] sample, which they compared to 133 age- and sex-matched controls from the adult general population (this is a larger sample than ours, and it includes both sexes, however we only included females in our study). They discovered that severe traumatization occurred in 8.3% of the controls and 6.2% of the OCD cases. There was no difference in the lifetime prevalence rates of acute stress disorder, PTSD, or traumatization between OCD and control patients (p > 0.05).

Physical abuse, emotional neglect and watching household member treated violently were the most common among (near half) of our patients, 51.3%, 46.1%, and 43.3%, respectively. These findings are consistent with findings by Boger et al. [23] that emotional neglect (76.5%) and emotional abuse (55.7%) were the most common, as well as elevated levels of emotional abuse and/or emotional neglect among OCD patients found by Hemmings et al. [22].

Sexual abuse was reported in roughly one-quarter (24.7%) of our sample; it wasn't a higher percentage, but it was still regarded as high. This is consistent with the finding that some studies [21, 27] found higher rates of sexual abuse among OCD patients, while other studies [27, 28] did not report it. Not all research, meanwhile, has made a distinction between the different kinds.

Compared to our data and earlier findings, the Kart et al. [24] study found that 97.5% of OCD patients experienced physical neglect and 55.6% of the patients claimed childhood trauma. The socioeconomic backgrounds of the study participants, who were drawn from a nearby government hospital, might be lower than those of the people in earlier research. The potential influence of cultural differences on these outcomes must also be taken into account.

According to research on the connections between OCD and CT types, all CT types are linked to OCD, and the magnitude of their effects is quite close [29].

A relevant clinical topic is whether OCD patients who do not improve with gold-standard therapies like exposure and response prevention should have their early traumatic experiences addressed. One of the most enduring forms of psychopathology is OCD [30].

Clarifying the function of early traumatic experiences in OCD is important because there may be clinical consequences if there is a correlation between the severity of OCD and childhood trauma. According to some research, OCD sufferers are more likely than healthy controls to get CT scans [3, 28], and many CT scans have been found to increase adult OCD by almost five times [31].

Despite the high prevalence of contamination obsessions and doubts among OCD patients with childhood trauma in our study, these symptoms were similarly strong among those who were not exposed, and there was no discernible difference between the two groups. However, there was a statistically significant difference in aggression between the two groups, which is in line with research by Ay and Erbay [32] that identified a correlation between higher CT scores in a group of OCD patients.

Even though the majority of OCD patients in our study (OCD with CT) reported severe levels of OCD symptoms, including obsessions and compulsions, we found no statistically significant relationship between exposure to childhood trauma and the age at which OCD onset occurred, the duration of the disease, the course of OCD, or even its severity. This is because even the majority of those without violence experienced severe OCD symptoms. Similar to our findings, several research involving OCD patients have not discovered a connection between the severity of OCD and the degree of maltreatment experienced as a kid [30, 33].

Additionally, Kart and Türkçapar's [24] study indicated that there was no significant difference in the severity of OCD symptoms, obsession, or compulsion scores between the OCD with and without CT groups, with the exception of violent obsessions, which were significantly more prevalent in the OCD with CT group. Aggressive obsessions were linked to scores for BDI, BAI, and childhood emotional maltreatment. When considering BDI and BAI scores, there were no statistically significant mediator effects of depression and anxiety characteristics on the relationship between violent obsessions and early emotional abuse.

But in Miller and Brock's study [29], trauma exposure was associated with the severity of compulsions but not with the severity of obsessions (2017) meta-analysis, which included all OCD and all OCD spectrum disorders. This could account for the discrepancy between their findings and ours. Additionally, Childhood trauma, specifically sexual, physical, and emotional abuse as well as emotional neglect, was linked to increased OCD symptom severity in a study involving 120 OCD patients [34].

According to Kadivari et al. [9], CM was significantly correlated with depressed symptoms, OCD severity, OC symptoms, and BIS ($p < 0.01$). Significant relationships ($p < 0.01$) were found between BIS and depressed symptoms, OCD severity, and OC symptoms. Mathews et al. [35] observed that 938 students reported that childhood trauma could have a direct or indirect impact on OCD symptoms. In a general population sample [36]

and two sizable college student samples [37], higher levels of childhood abuse were linked to more severe OCD symptoms.

Furthermore, Boger et al. [23] found a favorable correlation between higher levels of abuse and the severity of OCD symptoms. Crucially, this association persisted even after adjusting for PTSD, anxiety, and depression. Demirci's study of 201 college students revealed that those with high childhood trauma scores also had higher levels of obsessive-compulsive symptoms [38].

Conclusions

Our patients' high prevalence of childhood trauma ensures that it has a significant impact on the psychopathology of obsessive-compulsive disorder.

