The relationship between childhood traumas and dysfunctional attitudes in individuals with unipolar depression

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SUMMARY

Objective: This study aims to investigate the relationship between childhood trauma and dysfunctional attitudes in individuals diagnosed with unipolar depression.

Method: Two hundred patients diagnosed with unipolar depression were included in the study and comorbid diagnoses were determined with the help of a structured clinical interview (SCID-I) for DSM-IV axis-I disorders. Sociodemographic data form, Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Childhood Trauma Questionnaire (CTQ), and Dysfunctional Attitude Scale (DAS) were applied to the individuals included in the study.

Results: More than half (66,5%) of the individuals followed up due to unipolar depression had childhood trauma, the most common childhood trauma was emotional neglect (%57,5). While there was a positive correlation between DAS total score and physical neglect (p=0,027, r=0,205), emotional abuse(p=0,007, r=0,208) and physical abuse (p=0,039, r=0,124) score, there was a positive correlation between DAS independent attitude and emotional neglect (p=0,044, r=0,223), physical neglect (p=0,007, r=0,205) and emotional abuse(p=0,010, r=0,173), and a positive correlation between DAS perfectionism and emotional abuse(p=0,010, r=0,219) and physical abuse (p=0,029, r=0,139). In the logistic regression analysis, in the age-adjusted model, it was determined that the number of depressive episodes in those with CTQ was 1.39 times (p=0.02, 95% CI= 1.04-1.85) higher than in those without CTQ.

Discussion: As far as we know, it is one of the rare studies in the literature examining the relationship between DAS subscales and childhood trauma subscales. It was found that physical and emotional neglect from childhood traumas was associated with the development of an independent dysfunctional attitude, and emotional and physical abuse was associated with the development of a perfectionist dysfunctional attitude. We believe that addressing cognitive distortions in the light of this information in the follow-up and treatment of these patients may contribute positively to treatment response and prognosis.

Key Words: Unipolar Depression, Childhood Trauma, Dysfunctional Attitudes

INTRODUCTION

Depressive disorder is an important public health problem that can lead to work and social losses, including feeling sad, pessimistic, decreased interest in activities, lack of pleasure, hopelessness, guilt, worthlessness, thoughts of regret, impairment in psychophysiological functions such as attention, sleep and appetite, changes in psychomotor behaviors and sometimes recurrent thoughts of death (1). The one-year prevalence of depression was found to be 6.6%, while the lifetime prevalence was 16.2%. When analyzed by gender, the lifetime prevalence in males was 8-12%, whereas this rate was reported to be 20-26% in females (2).

Child abuse and neglect is all of the actions or inactions directed towards the child by the mother, father or other caregivers who are obliged to take care of the child, which are characterized as inappropriate and damaging by the society or expert individuals and which prevent or restrict the development of the child in many areas. This situation is a public health problem that affects not only families but also social organizations, the education system, the legal order and the general society (3,4). Traumatic experiences in childhood may cause physical and mental problems in later life periods. In many studies, a relationship has been found between depressive disorder and childhood traumas. A history of childhood neglect or abuse

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has been associated with an increase in the duration of depressive illness, the risk of self-murder and the likelihood of recurrence of depression (5,6).

According to Beck, beliefs and cognitions play an important role in the development of depression and dysfunctional attitudes are used to describe these cognitive processes in depressed individuals. Dysfunctional attitudes are shaped as a result of close relationships and intra-family relationships starting from early childhood and can contribute to the development of depression by becoming active with negative life events (7). Childhood trauma is an important early social risk factor for the development of depressive disorder and dysfunctional attitudes may mediate the effect of childhood trauma on the onset of depression (8).

The hypothesis of this study is that patients with unipolar depression who applied to our university psychiatry outpatient clinic between February 2019 and January 2020 have more dysfunctional attitudes than those without childhood trauma. In the light of this information, our study focused on the mediating role of dysfunctional attitudes between depression and childhood traumas and aimed to investigate the relationship between the subscales of the dysfunctional attitudes scale and the subscales of childhood traumas in these individuals. In addition, it was aimed to compare the sociodemographic data of depressed individuals with childhood trauma with those without childhood trauma and to determine whether there were any differences between the two groups in terms of age at onset, duration, frequency of depressive episodes, self-murder attempts, thoughts of self-murder and family history of psychiatric illness.

