



CLINICAL PROFILE OF DEPRESSIVE DISORDERS AMONG ADULT WITH HISTORY OF CHILDHOOD ABUSE

Mohamed Ahmed Gamal Mady Abouelazayem¹, Haydy Hassan Sayed Ahmed², Omnia Ibrahim Youssef³, Ashraf Mohamed Mohamed Ali El-Tantawy^{4*}

Article History: Received: 05.06.2023

Revised: 10.05.2023

Accepted: 15.05.2023

Abstract

Background: Mental disorders are one of the most common disorders in the world and mental health is a major concern of public health in today society.

Aim and objectives: To identify the relationship between history of childhood abuse and clinical profile of depressive disorders at adulthood in an Egyptian sample.

Patients and methods: This was case control study conducted on 110 patients who had depressive disorders at the psychiatry outpatient clinic Suez Canal University Hospitals. Patients were divided into two groups: Group A: 55 Patients diagnosed with depressive disorders and history of childhood abuse and Group B: 55 Patients diagnosed with depressive disorders without history of childhood abuse (control group).

Results: Emotional abuse in group A was statically significantly higher than in group B ($p < 0.001$). Physical abuse in group A was statically significantly higher than in group B ($p < 0.001$). Sexual abuse in group A was statically significantly higher than in group B ($p < 0.001$). Emotional neglect in group A was statically significantly higher than in group B ($p < 0.001$). And physical neglect in group A was statically significantly higher than in group B ($p < 0.001$).

Conclusion: Adults with history of childhood abuse either are more likely to have worse clinical profile of depressive disorders during their adulthood than adults without.

Key words: Clinical profile of depressive disorders, adult, childhood abuse

1Department of Psychiatry and Neurology, Faculty of Medicine- Suez Canal University

*Corresponding author: Mohamed Ahmed Gamal Mady Abouelazayem E-mail: maboelazayem@hotmail.com

DOI: 10.53555/ecb/2023.12.12.327

Introduction

Mental disorders are one of the most common disorders in the world and mental health is a major concern of public health in today society. Mental disorders affect a significant number of population's worldwide⁽¹⁾.

Depression is the leading cause of mental health related disease burden globally, affecting an estimated 300 million people worldwide. Depression prevents people from reaching their full potential, impairs human capital, and is associated with premature mortality from suicide and other illnesses⁽²⁾.

The rate of recurrence may be even higher in individuals who experience more persistent depressive episodes and in those who have a poor treatment outcome with residual sub threshold symptoms. Because of the large health impact and economic burden associated with a poor longitudinal course of depressive illness, it is important to identify factors that predict risk of developing recurrent and persistent depressive episodes and lack of remission or response during treatment for depression⁽³⁾.

A strong relationship between gender, behaviour problems, stressful events, exposure to physical & sexual abuse, cigarette smoking, alcohol use, and depression was well documented in many international studies⁽⁴⁾.

The relationship between early trauma and depression is often seen as central to the emergence of mental health issues. It is considered as a link between an external event and its consequences on the new psychic reality of the person. Early trauma is thought to have a global impact on the person's psychic pattern and is the main cause of cognitive, behavioral, emotional and somatic emotional problems⁽⁵⁾.

In Egypt, According to Mansour et al. the prevalence of child abuse in 963 cases study is: Physical neglect (44%), Emotional neglect (19%), and Sexual abuse (13%) Emotional abuse (8.9%) and Physical abuse (6%)⁽⁶⁾.

The aim of this study was to identify the relationship between history of childhood abuse and clinical profile of depressive disorders at adulthood in an Egyptian sample, describe the difference in clinical profile of depressive disorders between adults with childhood abuse and adult without, also to assess

relationship between history of childhood abuse and the clinical profile of depressive disorders at adulthood.

Patients and methods

This was Case control study conducted on 110 patients who had depressive disorders at the psychiatry outpatient clinic Suez Canal University Hospitals. Patients were divided into two groups: Group A: 55 Patients diagnosed with depressive disorders and history of childhood abuse and Group B: 55 Patients diagnosed with depressive disorders without history of childhood abuse (control group).