Conflict of interest

The authors declared that they have no conflicts of interest with respect to authorship and/or publication of this article.

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REFERENCES

1. American Psychiatric Association DS, American Psychiatric Association DS. Diagnostic and statistical manual of mental disorders: DSM-5. Washington, DC: APA, 2013 May 22.
2. Ruscio AM, Stein DJ, Chiu WT, Kessler RC. The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Mol Psychiatry*. 2010 Jan;15(1):53-63.
3. Adams TG, Kelmendi B, Brake CA, Gruner P, Badour CL, Pittenger C. The role of stress in the pathogenesis and maintenance of obsessive-compulsive disorder. *Chronic Stress*. 2018 Feb;2:2470547018758043.
4. Magruder KM, McLaughlin KA, Elmore Borbon DL. Trauma is a public health issue. *Eur J Psychotraumatol*. 2017 Jan 1;8(1):1375338.
5. Clemens V, Huber-Lang M, Plener PL, Brähler E, Brown RC, Fegert JM. Association of child maltreatment subtypes and long-term physical health in a German representative sample. *Eur J Psychotraumatol*. 2018 Jan 1;9(1):1510278.
6. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med*. 2012 Nov 27;9(11):e1001349.
7. Korkmaz S, Korucu T, Yildiz S, Kaya S, Izei F, Atmaca M. Frequency of domestic violence in psychiatric patients and related factors. *Dusunen*

- Adam J. *Psychiatry Neurol. Sci.* 2016;29(4):359.
8. Moasheri BN, Sharifzadeh G, Sharifi M, Ansarifard F, Abolhasannezhad V. Relationship Between Spouse Abuse and Obsessive-Compulsive Disorder and Predictors of Domestic Violence in Women Visiting Comprehensive Urban Health Service Centers in Birjand. *HTA*. 2021 Aug 1.
9. Kadivari F, Najafi M, Khosravani V. Childhood adversity affects symptomatology via behavioral inhibition in patients with obsessive-compulsive disorder. *Curr. Psychol*. 2023 Jun;42(16):13560-70.
10. Pellegrini L, Maietti E, Rucci P, Casadei G, Maina G, Fineberg NA, et al. Suicide attempts and suicidal ideation in patients with obsessive-compulsive disorder: A systematic review and meta-analysis. *J. Affect. Disord*. 2020 Nov 1;276:1001-21.
11. Krebs G, Mataix-Cols D, Rijdsdijk F, Rück C, Lichtenstein P, Lundström S, et al. Concurrent and prospective associations of obsessive-compulsive symptoms with suicidality in young adults: A genetically-informative study. *J. Affect. Disord*. 2021 Feb 15;281:422-30.
12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Text revision. 2000.
13. First MB, Gibbon M. The structured clinical interview for DSM-IV axis I disorders (SCID-I) and the structured clinical interview for DSM-IV axis II disorders (SCID-II). 2004.
14. El Missiry A, Sorour A, Sadek A, Fahy T, Abdel Mawgoud M, Asaad T. Homicide and psychiatric illness: an Egyptian study [MD thesis]. Cairo: Faculty of Medicine, ASU. 2003.
15. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, et al. The Yale-Brown obsessive compulsive scale: I. Development, use, and reliability. *Arch Gen Psychiatry*. 1989 Nov 1;46(11):1006-11.
16. Hamilton MA. Development of a rating scale for primary depressive illness. *Br J Soc Clin Psychol*. 1967 Dec;6(4):278-96.
17. Straus MA, Hamby SL, Boney-McCoy SU, Sugarman DB. The revised conflict tactics scales (CTS2) development and preliminary psychometric data. *J. Fam. Issues*. 1996 May;17(3):283-316.
18. Haj-Yahia MM. Wife abuse and battering in the sociocultural context of Arab society. *Fam. Process*. 2000 Jun;39(2):237-55.
19. Kazeem, O. T. A validation of the adverse childhood experiences scale in Nigeria. *Res on Humanities SocSci*, 2015, 5, 18-23.
20. Almuneef, M., Qayad, M., Aleissa, M., & Albuhairan, F. Adverse childhood experiences, chronic diseases, and risky health behaviors in Saudi Arabian adults: a pilot study. *Child abuse & neglect*, 2014, 38(11), 1787-1793.