METHODS

Sample

The sample of the study consisted of 200 patients diagnosed with unipolar depression who applied to the psychiatry outpatient clinic of our university medical faculty hospital between February 2019 and January 2020. In our study, no sample calculation was made and all patients who applied to the outpatient clinic between the relevant dates and met the inclusion criteria were included in the study.

Patients who were followed up for unipolar depression, between the ages of 18-65, volunteered to participate in the study, gave signed consent, agreed to fill out the scales, were literate, and did not have intellectual disability were included in the study.

This study was approved by the Clinical Research Ethics Committee of the Faculty of Medicine of our university with the decision dated 23.01.2019 and protocol no. 2019-10-23/01.

The purpose of the study was explained to the participants who agreed to participate in the study by the physician who conducted the clinical interview and their consent was obtained, the sociodemographic data form was filled out and information was given on how to fill out the scales.

Data Collection Tools

After the sociodemographic data form of 200 patients diagnosed with unipolar depression was completed by the researcher, the patients were asked to complete the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Childhood Traumas Scale (CTS) and Dysfunctional Attitudes Scale (DAS). In addition, a Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I) was conducted by the researcher to find out the current and past psychiatric disorders of the patients participating in the study. The Turkish reliability and validity study of SCID-I was conducted by Çorapçıoğlu et al. (9).

Sociodemographic Data Form: In the form developed in accordance with the literature, sociodemographic and clinical information such as age, gender, educational status, marital status, occupation, cohabitants, place of residence, whether there is a known psychiatric illness in the family, if any, type of illness, age at the onset of the first depressive episode, duration of the last depressive episode, treatments used, history of self-harm attempt, income level were questioned. This form was com-

pleted by the researcher after the interview with the patient.

Beck Depression Inventory: The Turkish validity and reliability study of the Beck depression inventory developed by Beck in 1961 was conducted by Hisli Şahin in 1988. This inventory, which can be used to determine the risk of depression and to measure the severity and level of the disease, consists of 21 self-assessment sentences (10). Each question in the four-point Likert scale receives 0, 1, 2 or 3 points and the total score varies between 0-63. The cut-off score was determined as 17 in the validity and reliability study. As the score obtained from the scale increases, the severity of depression also increases (11).

Beck Anxiety Inventory: The Turkish validity and reliability of the Beck Anxiety Inventory, which was developed by Beck et al. in 1988 to measure the severity of anxiety symptoms experienced by the person, was conducted by Ulusoy et al. in 1998. This scale consists of 21 items and is a 4-point Likert scale. Each item in the scale receives a score between 0-3 points and the total anxiety score can vary between 0-63. As the score on the Beck anxiety scale increases, the severity of anxiety also increases (12).

Childhood Traumas Scale: The Childhood Traumas Scale (CTS) was first developed by Bernstein et al. in 1994 with 70 items, but the number of items used in this scale was reduced over time and it was adapted into Turkish by Şar et al. in 1996 (13). This scale, which is used to screen abuse and neglect experiences of individuals before the age of 20, is based on self-report and is a 5-point Likert-type scale. In our study, the 28-item short form of the scale was used and in this form, the presence or absence of physical and emotional neglect and physical, sexual and emotional abuse in childhood was evaluated. The response options for each item in the scale are as follows; 1: never, 2: rarely, 3: occasionally, 4: frequently, 5: very frequently and each item is scored between 1-5.

With the CTS used in our study, childhood sexual, physical, emotional abuse and physical and emotional neglect can be calculated as five sub-scores separately, or a total score consisting of a combination of these can be calculated. While the subscores range from 5 to 25, the total CTS score ranges from 25 to 125. In Turkey, the cut-off scores for the CTS were determined as exceeding 5 points for sexual and physical abuse, exceeding 7 points for emotional abuse and physical neglect, and exceeding 12 points for emotional neglect. This limit was determined as 35 points for the total CTS score (13).

Dysfunctional Attitudes Scale: The Dysfunctional Attitudes Scale (DAS) was developed by Beck and Weismann on the basis of cognitive theory and is used to measure an individual's negative attitudes towards self, the outside world and the future. With this scale, it is aimed to evaluate the structural 'intermediate beliefs' between cognitive schemas and automatic thoughts (14). In addition, DAS can be used to differentiate depressive patients from groups with other mental illnesses, to identify individuals who are cognitively predisposed to depression, to find the risk of recurrence of the disease, to predict treatment response and to determine attitudes that change with treatment (15).

