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Article

Exploring the Interplay between Complex PTSD and Obsessive-Compulsive Disorder Severity: Implications for Clinical Practice

Martina D'Angelo ¹, Marta Valenza ², Anna Maria Iazzolino ¹, Grazia Longobardi ¹, Valeria Di Stefano ¹, Elena Lanzara ³, Giulia Visalli ¹, Luca Steardo ^{1,3}, Caterina Scuderi ² and Luca Steardo Jr ^{1,*}

¹ Psychiatry Unit, Department of Health Sciences, University of Catanzaro Magna Graecia, Catanzaro 88100, Italy

² Department of Physiology and Pharmacology "Vittorio Erspamer" SAPIENZA University of Rome, Rome, Italy

³ Università Giustino Fortunato, 82100 Benevento, Italy

* Correspondence: Correspondence: steardo@unicz.it

Abstract: Background: Traumatic events adversely affect the clinical course of obsessive-compulsive disorder (OCD). Our investigation explores the correlation between prolonged interpersonal trauma and the severity of symptoms related to obsessive-compulsive and anxiety disorders. **Methods:** The study follows a cross-sectional and observational design, employing the International Trauma Questionnaire (ITQ) to examine areas linked to interpersonal trauma, the Hamilton Anxiety Rating Scale (HAM-A), and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) to assess anxious and obsessive-compulsive symptoms, respectively. Descriptive analysis, analysis of variance (ANOVA), and logistic regression analyses were conducted. **Results:** We recruited 107 OCD-diagnosed patients, categorizing them into subgroups based on the presence or absence of complex post-traumatic stress disorder (cPTSD). The ANOVA revealed statistically significant differences between the two groups in the onset age of OCD ($p=0.083$), psychiatric familial history ($p=0.023$), HAM-A, and Y-BOCS ($p=0.000$). Logistic regression indicated a statistically significant association between the presence of cPTSD and Y-BOCS scores ($p=0.000$). **Conclusion:** The coexistence of cPTSD in OCD exacerbates obsessive-compulsive symptoms and increases the burden of anxiety. Further advancements in this field are crucial for mitigating the impact of early trauma on the trajectory of OCD and associated anxious symptoms.

Keywords: complex post-traumatic stress disorder; obsessive-compulsive disorder; anxiety

1. Introduction

Numerous recent investigations into psychological trauma have observed significant expansion [1]. An astounding revelation is that over 60% of young individuals report having encountered distressing experiences during childhood, which have lasting ramifications on their physical and mental well-being [2]. Consequently, prolonged exposure to traumatic events during childhood is strongly associated with an increased likelihood of developing Complex Posttraumatic Stress Disorder (cPTSD) [3]. It is noteworthy that cPTSD has gained acknowledgment as a novel diagnosis in the Eleventh International Classification of Diseases (ICD-11) [4,5]. The proposition of a repeated trauma-related disorder, as articulated by Herman, underscores the potentially profound impact of extended traumatic stressors, particularly on self-organization, with a focus on the affective and relational domains [6]. cPTSD manifests as a severe mental condition that arises in response to traumatic life events, involving a set of symptoms originating from the accumulation of interpersonal traumas experienced during developmental stages [7]. Importantly, cPTSD is characterized by three primary clusters of post-traumatic symptoms, alongside chronic, pervasive disturbances in emotion regulation, identity, and relationships [7]. A growing body of literature demonstrates how traumas serve as causal factors for a range of outcomes, including emotional dysregulation, behavioral dysfunction, challenges in interpersonal relationships, and dissociative symptoms in adulthood [8].