21. Grisham JR, Fullana MA, Mataix-Cols D, Moffitt TE, Caspi A, Poulton R. Risk factors prospectively associated with adult obsessive-compulsive symptom dimensions and obsessive-compulsive disorder. *Psychol. Med.* 2011 Dec;41(12):2495-506.
22. Hemmings SM, Lochner C, van der Merwe L, Cath DC, Seedat S, Stein DJ. BDNF Val66Met modifies the risk of childhood trauma on obsessive-compulsive disorder. *J. Psychiatr. Res.* 2013 Dec 1;47(12):1857-63.
23. Boger S, Ehring T, Berberich G, Werner GG. Impact of childhood maltreatment on obsessive-compulsive disorder symptom severity and treatment outcome. *Eur J Psychotraumatol.* 2020 Dec 31;11(1):1753942.
24. Kart A, Türkçapar H. The effects of childhood emotional abuse on aggressive obsessions among patients with obsessive compulsive disorder may be mediated by symptoms of depression and anxiety. *J Clin Psychopharmacol.* 2019 Oct 2;29(4):411-7.
25. Voderholzer U, Schwartz C, Thiel N, Kuelz AK, Hartmann A, Scheidt CE, et al. A comparison of schemas, schema modes and childhood traumas in obsessive-compulsive disorder, chronic pain
- 31.
32. Park S, Hong JP, Bae JN, Cho SJ, Lee DW, Lee JY, et al. Impact of childhood exposure to psychological trauma on the risk of psychiatric disorders and somatic discomfort: Single vs. multiple types of psychological trauma. *Psychiatry Res.*, 2014 Nov 30;219(3):443-9.
33. Ay R, Erbay LG. Relationship between childhood trauma and suicide probability in obsessive-compulsive disorder. *Psychiatry Res.* 2018; 261:132-6. PMID: 29304426
34. Bey K, Lennertz L, Riesel A, Klawohn J, Kaufmann C, Heinzl S, et al. Harm avoidance and childhood adversities in patients with obsessive-compulsive disorder and their unaffected first-degree relatives. *Acta Psychiatr. Scand.* 2017 Apr;135(4):328-38.
35. Semiz UB, Inanc L, Bezgin CH. Are trauma and dissociation related to treatment resistance in patients with obsessive-compulsive disorder? disorder and eating disorders. *Psychopathol.* 2013 May 16;47(1):24-31.
26. Grabe HJ, Ruhrmann S, Spitzer C, Josepeit J, Ettelt S, Buhtz F, et al. Obsessive-compulsive disorder and posttraumatic stress disorder. *Psychopathol.* 2007 Dec 5;41(2):129-34.
27. Caspi A, Vishne T, Sasson Y, Gross R, Livne A, Zohar J. Relationship between childhood sexual abuse and obsessive-compulsive disorder: case control study. *Isr. J. Psychiatry Relat. Sci.* 2008 Jul 1;45(3):177.
28. Carpenter L, Chung MC. Childhood trauma in obsessive compulsive disorder: The roles of alexithymia and attachment. *Psychology and Psychotherapy: Theory Res. Pract.* 2011 Dec;84(4):367-88.
29. Miller ML, Brock RL. The effect of trauma on the severity of obsessive-compulsive spectrum symptoms: a meta-analysis. *J Anxiety Disord.* 2017; 47: 29–44.
30. Visser HA, van Minnen A, van Megen H, Eikelenboom M, Hoogendoorn AW, Kaarsemaker M, et al. The relationship between adverse childhood experiences and symptom severity, chronicity, and comorbidity in patients with obsessive-compulsive disorder. *J. Clin. Psychiatry.* 2014 Jun 24;75(10):17275. *Soc Psychiatry Psychiatr Epidemiol.* 2014 Aug;49:1287-96.
36. Mathews CA, Kaur N, Stein MB. Childhood trauma and obsessive-compulsive symptoms. *Depress. Anxiety.* 2008 Sep;25(9):742-51.
37. Briggs ES, Price IR. The relationship between adverse childhood experience and obsessive-compulsive symptoms and beliefs: the role of anxiety, depression, and experiential avoidance. *J. Anxiety Disord.* 2009 Dec 1;23(8):1037-46.
38. Kroska EB, Miller ML, Roche AI, Kroska SK, O'Hara MW. Effects of traumatic experiences on obsessive-compulsive and internalizing symptoms: The role of avoidance and mindfulness. *J. Affect. Disord.* 2018 Jan 1;225:326-36.
39. Demirci K. The investigation of relationship between childhood trauma and obsessive-compulsive symptoms. *J Psychiatry Behav Sci.* 2016;6(1):7.

Citation

Elsafy, E., El_Masry, N., Fouad, A., Mohamed, A., Abdelsalam, H. Frequency and Clinical Impact of Abusive Relationships among Female Patients with Obsessive Compulsive Disorder at Zagazig University Hospitals. *Zagazig University Medical Journal*, 2025; (1458-1469): -. doi: 10.21608/zumj.2025.354686.3808