Sampling technique

Simple random sampling of all adults attended the outpatient clinic with any depressive disorder.

Inclusion criteria

All patients with any depressive disorder, age between 18-50 years and both Gender

Exclusion criteria

Patients with mental retardation, Patients with Intellectual Impairment, Patients with organic brain disorders and Patients with Sever medical diseases.

Sampling

The sample size was calculated using the following formula:

$$n = \left[\frac{Z_{\alpha/2} + Z_{\beta}}{P_1 - P_2} \right]^2 (p_1 q_1 + p_2 q_2)$$

Dawson and Trapp, (7).

Where:

n= sample size

$Z_{\alpha/2} = 1.96$ (The critical value that divides the central 95% of the Z distribution from the 5% in the tail)

$Z_{\beta} = 0.84$ (The critical value that separates the lower 20% of the Z distribution from the upper 80%)

p_1 = Prevalence of depression in child abuse group=39.3% (8).

p_2 = Prevalence of depression in the control group=19.2% (8).

$q = 1 - P$

All study participants were subjected to: Stage I: Beck Inventory:(Appendix I): for screening and severity of depression. The score range varies from 0 to 63, where a higher score indicates greater severity of depression. It has been translated into Arabic by **Gharib abdel Fattah** (9) and has been used in many studies. Stage II: International Classification of Diseases (ICD-10), Stage III: Childhood Trauma Questionnaire (CTQ), (10) (Appendix IV).

Statistical analysis

SPSS statistics for windows (Statistical Package for the Social Sciences) version 26 (IBM, Armonk, NY, USA) was used for statistical analysis of the collected data. Shapiro-Wilk test was used to check the normality of the data distribution. All tests were conducted with 95% confidence interval. P (probability) value < 0.05 was considered

statistically significant. Charts were generated using SPSS' chart builder and Microsoft Excel for windows 2019. Quantitative variables were expressed as mean and standard deviation while categorical variables were expressed as frequency and percentage. Independent sample T and Mann Whitney tests were used for inter-group (between subjects) comparison of parametric and non-parametric continuous data with no follow up readings respectively. Fisher exact and Chi square tests were used for inter-group comparison of nominal data using the crosstabs' function.

Ethical considerations

An informed consent was taken from all the patients before taking any data or doing any investigations. Explanation of the study aim in a simple manner to be understood by the common people. No harmful maneuvers were performed or used as questionnaire was the only tool used. All data was considered confidential and was not going to be used outside this study without patient's approval. All samples were used in the research only. Researcher phone number and all possible communicating methods were identified to the participants to return at any time for any explanation. All participants were announced by the result of the study. Participants had the right to withdraw from the study at any time without giving any reason. Patients received proper health education and suitable medical treatment according to international criteria for the management. Signature or fingerprints of the participants.

Results

Regarding age, there was no statistically significant difference between the two groups ($p = 0.385$). Also there was no statistically significant difference between the two groups ($p = 0.181$) regarding sex (Table 1).

There was no statistically significant difference between the two groups regarding the Severity of depression according to Beck score ($p = 0.850$) (Table 2).

Emotional abuse in group A was statically significantly higher than in group B ($p < 0.001$). Physical abuse in group A was statically significantly higher than in group B ($p < 0.001$). Sexual abuse in group A was statically significantly higher than in group B ($p < 0.001$). Emotional neglect in group A was statically significantly higher than in group B ($p < 0.001$). And physical neglect in group A was statically significantly higher than in group B ($p < 0.001$) (Table 3).

There was statically significant difference between the two groups regarding the grade of emotional abuse ($p < 0.001$) (Table 4).

There was a statically significant difference between the two groups regarding the diagnosis according to ICD 10 ($p < 0.001$) (Table 5).

There was a statically significant positive correlation between FSSS and Beck score (moderate correlation), Physical abuse (weak correlation) and Sexual abuse (moderate correlation) in group A.

