SCIE DOI: 10.14744/scie.2022.47113
South. Clin. Ist. Euras. 2022;33(4):379-383

Original Article

Childhood Traumas in Bipolar Disorder Patients with Social Phobia Comorbidity

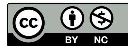
İsmail Koç

Department of Psychiatry, Kartal Dr. Lütfi Kırdar City Hospital, İstanbul, Türkiye

Submitted: 05.07.2021
Revised: 12.01.2022
Accepted: 25.02.2022

Correspondence: İsmail Koç, Kartal Dr. Lütfi Kırdar Şehir Hastanesi, Ruh ve Sinir Hastalıkları Bölümü, İstanbul, Türkiye
E-mail: drismailkoc@gmail.com

Keywords: Bipolar disorder; childhood trauma; social phobia.



This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

ABSTRACT

Objective: Main purpose of the study is to investigate the effects of childhood traumas on bipolar disorder (BD) patients with social phobia (SP) comorbidity.

Methods: Individuals were divided into three groups, with SP (n=96), without SP (n=27), and without BD divided as the control group (n=32). In this prospective study, the sociodemographic questionnaire, structured clinical interview for DSM-IV axis I disorders (SCID-I), childhood trauma questionnaire, and Liebowitz social anxiety scale were applied to the patients

Results: There were 52 (53.1%) men and 46 (46.9) women with the mean age 41.10±10.90 years during the study. Thirty-six patients (36.7%) were in the SP group, 30 patients (30.6%) were in the without SP group, and 32 (32.7) were in the control group. There is a statistically significant difference between bipolar patients with SP, without SP, and the control group in terms of childhood trauma questionnaire (CTQ) scores (p<0.05). It is found that this significant difference originated from the bipolar patients' group with SP also, while there is a statistically significant between female patients in terms of CTQ (p<0.05), but there is no statistically significant between male patients in terms of CTQ (p>0.05).

Conclusion: It was found that SP comorbidity in BD was highly correlated with childhood traumas in our study.

INTRODUCTION

Bipolar disorder (BD) is characterized as a depressive episode and is defined as the alternating course of mania or hypomania symptoms. While BD, which was a chronic disease, was defined as having normal periods in between and varying with periods of mania and depression during the course of the disease, it is now defined as bipolar affective disorders with heterogeneous and sub-forms.[1] The classical information that the prevalence of BD is 1% in the general population is being questioned more and more, and there are convincing data that the disorders in this group are seen in around 5% of the general population and up to 50% in all depressions.[2,3]

Social phobia (SP) is defined as the occurrence of anxiety symptoms when the person enters an unfamiliar environment, constantly fearing that strangers will be on top of his attention and fearing that he will be humiliated or embarrassed by what he has to say. Although SP is long-term and chronic, it causes intense anxiety in the exposed individual.[4] In case of progression of the disease, bad habits such as depression, alcohol addiction, and suicidal behaviors may be included in this picture over time. These comorbid diagnoses cause the disease process to progress more seriously and cause the person to lose their functions in self-care and social roles over time. In this article, after briefly mentioning the epidemiology and etiology of social anxiety, the frequency of comorbid mood disorders, the effect of comorbidity on the process, and possible causes of this association were tried to be explained.[5,6]

BD is a mental health disease that can be seen at any age, but often starts between the ages of 17 and 31, has a chronic course, has a significant risk of morbidity and mortality, and is seen at the same rate in men and women. The comorbidity of SP in patients with BD varies between 5% and 47.2%. Furthermore, BD is seen in 3–21% of SP patients.[5,7] Studies on patients with SP comorbidity are very limited in the literature. Kessler et al.[8] suggested that BD and comorbidity of SP are closely related. In another study, it is found that the frequency of SP comorbidity to be 17% in bipolar I patients and 12% in bipolar II disorder patients.[8]

Childhood traumas are defined in the literature as sudden and unexpected events that threaten the physical and mental integrity of the person. Psychological traumas in childhood can be in the form of accidents, natural disasters, sexual, physical, emotional abuse, and neglect. It is known that abuse and neglect situations can lead to serious psy-

chiatric problems as they start in childhood and continue into adulthood. Although studies on BD and childhood are limited in the literature, it shows that traumatic situations have long-term effects in relation to BD.[9]

In one study that included 100 patients diagnosed with BD I and II, it was determined that almost half of the study group had severe abuse in at least one category. It has been observed that the onset of the disease in abused patients is at a younger age when compared to patients without the onset of the disease, and also, the severity of manic symptoms is higher in these abused patients.[10]

In the study of Brown et al.[11] (2005), half of the patients with BD reported any form of abuse. It was not associated with an increased number of the early onset or additional medical conditions in the study.