cPTSD often ensues from unstable and distressing environmental contexts that negatively impact a child's self-regulation skills, emotional equilibrium, psychological well-being, and interpersonal bonds [9]. Notably, particular attention has been devoted to the manifestation of self-organization disorders (DSO) observed within this condition, encompassing symptomatology spanning affective dysregulation, negative self-concept, and disrupted relationships [5]. Moreover, alterations in consciousness and the emergence of dissociative symptoms disorganize individuals' functioning across various levels, encompassing the biological, physiological, relational, and behavioral domains [10]. Individuals afflicted with cPTSD typically undergo prolonged or recurrent exposures to interpersonal trauma, such as childhood abuse or domestic violence [11–14]. The lifetime prevalence of Post-Traumatic Stress Disorder (PTSD) varies from 3 to 9% within the adult population, contingent upon the nature and frequency of traumas experienced. Meanwhile, the prevalence of cPTSD ranges from 1 to 8% in the general population, escalating to 50% within mental health settings [15]. Notably, childhood trauma has been associated with the onset of obsessive-compulsive disorder (OCD). Scientific literature posits that predisposing factors for this disorder, such as genetic vulnerability and typical OCD characteristics, interact with prolonged exposure to stressful and traumatic events during a child's formative years [16–20]. Psychological distress often manifests as intrusive thoughts (flashbacks, nightmares) related to the traumatic experience, occasionally leading to anxiety, fear, aggression, anger, or depressive symptoms [20,21]. Recent studies suggest that OCD can emerge as a response to profoundly distressing events, with individuals exposed to trauma being more susceptible to developing OCD [17,22,23]. Childhood trauma exerts a profound impact on the development, progression, and severity of obsessive-compulsive symptoms, encompassing diverse clinical presentations [24]. Furthermore, previous trauma exposure among individuals with OCD has been correlated with greater functional impairment [25–27]. Traumatic experiences, particularly those occurring during childhood, represent the most extensively studied etiological factor in the development of dissociation [8]. In clinical contexts, dissociation constitutes a core symptom across various disorders, including obsessive-compulsive disorder and Complex Posttraumatic Stress Disorder [28]. Dissociative phenomena serve as defense mechanisms against external traumatic experiences, with obsessions and compulsions often arising as responses to thoughts that intensify dissociation [8]. Psychological trauma is recognized as a risk factor in the development of dissociation, with numerous empirical studies substantiating the association between dissociation and trauma, especially severe childhood maltreatment [29–32]. This study aims to determine whether the presence of cPTSD is linked to heightened obsessive-compulsive symptoms and related anxiety symptomatology. Given that cPTSD represents a substantial domain of symptoms within the spectrum of psychiatric disorders, unraveling this correlation is believed to assist clinicians in optimizing treatment strategies for OCD in the context of this comorbidity.

2. Materials and Methods

The current investigation is structured as an observational cross-sectional study conducted in a clinical environment. It entails the consecutive inclusion of individuals diagnosed with obsessive-compulsive disorder (OCD) at the Psychiatry Unit of the "Magna Graecia" University of Catanzaro, spanning from January 2021 to April 2022. All participants received comprehensive information regarding the research protocol's objectives, data protection, privacy, and the maintenance of anonymity. Their involvement was voluntary and contingent upon providing formal written consent after a thorough explanation of the study's goals and design. The study adhered to the most recent iteration of the Declaration of Helsinki and obtained approval from the Ethics Committee of the University of Catanzaro (Ethics Committee Approval No. 307/2020). Inclusion criteria encompassed:

1. Patients diagnosed with OCD based on DSM-5 criteria, as determined by clinical interviews and psychometric assessments (Structured Clinical Interview for DSM-5 - Clinical Version, SCID-5-CV).
2. Patients aged between 18 and 75 years.

The exclusion criteria were:

1. Patient refusal to participate.

- 2. Presence of significant neurological or psychiatric disorders (e.g., epilepsy, cognitive disability, genetic syndromes with psychiatric symptoms).
- 3. Any condition hindering comprehensive assessment

Following that, participants underwent a series of clinical and psychopathological assessments during outpatient clinical visits. Researchers, medical trainees, and PhD students conducted psychometric rating scales and collected sociodemographic data. OCD diagnoses were determined based on DSM-5 criteria, utilizing the SCID-5-CV. Each enrolled patient underwent a semi-structured clinical interview to collect clinical and anamnestic information. Sociodemographic and clinical data were acquired using a tailored medical history questionnaire developed within our department. Administered by trained personnel, this questionnaire comprised two sections: the first concentrated on gathering sociodemographic information, and the second on the patient's psychiatric history. The evaluation instruments used included the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), the International Trauma Questionnaire (ITQ), and the Hamilton Anxiety Scale (HAM-A). Y-BOCS, acknowledged as the gold standard for evaluating obsessive-compulsive symptoms, consists of a comprehensive symptom checklist categorized into various groups. It also incorporates a 10-item severity scale assessing time, interference, discomfort, resistance, and symptom control [33,34]. Each item is rated on a scale of 0 to 4, resulting in a total score ranging from 0 to 40, where higher scores indicate more severe OCD symptoms [35]. ITQ is an 18-item self-administered questionnaire designed to explore interpersonal traumas and their impact on an individual's development, distinguishing between post-traumatic stress disorder (PTSD) and complex PTSD (cPTSD) [36]. Following ICD-11 principles, this questionnaire provides both categorical diagnostic scores and dimensional severity scores [37]. HAM-A, a 14-item rating scale, assesses the severity of anxiety symptoms, covering both psychological and somatic manifestations [38]. Each item is scored from 0 (absent) to 4 (severe), resulting in a total score ranging from 0 to 56. Severity levels are categorized as mild (<17), mild to moderate (18-24), and moderate to severe (25/30) [39]. All variable data were input into an electronic dataset. Descriptive statistical analyses were conducted to evaluate the distributional characteristics of sociodemographic and clinical variables within the sample. Continuous variables were presented as means with standard deviations (SD), while categorical variables were expressed as frequencies and percentages (%). The sample was divided into two groups: those with a history of cPTSD (cPTSD+) and those without (cPTSD-). Analysis of variance (ANOVA) was used to compare variances among the means of different groups, considering $p<0.005$ as statistically significant. A regression analysis was performed to explore the association between cPTSD and the Y-BOCS scale score. Statistical Package for the Social Sciences version 26 (SPSS, Chicago, IL, USA) was used for statistical analyses.