There was no statically significant correlation between FSSS and other studied scores in group B (Table 6).

Table1. Age and Gender Distribution of The Studied Groups:

		Group A (n= 55)	Group B (n= 55)	P
Age		42.13 ± 11.842	43.31 ± 10.611	0.583
Gender	Male	33 (60.0%)	26 (47.3%)	0.181
	Female	22 (40.0%)	29 (52.7%)	

Data was expressed as mean and standard deviation or as percentage and frequency. P is significant when < 0.05.

Table 2. Severity Of Depression According to Beck Score of The Studied Groups:

	Group A (n= 55)	Group B (n= 55)	P
Mild (14-19)	0 (0.0%)	5 (9.1%)	0.850
Moderate (20-28)	36 (65.5%)	40 (72.7%)	
Severe (29-63)	19 (34.5%)	10 (18.2%)	

Data is expressed as mean and standard deviation. P is significant when < 0.05.

Table 3. Childhood Abuse Scores According to CTQ of The Studied Groups:

	Group A (n= 55)	Group B (n= 55)	P
Emotional abuse	35.85 ± 4.656	13.20 ± 1.161	< 0.001
Physical abuse	21.27 ± 3.546	7.64 ± 0.704	< 0.001
Sexual abuse	21.25 ± 3.743	7.60 ± 0.760	< 0.001
Emotional neglect	24.51 ± 3.237	8.67 ± 0.747	< 0.001
Physical neglect	48.47 ± 4.985	17.53 ± 1.303	< 0.001

Data was expressed as mean and standard deviation. P is significant when < 0.05.

Table 4 Grade Of Emotional Abuse Of The Studied Groups:

		Group A (n= 55)	Group B (n= 55)	P
Emotional abuse	None (12-29)	3 (5.5%)	55 (100.0%)	< 0.001
	Low (30-34)	21 (38.2%)	0 (0.0%)	
	Moderate (35, 40)	22 (40.0%)	0 (0.0%)	
	Severe (41 and above)	9 (16.4%)	0 (0.0%)	

Data was expressed as percentage and frequency. P is significant when < 0.05.

Table 5. Correlation between FSSS and other studied scores

	Group A		Group B	
	Correlation coefficient	P	Correlation coefficient	P
Beck score	0.544	0.003	0.079	0.564
Emotional abuse	0.001	0.994	0.118	0.390
Physical abuse	0.268	0.048	0.239	0.079
Sexual abuse	0.326	0.016	0.140	0.307
Emotional neglect	0.098	0.478	0.220	0.106
Physical neglect	0.232	0.088	0.230	0.092

P is significant when < 0.05.

Table 6. Diagnosis According To ICD 10 Of The Studied Groups:

	Group A (n= 55)	Group B (n= 55)	P
Mild depressive episode	0 (0.0%)	6 (10.9%)	< 0.001
Moderate depressive episode	15 (27.3%)	39 (70.9%)	
Recurrent depressive disorders current episode moderate	15 (27.3%)	0 (0.0%)	
Severe depressive episode without psychotic features	20 (36.4%)	10 (18.2%)	
Recurrent depressive disorder current episode severe without psychotic	5 (9.1%)	0 (0.0%)	

Discussion

Our study results have revealed that the mean age of group A was (42.13 ± 11.842 years), which demonstrate that childhood abuse may be considered an important risk factor for late-life depression. Although childhood abuse was strongest associated with early-onset depression, we found also a robust association with a middle age-and late-onset of depression.

This is in line with **Green et al.** who showed in a large nationally representative sample of adults (> 18 years) that about 30% of the later-onset disorders were associated with childhood abuse⁽¹¹⁾.

In the current study we found that the majority of the group of patients diagnosed with depressive disorders and history of childhood abuse were males.

However, **Chen et al.** found that the prevalence of emotional abuse and neglect were higher among women (7.5% and 31.1% respectively) than men (4.5% and 24.0% respectively). And male participants reported higher rates of sexual abuse (19.7%) in childhood compared with female participants (14.8%)⁽¹²⁾.