The DAS is a self-report scale consisting of a total of 40 items to assess dysfunctional attitudes, each of which is scored between 1-7. The score range of DAS is between 40-280, and a high score on the scale is associated with a high number of dysfunctional attitudes. The study on the validity and reliability of the scale in Turkey was conducted by Şahin and Şahin and it was found that the scale consists of 4 subscales: 'perfectionist attitude', 'need for approval', 'independent attitude' and 'variable attitude'. 18 items (1, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 20, 25, 26, 31, 33) represent perfectionist attitudes of the individual, 11 items (19, 21, 22, 23, 27, 28, 32, 34, 38, 39, 40) represent the individual's need for environmental approval, The 6-item independent attitude (2, 12, 17, 18, 24, 35) refers to the individual's independence from environmental approval needs, and the 5-item variable attitude (6, 29, 30, 36, 37) refers to the individual's flexible attitudes (16). In our study, it was aimed to determine the therapeutic intervention areas by calculating the scores obtained from the subscales as well as the total score.

Statistical Analysis

Statistical evaluation was performed using PASW (Predictive Analytics SoftWare) program. The compatibility of numerical variables with normal distribution was analyzed by Shapiro-Wilk test. Descriptive statistics were expressed as arithmetic mean±standard deviation and median (minimum-maximum) for numerical variables and as number and percentage for verbal data. Differences between the groups in terms of verbal variables were analyzed by Pearson Chi-square, Yates Chi-square and Fisher Exact tests. In the comparison of two groups in terms of numerical variables, the significance test of the difference between two means was used when the parametric test assumptions were met, and the Mann-Whitney U test was used when they were not met. The linear relationship between two numerical variables was analyzed by Pearson correlation analysis if parametric test assumptions were met, and by Spearman correlation analysis if not. Logistic regression analysis was performed for the variables as further analysis and $p<0.05$ was considered significant for all evaluations.

RESULTS

The study included 200 patients with a diagnosis of depression. Of the participants, 80% (160) were female, 40.5% (81) were primary school graduates, 64% (128) were married, and 51.5% (103) were unemployed/housewives. The ages of the participants ranged between 18 and 65 years, with a mean age of 40.5 ± 11.9 years (Table 1). Sociodemographic characteristics and disease-

Table 1. Comparison of sociodemographic characteristics between those with and without childhood trauma

		Childhood Trauma n=133	Without Childhood Trauma n=67	Total	p
		n(%)	n(%)	n(%)	
Gender	Female	103 (%77,4)	57 (%85,1)	160 (%80)	0,277[1]
	Male	30 (%22,6)	10 (%14,9)	40 (%20)	
Educatian Level	Primary school	60 (%45,1)	21(%31,3)	81 (%40,5)	0,047[1]*
	Secondary school	16 (%12,0)	5 (%7,5)	21 (%10,5)	
	High school	30 (%22,6)	16 (%23,9)	46 (%23)	
	College/university graduate	27 (%20,3)	26 (%37,3)	52 (%26)	
Marital status	Married	88 (%66,2)	40 (%59,7)	128 (%64)	0,139[1]
	Single	26 (%19,5)	21 (%31,3)	47 (%23,5)	
	Divorced- widow	19 (%14,3)	6 (%9,0)	25 (%12,5)	
Job	Unemployed/housewife	70 (%52,6)	33 (%49,3)	103 (%51,5)	0,560[1]
	Worker/ civil servant/ employee	35 (%26,3)	22 (%32,8)	57 (%28,5)	
	Student	16 (%12,0)	9 (%13,4)	25 (%12,5)	
	Retired	12 (%9,0)	3 (%4,5)	15 (%7,5)	
People he/she lives with	With his wife and children	86 (%64,7)	37 (%55,2)	123 (%61,5)	0,504[1]
	With parents	16 (%12,0)	14 (%20,9)	30 (%15)	
	Alone	14 (%10,5)	8 (%11,9)	22 (%11)	
	Large family	11 (%8,3)	6 (%9,0)	17 (%8,5)	
	With friends	6 (%4,5)	2 (%3,0)	8 (%4)	
Place of residence	Province	57 (%42,9)	28 (%41,8)	85 (%42,5)	0,425[1]
	District	61 (%45,9)	35 (%52,2)	96 (%48)	
	Village	15 (%11,3)	4 (%6,0)	19 (%9,5)	
Level of income	Income less than expenses	86 (%64,7)	40 (%59,7)	126 (%63)	0,679[1]
	Income equals expenses	40 (%30,1)	22 (%32,8)	62 (%31)	
	Income more than expenses	7 (%5,3)	5 (%7,5)	12 (%6)	
Thoughts of suicide	Yes	56 (%42,1)	24 (%35,8)	80 (%40)	0,392[1]
	No	77 (%57,9)	43 (%64,2)	120 (%60)	
Attempted suicide	Yes	13 (%9,8)	3 (%4,5)	16 (%8)	0,304[1]
	No	120 (%90,2)	64 (%95,5)	184 (%92)	
Comorbid psychiatric disorder	Yes	59 (%44,4)	33 (%49,3)	92 (%46)	0,512[1]
	No	74 (%55,6)	34 (%50,7)	108 (%54)	