In another study conducted on 333 BD patients, 12% of individuals were sexually abused, 56% were physically abused, and 10% were both physically and sexually abused. They stated that these rates were in line with the general community standards, but that the abused victims had longer hospital stays and had more depressive episodes than others.[12]

As far as we know, there is no other study in the literature investigating the SP comorbidity of childhood traumas in individuals with BD. The main purpose of the study is to identify the causes associated with the BD, to draw attention to the factors in the treatment processes and the formation of the disease, to create sensitivity both as literature and childhood traumas on BD patients with SP comorbidity.

MATERIALS AND METHODS

The study was conducted with the 98 individuals (n=66 having BD, n=32 healthy group) who met the inclusion criteria. The individuals registered at the Community Mental Health Center and followed up regularly were included to this study. Individuals who gave written consent to participate in the study were divided into three groups according to Liebowitz social anxiety scale, respectively, with SP (n=39), without SP (n=27), and control group (n=32). The criteria for acceptance of the subjects into the study was being literate, being between the ages of 18 and 65, absence of diseases with cognitive deficit (such as Delirium-Dementia), which had been diagnosed with BD according to DSM-IV-TR, currently not having an active comorbid psychiatric disease other than SP, still in the euthymic stage. Individuals with cognitive and physical dysfunction that would prevent interview or testing, active psychotic symptoms, and substance use were excluded from the study.

The study was planned as a cross-sectional study. Sociodemographic questionnaire, Structured Clinical Interview for DSM-IV axis I disorders (SCID-I), childhood trauma questionnaire (CTQ), and Liebowitz social anxiety scale were applied to the patients.

Ethics committee approval of the study and the decision number was given 514/194/41 on January 27, 2021.

Interview form for BD patients

The interview form was created by scanning the relevant resources and using the interviews of individuals diagnosed with BD who applied between January and June 2021. In the first part of this form, information about the sociodemographic characteristics of the subjects was collected (age, marital status, economic status, educational status, employment status, social security presence, family structure, and place of residence). In the second part, information about the clinical determinants of the first episode of the disease, the severity of the episodes, hospitalization, and suicide attempts before and after the initiation of protective mood stabilizer therapy were collected.

Structured clinical interview for DSM-IV Axis I disorders SCID-I

Developed by First, Spitzer, Gibbon, and Williams in 1987, this scale is a structured clinical assessment form applied by the interviewer in the investigation of Axis I psychiatric disorders according to DSM-IV. It consists of questions and sections developed to identify a total of seven diagnostic groups. These diagnostic groups are; mood disorders, psychotic disorders, substance abuse, anxiety disorders, somatoform disorders, eating disorders, and adjustment disorders. In the clinical interview, demographic data and identity information are obtained first, and then, the questions created to determine the diagnosis groups are asked to the patient one by one. Turkish validity and reliability of DSM-IV SCID-I in Turkey were done by Çorapçıoğlu et al.[13]

Childhood Trauma Scale (CTQ)

It is a self-report scale designed to retrospectively screen childhood and adolescence experiences of abuse and neglect, originally developed by Bernstein et al.[14] There are forms with 28 and 53 questions (we used a 28-question form in our study). Physical abuse (sum of scores of items 8, 9, 10, 14, and 16), physical neglect (sum of scores of items 1, 3, 5, 15, and 28), emotional abuse (2, 7, 13, 17, and 64), emotional neglect (sum of the scores of the items 4, 6, 12, 18, and 27), and sexual abuse (the sum of the scores of the items 19, 20, 22, 23 and 26) were determined separately. Items 4, 6, 12, 15, 18, and 27 were reverse scored.[15] Turkish version of this scale done by Sar et al.[16] (2012).