In the current study the mean total Beck score in depressive patients with depressive disorders and history of childhood abuse was statistically significantly

higher than among depressive patients without depressive disorders and history of childhood abuse.

This study results showed that severity of depression according to Beck score in depressive patients with depressive disorders and history of childhood abuse was statistically significantly higher than among depressive patients without depressive disorders and history of childhood abuse.

Results of **Hayashi et al.** study indicated that childhood abuse directly predicted the severity of depression. Correlation analysis also indicated that major depressive disorder patients showed a weak, but a positive correlation between neglect, punishment, and emotional abuse subscales of CATS and BDI-II⁽¹³⁾.

Korkela et al. reported that the interaction between childhood abuse and life stress in adulthood increased depression in adulthood, because abuse affected coping styles, the attachment style, and resilience, and because depression impaired interpersonal relationships⁽¹⁴⁾.

In this study, all of the grades of physical, sexual and emotional abuse were statistically significantly higher in depressive patients with depressive disorders and history of childhood abuse was statistically significantly higher than among depressive patients without depressive disorders and history of childhood abuse.

Regarding the grade of emotional abuse among group A it was moderate in 40 % of them, low in 38.2% low, severe in only 16.4% and 5.5% had no emotional abuse, the majority of group A (96.4%) had severe emotional neglect while only 3.6% of them had

moderate emotional neglect. Our results suggest that emotional abuse is characteristically combined with other forms of abuse, thereby potentiating its impact. Succinctly stated, “names do hurt” and assessment for childhood emotional abuse may provide an important benchmark for other forms of abuse and a heightened risk for depressive symptoms in adulthood.

Also, **Nelson et al.** stated that whenever data allowed for differential consideration of separate types of childhood maltreatment, emotional abuse or neglect appeared to be of particular importance, for prevalence of childhood maltreatment in depression, risk of depression as well as correlations between childhood maltreatment and depression severity, a consistent trend of larger effect sizes for emotional abuse and neglect was found. When looking at statistically significant differences only, emotional neglect was the most commonly reported form of childhood maltreatment in individuals with depression, and emotional abuse was shown to be the most closely related to depression severity⁽¹⁵⁾.

Summarising 124 studies, **Norman et al.** showed that emotional abuse increases the risk of depression by an odds ratio of 3.06, whereas physical abuse increases the risk of depression by an odds ratio of 1.5, merely half that of emotional abuse⁽¹⁶⁾.

This result only showed that emotional abuse also increased the risk of major depressive disorder, as an isolated incident. However, we argued that childhood traumas should not be considered as the sum of isolated incidents but a pattern of relationship⁽¹⁷⁾.

So, we compared median CTQ scores of participants in different pattern groups to examine the pattern of relationship and we found that, all the comparisons between pattern groups 1 and 2 for mean CTQ scores in all categories were statistically significant. These results supported our argument that isolated physical or sexual abuse incidents were not the only stressful events attributed to increasing the risk of depression. On top of the traumatic effects of physical and sexual abuse, they also indicate a defective pattern of emotional relationship. Mean CTQ scores of pattern group 1 for physical neglect and emotional abuse were the most significantly higher than others

In the current study, according to CTQ we found that the mean emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect in group A were statically significantly higher than in group B.

Chen et al. results suggest that the prevalence of emotional neglect (26.5%) ranked first among CTQ subscales, and thus emotional neglect and duration of drug use (≥ 10 years) as factors for depression should be paid attention by clinicians⁽¹²⁾.

In this study according to ICD 10, we found that 36.4% had severe depressive episode without psychotic features, 27.3% had recurrent depressive disorders current episode moderate, 27.3% had moderate depressive episode, and 9.1% had recurrent

depressive disorder current episode severe without psychotic. While in group B 70.9% had moderate depressive episode, 18.2% had severe depressive episode without psychotic features and 10.9 % had mild depressive episode.