	Median(min-max)	Median (min-max)	Median(min-max)	
Age	42 (18-65)	38 (19-65)	40,5 (18-65)	0,038[2]*
Age of onset of depression	35 (14-65)	32 (17-61)	33,6 (14-65)	0,285[2]
Duration of depression (in last illness) (months)	24 (1-420)	24 (1-360)	53,3 (1-420)	0,491[3]
Number of previous attacks	2 (1-10)	1 (1-6)	2,1 (1-10)	0,003[3]*
Time without treatment (months)	6 (1-180)	8 (1-84)	13,7 (1-180)	0,048[3]*
Duration of last regular treatment (months)	12 (1-108)	7,5 (1-84)	17,9 (1-108)	0,151[3]
Number of suicide attempts	0 (0-4)	0 (0-3)	0,3 (0-4)	0,061[3]
Number of hospitalizations	2 (1-10)	1 (1-3)	2,3 (1-10)	0,117[3]

[1]Ki kare, [2]Two sample t test, [3]Mann-Whitney U, *p<0,05.

Table 2. Comparison of the scale scores of those with and without childhood trauma in groups

	Childhood Trauma n=133	Without Childhood Trauma n=67	p
	Median (Min Maks)	Median (Min Maks)	
BDI	26,0 (0-52)	20,0 (0-43)	0,024*
BAI	22,0 (0-61)	21,0 (0-49)	0,233
DAS T	134,0 (61-251)	131,0 (76-230)	0,315
DAS- PA	51,0 (21-109)	50,0 (24-106)	0,727
DAS-NA	41,0 (12-70)	40,0 (11-67)	0,540
DAS -IA	24,0 (6-41)	21,0 (10-35)	0,080
DAS- VA	19,0 (5-31)	18,0 (9-26)	0,593

Mann-Whitney U test was used. *p<0,05. BDI: Beck Depression Inventory, BAI: Beck Anxiety Inventory, DAS T: Dysfunctional Attitudes Scale Total score, DAS PA: Dysfunctional Attitudes Scale Perfectionist Attitude, DAS NA: Dysfunctional Attitudes Scale Need for Approval, DAS IA: Dysfunctional Attitudes Scale Independent Attitude, DAS VA: Dysfunctional Attitudes Scale Variable Attitude

related descriptive characteristics of the participants with and without childhood trauma are given in Table 1.

The mean age at onset of depression was 33.6 ± 11.3 years, although the age of onset ranged between 14 and 65 years in these individuals who were followed up for depression. The duration of the current illness was between 1 month and 420 months with a mean of 53.3 ± 75.2 months. The number of previous episodes of depression ranged between 1 and 10 (mean 2.1 ± 1.4) (Table 1).

In the last depressive episode, 40% of the participants (80 people) had thoughts of killing themselves, while 8% (16 people) had attempted to kill themselves. In general, when all previous depressive episodes were considered, those who attempted to kill themselves constituted 20% of the participants (40 people). 61.5% of the participants had a family history of psychiatric illness (Table 1).

Co-diagnoses were determined with the Structured Clinical Interview for DSM-IV Axis-I Disorders (SCID-I) applied to these individuals who were followed up for depression. Accordingly, 46% of the participants (92 individuals) had comorbid psychiatric disorders. The most common comorbidity was anxiety disorder not otherwise specified with 25.5% (51 people). In addition, 8% (16 people) had panic disorder, 4.5% (9 people) had somatoform disorder, 2.5% (5 people) had generalized anxiety disorder, 2% (4 people) had alcohol abuse, 1.5% (3 people) had obsessive-compulsive disorder, 1.5% (3 people) had posttraumatic stress disorder, and 0.5% (1 person) had eating disorder.