Liebowitz social anxiety scale

It was prepared to determine the fear and/or avoidance levels of patients with social anxiety disorder in social interaction and performance situations. It is the scale evaluated by the interviewer who knows psychopathology. The main application group is patients with social anxiety disorder, but it can also be used in healthy society for screening purposes. A total of 24 items were evaluated separately for anxiety and avoidance in a four-point Likert

type. The result of the interview with the patient is filled in by marking on the scale. During the interview, for each item, how much anxiety or fear the situation creates and how much avoidance it causes are questioned. The scores obtained by the patient from the items in each section are summed to obtain separate subscale scores.[17] The Turkish version of the scale was done by Dilbaz and Güz[18] (2001). The cutoff score was calculated in the Turkish version of the scale.

Statistical analysis

Statistical evaluations were made using the "Statistical Package for the Social Sciences for Windows 25" package program. The mean and percentage values of data and results were presented as comparison of independent groups. Arithmetic means and standard deviation values were used for descriptive statistics. For non-parametric test analysis, Mann–Whitney U-test and Kruskal–Wallis test were used for the analysis of three groups among themselves. Statistical significance value was accepted as "p<0.05".

RESULTS

A total of 98 patients with BD were included to this study. There were 52 (53.1%) men and 46 (46.9%) women with the mean age 41.10±10.90 years. Thirty-nine patients (39.8%) were in SP group and 27 patients (27.6%) in without SP group according to the result of Liebowitz social anxiety scale (Table 1). Furthermore, 32 (32.7%) patients were included to the control group.

There was statistically significance in age, judicial history, history of disease in first-degree relatives, total hospital stay, suicide attempt, and life event in the emergence of attacks between all groups (p<0.05), but there was no statistically significant difference in gender between groups (p>0.05) (Table 1).

It was found a statistically significant difference between bipolar patients with SP, without SP, and control groups in terms of CTQ scores (p<0.05). The Kruskal–Wallis test was used in evaluation between groups (Table 2).

Mann–Whitney U-test was applied to the paired groups to

Table 1. Demographic characteristics of bipolar patients with social phobia, without social phobia, and control group in the study

	Bipolar patients with social phobia	Bipolar patients without social phobia	Control group		p-value
Age (Mean±SD)	46.07±7.57	42.77±12.78	33.62±8.57	48.939[a]	0.001*
Gender, n (%)					
Female	21 (53.8)	12 (44.4)	13 (40.6)	0.367[b]	0.544
Male	18 (46.2)	15 (55.6)	19 (59.4)		
Judicial history, n (%)					
Available	10 (25.6)	9 (33.3)	0	36.73[b]	0.00*
Absent	29 (74.4)	18 (66.7)	32 (100)		
History of disease in first-degree relatives, n (%)					
Available	23 (59)	12 (44.4)	0	8.00[b]	0.005*
Absent	16 (41)	15 (55.6)	32 (100)		
Total hospital stay (Mean±SD)	37.18±32.07	81.89±108.24	0	225.59[c]	0.00*
Suicide attempt, n (%)					
Available	21 (53.8)	8 (29.6)	0	16.32[b]	0.00*
Absent	18 (46.2)	19 (70.4)	32 (100)		
Life event in the emergence of attacks, n (%)					
Available	31 (79.5)	13 (48.10)	0	7.42[d]	0.024*
Absent	8 (20.5)	14 (51.90)	32 (100)		

*P<0.05.

Table 2. Comparison of the results of the bipolar patients with social phobia, without social phobia and control group with the results of the Childhood Trauma Questionnaire between groups

	Bipolar patients with social phobia Median (min-max)	Bipolar patients without social phobia Median (min-max)	Control group Median (min-max)	p-value
CTQ	80 (58.00–91.00)	84 (78.00–92.00)	86 (72.00–91.00)	0.00*

*P<0.05.

Table 3. Distribution of childhood trauma questionnaire results in male and female genders

	CTQ	p-value
Female, Median (min-max)	82 (58.00–92.00)	0.00*
Male, Median (min-max)	82 (67.00–91.00)	0.291

*P<0.05.

find out which group caused this significant difference and it was concluded that the significant difference originated from the bipolar patients group with SP (p<0.05) (Table 2).