Similarly, **Baykan et al.** found that depression levels, which were assessed by HAM-D, had positive correlations with emotional, physical, and sexual abuse. However, there were no statistically significant correlations between HAM-D scores and emotional or physical neglect⁽¹⁸⁾.

Since CTQ is a self-report questionnaire, self-report bias is another possible limitation of our study. Moreover, psychological resilience is another confounding factor. Psychological resilience is another major factor that affects the clinical outcome of childhood trauma^(19, 20).

Conclusion

Adults with history of childhood abuse either are more likely to have worse clinical profile of depressive disorders during their adulthood than adults without.

References

1. STUART, Heather; ARBOLEDA-FLÓREZ, Julio. A public health perspective on the stigmatization of mental illnesses. *Public Health Reviews*, 2012, 34: 1-18.
2. PATEL, Vikram, et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities. *The Lancet*, 2016, 387.10028: 1672-1685.
3. KELLER, Martin B. Past, present, and future directions for defining optimal treatment outcome in depression: remission and beyond. *Jama*, 2003, 289.23: 3152-3160.
4. BODEN, Joseph M.; FOULDS, James A. Major depression and alcohol use disorder in adolescence: Does comorbidity lead to poorer outcomes of depression?. *Journal of Affective Disorders*, 2016, 206: 287-293.
5. FUCHSHUBER, Jürgen, et al. Depressive symptoms and addictive behaviors in young adults after childhood trauma: The mediating role of personality organization and despair. *Frontiers in psychiatry*, 2018, 9: 318.
6. MANSOUR, Khalid, et al. Child abuse and its long-term consequences: An exploratory study on Egyptian university students. *The Arab Journal of Psychiatry*, 2010, 21.2: 137-163.
7. BETH, Dawson; ROBERT, G. T. Basic and clinical biostatistics. 2004.
8. MOLNAR, Beth E.; BUKA, Stephen L.; KESSLER, Ronald C. Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American journal of public health*, 2001, 91.5: 753.
9. Abdel Fattah G. The Beck Depression Inventory (Arabic translation); 2000 Cairo, El Anglo Library. 2000.
10. BERNSTEIN, David P., et al. Childhood trauma questionnaire. Assessment of family violence: A handbook for researchers and practitioners., 1998.
11. GREEN, Jennifer Greif, et al. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. *Archives of general psychiatry*, 2010, 67.2: 113-123.
12. CHEN, Edith, et al. Association of reports of childhood abuse and all-cause mortality rates in women. *JAMA psychiatry*, 2016, 73.9: 920-927.
13. HAYASHI, Yumi, et al. Direct and indirect influences of childhood abuse on depression symptoms in patients with major depressive disorder. *BMC psychiatry*, 2015, 15: 1-8.
14. KORKEILA, Jyrki, et al. Childhood adversities, adulthood life events and depression. *Journal of affective disorders*, 2010, 127.1-3: 130-138.
15. NELSON, Janna, et al. Childhood maltreatment and characteristics of adult depression: meta-analysis. *The British Journal of Psychiatry*, 2017, 210.2: 96-104.
16. SCHILLING, Christoph, et al. Patterns of childhood abuse and neglect in a representative German population sample. *PLoS one*, 2016, 11.7: e0159510.
17. NORMAN, Rosana E., et al. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS medicine*, 2012, 9.11: e1001349.
18. BAYKAN, Hayriye, et al. Effects of childhood abuse on major depressive disorder. *Clinical and Experimental Health Sciences*, 2019, 9.1: 57-62.
19. DING, Huisi, et al. Moderating and mediating effects of resilience between childhood trauma and depressive symptoms in Chinese children. *Journal of affective disorders*, 2017, 211: 130-135.
20. POOLE, Julia C.; DOBSON, Keith S.; PUSCH, Dennis. Childhood adversity and adult depression: The protective role of psychological resilience. *Child abuse & neglect*, 2017, 64: 89-100.