Regarding the medications used by the participants, 81% (162 people) were using psychiatric medication while 19% (38 people) were not using any medication. Antidepressants were used by 80% (160 people), benzodiazepines by 20.5% (41 people) and antipsychotics by 17% (34 people).

While 66.5% (133 people) of the participants had childhood trauma, 57.5% (115 people) had emotional neglect, 56.5% (113 people) had physical neglect, 45% (90 people) had emotional abuse, 32.5% (65 people) had physical abuse, and 21% (42 people) had sexual abuse. Among the participants, 29% (58 people) were not neglected, 28% (56 people) were exposed to only one of physical or emotional neglect, and 43% (86 people) were exposed to both physical and emotional neglect. In addition, 29.5% (59 people) had experienced only one of physical, emotional or sexual abuse, 21% (42 people) had experienced both types of abuse, and 9% (18 people) had experienced both physical, emotional and sexual abuse.

The sociodemographic characteristics of those with childhood trauma (CT) (66.5%-1133) and those without (33.5%-567) were analyzed. The mean age was higher (p=0.038) and the mean duration of education was lower (p=0.047) in those with childhood trauma (Table-1). No statistically significant difference was found between the groups with and without CT in terms of gender (p=0.277), marital status (p=0.139), employment status (p=0.560), cohabitants (p=0.504), place of residence (p=0.425), and income level (p=0.679) (Table 1).

Table 1 shows that the number of previous depressive episodes (p=0.003) was higher and the duration of treatment-free period (p=0.048) was shorter in the group with CT compared to the group without CT. No significant statistical difference was

Table 3. Comparison of the subscale scores of the CT with the subscales of the BDI, BAI and DAS

		BDI	BAI	DAS-PA	DAS -NA	DAS -IA	DAS -VA	DAS- T
Emotional neglect n=115 (%57.5)	Median (Min Maks)	26,0 (0-52)	23,0 (0-61)	51,0 (21-109)	42,0 (14-70)	24,0 (6-41)	19,0 (5-31)	135,0 (61-251)
No emotional neglect n=85 (%42.5)	Median (Min Maks)	21,0 (0-43)	19,0 (0-54)	50,0 (24-106)	40,0 (11-67)	21,0 (10-35)	18,0 (9-26)	130,0 (74-230)
p		0,056	0,105	0,771	0,454	0,044*	0,675	0,358
Physical neglect n=113 (%56.5)	Median (Min Maks)	26,0 (0-52)	23,0 (0-61)	54,0 (23-99)	42,0 (12-68)	24,0 (7-37)	20,0 (5-30)	142,0 (61-215)
Without physical neglect n=87 (%43.5)	Median (Min Maks)	20,0 (0-48)	16,0 (0-49)	49,0 (21-109)	40,0 (11-70)	21,0 (6-41)	17,0 (9-31)	17,0 (64-251)
p		0,042*	0,012*	0,104	0,517	0,007*	0,178	0,027*
Emotionally abused n= 90 (%45)	Median (Min Maks)	28,0 (1-52)	23,5 (0-61)	55,0 (21-109)	42,5 (12-70)	24,0 (7-41)	18,0 (7-31)	142,5 (64-251)
Not emotionally abused n=110 (%55)	Median (Min Maks)	20,0 (0-43)	16,0 (0-53)	49,0 (24-106)	40,0 (11-68)	21,0 (6-37)	19,0 (5-30)	129,0 (61-230)
p		?0,001*	0,011*	0,010*	0,074	0,010*	0,553	0,007*
Physically abused n=65 (%32.5)	Median (Min Maks)	28,0 (1-52)	26,0 (0-61)	55,0 (21-99)	43,0 (18-64)	24,0 (6-37)	18,0 (7-29)	144,0 (64-210)
Not physically abused n=135 (%67.5)	Median (Min Maks)	21,0 (0-46)	19,0 (0-54)	49,0 (24-109)	40,0 (11-70)	21,0 (7-41)	19,0 (5-31)	130,0 (61-251)
p		0,003*	0,005*	0,029*	0,109	0,957	0,824	0,039*
Sexually abused n=42 (%21)	Median (Min Maks)	26,5 (2-52)	21,0 (0-61)	52,5 (21-99)	41,0 (14-64)	24,0 (8-37)	17,5(11-30)	134,0 (84-210)
Not sexually abused n=158 (%79)	Median (Min Maks)	22,0 (0-48)	21,5 (0-54)	50,0 (23-109)	41,0 (11-70)	21,0 (6-41)	19,0 (5-31)	132,5 (61-251)
p		0,198	0,970	0,621	0,846	0,246	0,739	0,618