While there was a statistically significant difference between female patients in terms of CTQ-28 (p<0.05), but there was no statistically significant difference between male patients in terms of CTQ-28 (Table 3).

DISCUSSION

In this study, we aimed to investigate the effects of childhood traumas on BD patients with SP comorbidity.

In the literature, it was shown that stress and emotional trauma in early childhood are associated with increased psychopathology and increased risk of suicide and constitute a more severe subtype of BPD.[19] Schneier et al.[20] suggested that BD and co-diagnosis of SP are closely related.

In a study conducted in Hungary, the lifetime SP rate in bipolar patients was 7.8%, and in a study conducted in Italy, it was 8.2% in 77 patients with bipolar and schizoaffective disorder.[21,22] Furthermore, McElroy et al.[23] studied in bipolar II disorder patients. In this study, a significant relationship was determined with the presence of current and lifetime axis I comorbidity, earlier onset of affective symptoms and BD, rapid cycling, and more severe attacks.

In a recent study by Koyuncu et al.,[24] the frequency of obsession was found to be 16.2% in patients with BD, while the comorbidity of SP was found to be 28% in the bipolar-obsession group and 34% in the bipolar group without obsession. Although there was no significant difference between the two groups, the high comorbidity rate of 30% draws attention. In a study conducted in our country, Tamam and Ozpoyraz[25] reported that at least one anxiety disorder comorbidity rate was 61% and SP comorbidity rate was 20% in bipolar I disorder patients.

It has been reported that general psychopathology and anxiety levels in bipolar patients with BD showed parallelism with the increase in the number of anxiety disorder comorbidities. Despite the significant increase in psychometric scales; it was emphasized that there was no significant change in variables such as suicide, duration of illness, and hospitalization, it was difficult to determine exactly how anxiety disorder comorbidity affects the process and outcome of BD.[26]

Simon et al.[27] examined 475 patients diagnosed with bipolar I and II disorders and found the rate of SP to be 22%, higher than that of the general population. In this study, lifetime anxiety disorder comorbidity was found to be associated with earlier onset, decreased probability of recovery, worse functionality and quality of life, less euthymic life span, and more suicide attempts.

In the study by Henry et al.[28] (2005), patients with a history of abuse reported lifetime comorbidities such as post-traumatic stress disorder, anxiety disorders, and substance abuse disorders more intensely. It was not associated with an increased number of the early onset or additional medical conditions, except for those with a history of abuse in either type. However, rapid cycling was reported to be twice as common in the physically abused group.

While more suicidal attempts were found in patients with bipolar patients in patients with emotional abuse, this rate was not the same for emotional neglect, physical neglect, or physical abuse. It is reported that as the number of childhood trauma increases, the number of suicide attempts also increases.[29]

The limitation of our study was the absence of a SP group in the normal healthy population. Therefore, it can be planned to involve one more SP healthy group and can be compared between groups in the future. Furthermore, more comprehensive studies are needed to assess the relationship between childhood traumas and SP with BD.

In conclusion, it was found that SP comorbidity in BD was highly correlated with childhood traumas in our study.

Ethics Committee Approval

This study approved by the Kartal Dr. Lütfi Kırdar City Hospital Clinical Research Ethics Committee (Date: 27.01.2021, Decision No: 514/194/41).

Informed Consent

Prospective study.

Peer-review

Externally peer-reviewed.

Authorship Contributions

Conflict of Interest

None declared.

REFERENCES

1. Leboyer M, Henry C, Paillere-Martinot ML, Bellivier F. Age at onset in bipolar affective disorders: a review. Bipolar Disord 2005;7:111–8.
2. Akiskal HS. The bipolar spectrum: research and clinical perspectives. Encephale 1995;21 Spec No 6:3–11.
3. Schou M. The new bipolar era and beyond. J Affect Disord 2001;67:1–2. [CrossRef]
4. Evren C. Sosyal anksiyete bozukluğu ve alkol kullanım bozuklukları. Psikiyatride Güncel Yaklaşımlar 2010;2:473–515.
5. Van Ameringen M, Mancini C, Styan G, Donison D. Relationship of social phobia with other psychiatric illness. J Affect Disord 1991;21:93–9. [CrossRef]
6. Perugi G, Frare F, Toni C, Mata B, Akiskal HS. Bipolar II and unipolar comorbidity in 153 outpatients with social phobia. Compr Psychiatry 2001;42:375–81.