Results

Table 1 presents the clinical and sociodemographic characteristics of the study sample. The final cohort for our investigation comprised 107 individuals diagnosed with obsessive-compulsive disorder (OCD), with 50 of them (46.7%) additionally diagnosed with comorbid Complex Post-Traumatic Stress Disorder (cPTSD). The sociodemographic profile of the sample exhibited homogeneity, with 54 (50.5%) male participants. 84 subjects (78.5%) had attained a diploma. Patients with a co-occurrence of OCD and cPTSD exhibited a familial psychiatric history prevalence of 69.2%. Within this segmented sample, the average age among OCD patients was 45.75 years (SD \pm 13.9). From a psychopathological perspective, patients scored an average of 11.50 (SD \pm 9.9) on the Hamilton Anxiety Rating Scale (HAM-A), while the score reflecting obsessive-compulsive symptoms on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was approximately 10.49 (SD \pm 6.9).

Table 1. Socio-Demographic Characteristics (107 Patients).

SEX MALE YES (N%)	54	50.5
DIPLOMA YES (N%)	84	78.5

PSYCHIATRIC FAMILIARITY YES (N%)	74	69.2
CPTSD YES (N%)	50	46.7
AGE M (SD)	45.75	13,902
HAM A_TOT M (SD)	11.50	9,999
Y-BOCS_TOT M (SD)	10.49	6,931

HAM-A: Hamilton Anxiety Rating Scale; Y-BOCS: Yale-Brown Obsessive Compulsive Scale; cPTSD: complex posttraumatic disorder; N: total number; SD: standard deviation; %: percentage.

Table 2 shows the analysis of variance (ANOVA). Significant differences emerged between the two groups in the age of onset of the OCD (p=0.083), psychiatric familiarity (p=0.023), HAM-A total score (p=0.000), and Y-BOCS (p=0.000).

Table 2. ANOVA Between the Two Groups (cPTSD+ and cPTSD-).

CHARACTERISTIC	DF	F-VALUE	P-VALUE
AGE OF OCD ONSET	1	3.073	0.083
FAMILIARITY WITH OTHER PATHOLOGIES	1	0.065	0.799
PSYCHIATRIC FAMILY HISTORY	1	5.333	0.023
HAM-A_TOT	1	64.803	0.000
Y-BOCS_TOT	1	38.462	0.000

HAM-A: Hamilton Anxiety Rating Scale; Y-BOCS: Yale-Brown Obsessive Compulsive Scale; OCD: obsessive-compulsive disorder. Bold p-values indicate statistical significance.

In Table 3 is reported the logistic regression analysis that revealed a statistically significant association between the presence of cPTSD and the Y-BOCS total score (p=0.000).

Table 3. Logistic Regression.

characteristic	B	STANDARD ERROR (SE)	WALD STATISTIC	DF	P-VALUE
Y-BOCS_TOT	0.202	0.043	22.111	1	0.000
INTERCEPT	-4.759	1.028	21.453	1	0.000

Y-BOCS: Yale-Brown Obsessive Compulsive Scale. Bold p-values indicate statistical significance.