Mann-Whitney U test was used. *p<0,05.CT: Childhood trauma . BDI: Beck Depression Inventory, BAI: Beck Anxiety Inventory, DAS T: Dysfunctional Attitudes Scale Total score, DAS PA: Dysfunctional Attitudes Scale Perfectionist Attitude, DAS NA: Dysfunctional Attitudes Scale Need for Approval, DAS, IA: Dysfunctional Attitudes Scale Independent Attitude, DAS VA: Dysfunctional Attitudes Scale Variable Attitude

found between the groups with and without CT in terms of age at onset of depression (p=0.285), duration of the last episode (p=0.491), duration of the last regular treatment (p=0.151), number of self-murder attempts (p=0.061), number of hospitalizations (p=0.117), thoughts (p=0.392) and attempts (p=0.304) of self-murder during the last illness (Table-1).

No significant statistical difference was found between the groups with childhood trauma and the groups without CT in terms of BDI (p=0.233), DAS total score (p=0.315) and subscores (Table-2). Only the mean score of the BDI was found to be statistically significantly higher in those with CT compared to those without CT (p=0.024) (Table 2).

Using the cut-off scores of the subscale scores of the childhood traumas scale, the groups were divided into two groups as with and without physical and emotional neglect/abuse and sexual abuse and comparisons were made between the groups in terms of scale scores. The independent attitude subscale score of the DAS was found to be significantly higher in those with emotional neglect (EN) (57.5%-115 participants) compared to those without emotional neglect (42.5% 5-85 participants) (p=0.044, Table 3).

It is seen in Table 3 that the scores of the BDI (p=0.042), BAI (p=0.012), total score of the DAS (p=0.027), and independent attitude subscale scores of the DAS (p=0.007) were higher in those with physical neglect (PN) (56.5%-113 persons) compared to those without (43.5%-587 persons).

It was found that those who were exposed to emotional abuse (EA) (45-90%) had significantly higher scores on the BDI (p<0.001), BAI (p=0.011), total score of the DAS (p=0.007), perfectionist attitude of the DAS (p=0.010), and independent attitude of the DAS (p=0.010) subscale scores than those who were not exposed to EA (55-110%) (Table 3).

The BDI (p<0.003), BAI (p=0.005), DAS total score (p=0.039), and DAS perfectionist attitude (p=0.029) subscale scores were found to be significantly higher in those with physical abuse (32.5-65%) compared to those without (67.5-135%) (Table-3).

There was no significant difference between those who had been exposed to sexual abuse (SA) (21-42%) and those who had no history of SA (79-158%) in terms of scale scores (Table 3).

The relationships between the total and subscale

Table 4. Correlations associated with scale scores

Spearman's Rho	Emotional Abuse	Physical Abuse	Physical Neglect	Emotional Neglect	Sexual Abuse	Total CTS	BDI	BAI	DAS-PA	DAS-NA	DAS-IA	DAS-VA
	r	r	r	r	r	r	r	r	r	r	r	r
Emotional Abuse	-											
Physical Abuse	0,521***	-										
Physical Neglect	0,370***	0,401***	-									
Emotional Neglect	0,492***	0,440***	0,615***	-								
Sexual Abuse	0,254***	0,182**	0,145*	0,179*	-							
Total CTS	0,735***	0,616***	0,747***	0,878***	0,355***	-						
BDI	0,283***	0,200**	0,149*	0,141*	0,90	0,236***	-					
BAI	0,204**	0,192**	0,195**	0,157*	0,016	0,225***	0,609***	-				
DAS-PA	0,219**	0,139*	0,159*	0,019	0,031	0,139	0,320***	0,256***	-			
DAS-NA	0,128	0,098	0,144*	0,060	0,004	0,108	0,279***	0,227***	0,705***	-		
DAS-IA	0,173*	0,015	0,205**	0,223**	0,099	0,238***	0,186**	0,169*	0,218**	0,261***	-	
DAS-VA	-0.057	-0,013	0,091	0,063	-0,057	0,032	0,125	0,095	0,219**	0,295***	0,383***	-
DAS-T	0.208**	0,124	0,205**	0,097	0,034	0,182**	0,339***	0,280***	0,908***	0,858***	0,455***	0,435***