7. Rush AJ, Zimmerman M, Wisniewski SR, Fava M, Hollon SD, Warden D, et al. Comorbid psychiatric disorders in depressed outpatients: demographic and clinical features. J Affect Disord 2005;87:43–55.
8. Kessler RC, Stang P, Wittchen HU, Stein M, Walters EE. Lifetime co-morbidities between social phobia and mood disorders in the US national comorbidity survey. Psychol Med 1999;29:555–67.
9. Popovic D, Schmitt A, Kaurani L, Senner F, Papiol S, Malchow B, et al. Childhood trauma in schizophrenia: current findings and research perspectives. Front Neurosci 2019;13:274. [CrossRef]
10. Anisman H, Zaharia MD, Meaney MJ, Merali Z. Do early-life events permanently alter behavioral and hormonal responses to stressors? Int J Dev Neurosci 1998;16:149–64. [CrossRef]
11. Brown GR, McBride L, Bauer MS, Williford WO; Cooperative Studies Program 430 Study Team. Impact of childhood abuse on the course of bipolar disorder: a replication study in U.S. veterans. J Affect Disord 2005;89:57–67. [CrossRef]
12. Francis DD, Caldji C, Champagne F, Plotsky PM, Meaney MJ. The role of corticotropin-releasing factor--norepinephrine systems in mediating the effects of early experience on the development of behavioral and endocrine responses to stress. Biol Psychiatry 1999;46:1153–66.
13. Çorapçıoğlu A, Aydemir Ö, Yıldız M. Turkish adaptation and reliability study of the structured clinical interview for DSM-IV Axis I disorders. Adaptation into Turkish and reliability of structured clinical interview for DSM-IV (SCID). İlaç ve Tedavi Dergisi 1999;12:33–6.
14. Bernstein DP, Stein JA, Newcomb MD, Walker E, Pogge D, Ahluvalia T, et al. Development and validation of a brief screening version of the Childhood Trauma Questionnaire. Child Abuse Negl 2003;27:169-90. [CrossRef]
15. Tyrka RT, Wyche MC, Kelly MM, Price LH, Carpenter LL. Childhood maltreatment and adult personality disorder symptoms: influence of maltreatment type. Psychiatry Res 2009;165:281–7.
16. Sar V, Öztürk E, İkikardeş E. Validity and reliability of the Turkish version of Childhood Trauma Questionnaire. Türkiye Klinikleri J Med Sci 2012;32:1054–63. [CrossRef]
17. Liebowitz MR. Social phobia. Mod Probl Pharmacopsychiatry 1987;22:141–73. [CrossRef]
18. Dilbaz N, Güz H. Liebowitz sosyal kaygı ölçeğinin geçerlik ve güvenirliği. 37. Ulusal Psikiyatri Kongresi. Istanbul; 2-6 Ekim 2001.
19. Erten E, Uney AFK, Fıstıkcı N. Bipolar disorder and childhood trauma. Current Approaches in Psychiatry 2015;7:157–65.
20. Schneier FR, Johnson J, Hornig CD, Liebowitz MR, Weissman MM. Social phobia: Comorbidity and morbidity in an epidemiologic sample. Arch Gen Psychiatry 1992;49:282–8. [CrossRef]
21. Szadoczky E, Papp ZS, Vitrai J, Rihmer Z, Furedi J. The prevalence of major depressive and bipolar disorders in Hungary. Results from a national epidemiologic survey. J Affect Disord 1998;50:153–62.
22. Pini S, Maser JD, Dell'Osso L, Abelli M, Muti M, Gesi C, et al. Social anxiety disorder comorbidity in patients with bipolar disorder: A clinical replication. J Anxiety Disord 2006;20:1148–57. [CrossRef]
23. McElroy SL, Altshuler LL, Suppes T, Keck PEJ, Frye MA, Denicoff KD, et al. Axis I psychiatric comorbidity and its relationship to historical illness. Am J Psychiatry 2001;158:420–6.
24. Koyuncu A, Tukel R, Ozyildirim I, Meteris H, Yazici O. Impact of obsessivecompulsive disorder comorbidity on the sociodemographic and clinical features of patients with bipolar disorder. Compr Psychiatry 2010;51:293–7. [CrossRef]
25. Tamam L, Ozpoyraz N. Comorbidity of anxiety disorder among patients with bipolar I disorder in remission. Psychopathology 2002;35:203–9. [CrossRef]
26. Etain B, Aas M, Andreassen OA, Lorentzen S, Dieset I, Gard S, et al. Childhood trauma is associated with severe clinical characteristics of bipolar disorders. J Clin Psychiatry 2013;74:991–8.
27. Simon NM, Otto MW, Wisniewski SR, Fossey M, Sagduyu K, Frank E, et al. Anxiety disorder comorbidity in bipolar disorder patients: data from the first 500 participants in the Systematic Treatment Enhancement Program for BD (STEP-BD). Am J Psychiatry 2004;161:2222–9. [CrossRef]
28. Henry C, Van den Bulke D, Bellivier F, Etain B, Rouillon F, Leboyer M. Anxiety disorders in 318 bipolar patients: prevalence and impact on illness severity and response to mood stabilizer. J Clin Psychiatry 2003;64:331–5. [CrossRef]
29. Martin MS, Dykxhoorn J, Afifi TO, Colman I. Child abuse and the prevalence of suicide attempts among those reporting suicide ideation. Soc Psychiatry Psychiatr Epidemiol 2016;51:1477-84.