3. Discussion

The present study addresses a topic of great interest that is still little debated, probing the intriguing nexus between Complex Post-Traumatic Stress Disorder (cPTSD) and the clinical severity of the obsessive-compulsive disorder (OCD). Our statistical analysis has unveiled a compelling correlation between the presence of cPTSD and a notably exacerbated clinical trajectory of OCD, as evidenced by higher scores on the Hamilton Anxiety Rating Scale (HAM-A) and the Yale-Brown

Obsessive-Compulsive Scale (Y-BOCS). These findings are in line with existing literature, reinforcing the notion that cPTSD predisposes individuals to compromised outcomes across a spectrum of psychiatric disorders [19]. Furthermore, our logistic regression analysis has demonstrated a significant association between Y-BOCS scores and the International Trauma Questionnaire (ITQ), underscoring the profound influence of cPTSD on the augmentation of obsessive-compulsive symptoms. This revelation warrants elucidation, as it implies that exposure to traumatic stressors during critical phases of psychological development may catalyze the intensification of affective disturbances and relational challenges. These disturbances, in turn, give rise to disruptions in self-organization, thereby exacerbating obsessive symptoms. This alignment with prior literature substantiates the association between traumatic stressors and the severity of OCD symptomatology [6,40]. The multifaceted consequences of trauma on OCD encompass a spectrum of distressing phenomena, including dissociative symptoms, intrusive thoughts and images, profound anxiety, a sense of helplessness, and heightened vigilance, all of which contribute to the chronicity and severity of the disorder [41]. Empirical studies have reported that traumas, especially when occurring during childhood, disproportionately impact the obsessive dimension of OCD. Trauma types encompass sexual abuse, adverse living conditions, bullying, and exposure to traumatic events such as bereavement [42,43]. Notably, prolonged exposure to such trauma has been correlated with the emergence of Complex Post-Traumatic Stress Disorder (cPTSD), with higher incidence rates among individuals exposed to chronic abuse or neglect [44]. It is pertinent to highlight that interpersonal trauma assumes a pivotal role in the psychopathology of both cPTSD and OCD [17,41]. Compared to non-interpersonal trauma, interpersonal trauma has a more profound impact on self-regulation, frequently inducing dissociation [45]. Aligned with current literature, elevated occurrences of childhood trauma are positively associated with heightened levels of dissociation, acting as an intermediary element between exposure to trauma and psychiatric symptoms. [8,46]. This can be attributed to patients with OCD, who have experienced multiple traumatic events, exhibiting a greater propensity for decompensation, a lack of functional and cognitive recovery, and the onset of dissociative symptoms [47,48]. In addition to cognitive-behavioral and pharmacological interventions, trauma-focused treatments have been recommended for managing OCD, highlighting the necessity of addressing trauma within the therapeutic framework. Modalities such as mindfulness, sensorimotor psychotherapy, and Eye Movement Desensitization and Reprocessing (EMDR) have shown promise [49]. Recognizing the complexities introduced by prior prolonged trauma is paramount, as individuals may exhibit resistance to traditional OCD treatment and may resort to alternative maladaptive coping mechanisms to mitigate the distress associated with traumatic memories [23,50]. An in-depth exploration of the physical, emotional, and psychological turmoil stemming from trauma is essential for tailoring therapeutic approaches, ultimately enhancing the quality of life for patients [17]. Future investigations should focus on elucidating how complex trauma influences an individual's quality of life and interpersonal functioning. This knowledge can inform psychosocial interventions, including rehabilitation activities aimed at fostering relationships and mitigating social isolation. Identifying optimal strategies for enhancing cognitive functioning and managing behavioral disorders holds the promise of improving the well-being of patients and their families.

This research acts as a stimulus to enhance investigative endeavors into the intricate interplay between intricate trauma and the intensity of OCD symptoms. The scarcity of studies investigating this crucial connection demands further exploration, underscoring the pressing need for ongoing research. Furthermore, our findings shed light on the earlier manifestation of cPTSD, likely linked to extended or recurrent exposure to interpersonal traumas, such as childhood abuse or domestic violence. Importantly, the current study reaffirms the familial aspect in psychiatric disorders, particularly in instances of early-onset OCD. [51,52].

4. Conclusions

In conclusion, our investigation has shed light on the intricate web connecting cPTSD and the severity of OCD. While we acknowledge limitations, including sample size and study design, our

findings underscore the imperative for a holistic understanding of how trauma shapes the trajectory of OCD. This knowledge is instrumental in devising effective interventions that consider the complexities of trauma and its profound impact on individuals' lives. Future research endeavors should build upon these insights, providing a comprehensive framework for enhancing the well-being of those grappling with the confluence of complex trauma and obsessive-compulsive challenges.

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Informed Consent Statement: All participants in the study provided informed consent. Written consent has been acquired from the participant(s) for the publication of this paper.

Data Availability Statement: The data supporting the conclusions of this study can be obtained from the corresponding author upon a reasonable request.

Conflicts of Interest: The authors state that they have no conflicts of interest.

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