r: Spearman korelasyon katsay s ,***p?0,001, **p?0,01, *p<0,05. BDI: Beck Depression Inventory, BAI: Beck Anxiety Inventory, DAS T: Dysfunctional Attitudes Scale Total score, DAS PA: Dysfunctional Attitudes Scale Perfectionist Attitude, DAS NA: Dysfunctional Attitudes Scale Need for Approval, DAS, IA: Dysfunctional Attitudes Scale Independent Attitude, DAS VA: Dysfunctional Attitudes Scale Variable Attitude, CTS: Childhood Trauma Scala

scores of the BDI, BAI, dysfunctional attitudes and childhood traumas scale were shown in Table-4. A weak positive correlation was found between the scores of emotional neglect and the scores of the independent attitude subscale of the BDI, BAI, and DAS ($p<0.05$, Table 4). There was a weak positive correlation between the physical neglect scores and the total scores of BDI, BAI, DAS, and DAS perfectionist attitude, DAS need for approval, and DAS independent attitude subscale scores ($p<0.05$, Table 4). A weak positive correlation was found between emotional abuse scores and total scores of BDI, BAI, DAS and subscale scores of perfectionist attitude of DAS and independent attitude of DAS ($p<0.05$, Table 4). A weak positive correlation was found between the physical abuse scores and the BDI, BAI and DAS perfectionist attitude subscale scores ($p<0.05$, Table 4).

As a result of binary logistic regression analysis including age, gender and marital status as confounding factors, no statistically significant difference was found between the total score and subscale scores of the BDI, BAI, dysfunctional attitudes and childhood traumas scale included in the correlation analysis and depression in remission and moderate-severe depression groups.

Since the mean age and number of depressive episodes were found to be high in patients with CT, logistic regression analysis was performed to examine the effect of these variables. In the logistic regression analysis, it was found that the number of previous depressive episodes was 1.39 times ($p=0.02$, 95% CI=1.04- 1.85) higher in the age-adjusted model in patients with CT compared to those without CT.

DISCUSSION

In our study, it was found that those with childhood trauma comprised more than half of the sample (66.5%), had a higher number of previous depressive episodes, higher depression severity scores and were less educated.

Child abuse and neglect is an important public health problem and has been associated with psychiatric diseases in many long-term studies (2). In our study, it was found that two thirds of the patients followed up for depression had childhood trauma. The most common CT was emotional neglect, followed by physical neglect, emotional abuse, physical abuse and sexual abuse, respectively.

In a study by Bülbül F et al. it was found that when patients with recurrent depression were compared with the first episode depression group, their childhood trauma scores were higher and their illnesses started at an earlier age (17). In our study, no difference was found in the age of onset unlike the literature. On the other hand, both the number of previous depressive episodes and the mean age were found to be higher in those with a history of childhood trauma. Statistical analysis was performed to investigate the effect of age and the presence of CT on the risk of having a depressive episode. In the logistic regression analysis, when age was standardized, it was found that the number of previous depressive episodes was 1.36 times higher in those who had a history of CT compared to those who did not, and the presence of childhood trauma increased the likelihood of recurrence of depression. In a study of 2288 individuals with depression and anxiety disorders in the Netherlands, emotional neglect was found to be

particularly associated with depressive disorder, dysthymia and social phobia. In the same study, it was found that those with a history of emotional neglect and sexual abuse had a higher lifetime risk of developing more than one affective disorder (18). However, a few studies reporting the opposite view have reported that adversities experienced at an early age have a protective effect against the development of depression and anxiety in adulthood (19,20). In our study, the most common comorbidity among comorbidities in patients with depression was anxiety disorder not otherwise specified. However, no significant difference was found in terms of comorbidities in cases with and without childhood trauma.

Although it varies according to regions in Turkey, it has been shown that sexual abuse is observed with a rate of 10-53% and 30% of this rate occurs between the ages of 2-5 years and 40% between the ages of 6-10 years (21). In our study, in accordance with the literature, those who were sexually abused were approximately one fifth of the depressed individuals who participated in the study. In our study, the rate of those with at least one type of neglect was 28% and two types of neglect was 43%, while the rate of those exposed to one type of abuse was 29.5%, two types of abuse was 21% and three types of abuse was 9%. These results show that children who are exposed to any type of neglect or abuse become vulnerable to other types of neglect and abuse, and that these individuals experience many dimensions of abuse together.