Sosyal Fobi Komorbidliği olan Bipolar Bozukluk Hastalarında Çocukluk Çağı Travmaları

Amaç: Çalışmanın temel amacı sosyal fobi komorbidliği olan bipolar bozukluğu hastalarında çocukluk çağı travmasının etkilerini araştırmaktır.

Gereç ve Yöntem: Çalışmada, psikiyatrist tarafından Bipolar bozukluk teşhisi almış olan bireyler sırasıyla sosyal fobisi olan (n=39) ve sosyal fobisi olmayan (n=27) olarak, sağlıklı bireyler ise kontrol grubu (n=32) olarak belirlenmiştir. Çalışmada bireylere, sosyodemografik anket, DSM IV Eksen I Bozuklukları için Yapılandırılmış Klinik Görüşme (SCID-I) anketi, Çocukluk çağı travma ölçeği ve Liebowitz Sosyal Anksiyete Ölçeği uygulanmıştır.

Bulgular: Çalışmaya katılan 52 erkek (%53.1) ve 46 kadın (%46.9) bireylerin ortalama yaşları 41.10±10.90 olarak bulunmuştur. Sosyal fobi grubunda 39 birey (%36.7), sosyal fobisi olmayan grupta 27 birey (27.6) ve kontrol grubunda ise 30 birey (%30.6) çalışmada yer almıştır. Sosyal fobisi olan, olmayan ve kontrol grupları arasında Çocukluk Çağı travma anketi açısından istatistiksel açıdan anlamlı bir fark saptanmıştır ($p<0.05$). Gruplar arasındaki bu farkın hangi gruptan kaynaklandığına ise ikili test ile bakılmış ve bu farklılığın sosyal fobisi olan bipolar hastalarından kaynaklandığı saptanmıştır. Ayrıca, Çocukluk çağı travma anketi, kadın ve erkek cinsiyetleri açısından incelendiğinde kadın bireyler arasında istatistiksel açıdan anlamlı bir fark bulunurken, erkek bireyler arasında ise istatistiksel açıdan herhangi bir anlamlılık bulunmamıştır ($p>0.05$).

Sonuç: Çalışmamızda sosyal fobi komorbiditesi olan bipolar bozukluk hastalığının çocukluk çağı travması ile yüksek derece ilişkili olduğu sonucunda varılmıştır.

Anahtar Sözcükler: Bipolar bozukluk; çocukluk çağı travması; sosyal fobi.