Dysfunctional attitudes observed in depressed individuals are one of the important parts of the cognitive structure and play a fundamental role in the formation of cognitive distortions. Childhood traumas may mediate the development of dysfunctional attitudes through their effects on the formation of schemas and increase the susceptibility to psychopathology, especially to the development of depression (22,23). The perfectionist attitude of the DAS is associated with worrying about being criticized and negatively evaluated by others and evaluating the slightest mistakes and deficiencies as inadequacy and incompetence. While need for approval is related to the fact that one's self-worth depends on love, approval and support from others, independent attitude is related to the fact that one is independent from environmental approval needs. The last subscale, the DAS variable attitude, includes the flexible attitudes of the individual (24,25). In our study, a positive correlation was found between the scores of the emotional neglect and physical neglect subscales of the CTS and the independent attitude of the DAS. Based on these findings, it can be thought that emotional and physical neglect leads to a decrease in the need for approval from other people and a decrease in the need for bonding with people as a result of individuals growing up in an environment where their needs are not constantly met. The weakening of social ties as a result of this attitude may also mediate depression. The high level of perfectionist dysfunctional attitudes in individuals who experienced emotional and physical abuse in our study may be related to the fact that they try to avoid being criticized, blamed and punished by not making mistakes, doing everything completely, focusing on their own responsibilities in every event and trying to correct them. In addition, a significant correlation was also found between the emotional abuse score of the CTS and the independent attitude of the DAS. In a study conducted in China, exposure to more childhood trauma was associated with more dysfunctional attitudes in individuals with depression. In addition, emotional abuse and physical neglect among childhood trauma subscales were found to be more associated with dysfunctional attitudes (26). This result is similar to other studies in the literature supporting the positive relationship between emotional neglect and dysfunctional attitudes in individuals diagnosed with depression (27). In addition, in our study, depression and anxiety scale scores were found to be higher in those who were exposed to emotional abuse, physical neglect or abuse in childhood. This is consistent with literature studies. In a study conducted in Eskişehir (62 patients with depressive disorder, 8 patients with dysthymic disorder, 50 healthy controls), a significant correlation was found between the BDI score and the DAS score and the emotional abuse and neglect score of the CTS, and it was reported that dysfunctional attitudes developed in women, especially with exposure to emotional abuse, and thus people became more prone to depression (28). In our study, no significant correlation was found between the sexual abuse subscale score of the CTS and the subscale scores of the

BDI, BAI and DAS. This may be related to the low number of patients reporting sexual abuse, or it may be related to the fact that emotional abuse in childhood is more traumatizing than sexual abuse, contrary to popular belief.

In our study, there was a significant positive correlation between depression and anxiety scale scores and all subscale scores except the total score of the DAS and variable attitude. Some of the patients who participated in our study had depression in remission under treatment, while others had depression with active symptoms. Logistic regression analysis was performed to examine whether dysfunctional attitudes and CTS scale scores were different between depression in remission and moderate to severe depression groups, and no statistically significant difference was found. Based on this finding, it can be thought that dysfunctional attitudes are not caused by depression, but rather a factor that causes depression. This finding supports the role of dysfunctional attitudes in the formation of depression and anxiety in line with the literature.

The presence of any dysfunctional attitude, especially perfectionist attitude and need for approval, was positively correlated with other subscale scores. Based on this finding, it can be said that the presence of any dysfunctional attitude may play a facilitating role for other dysfunctional beliefs and attitudes.

Limitations of the Study

The fact that we used self-report-based scales in our study constitutes a limitation. In particular, there is a risk that self-report of sexual abuse in the scale used in our study is lower than it actually is as a result of embarrassment, fear and social prejudices.

Childhood trauma was present in more than half (66.5%-133%) of the individuals who were followed up for unipolar depression. The most common CTS was emotional neglect, followed by physical neglect, emotional abuse, physical abuse and sexual abuse, respectively. Being exposed to any childhood trauma in depressed individuals increases the likelihood of being subjected to other abuses and neglect. Having any dysfunctional attitude also increases the likelihood of having other dysfunctional attitudes. The presence of childhood trauma increased the likelihood of recurrence of depression by 1.39 times.

To the best of our knowledge, our study is one of the rare studies in the literature examining the relationship between the subscales of the DAS and the subscales of the CT. In particular, physical and emotional neglect among childhood traumas was found to be associated with the development of independent dysfunctional attitude, while emotional and physical abuse was found to be associated with the development of perfectionist dysfunctional attitude. We think that addressing cognitive distortions in the follow-up and treatment of these patients in the light of this information may contribute positively to treatment response and prognosis.

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