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RESEARCH ARTICLE

The Association Between Obsessive Compulsive Symptoms, Childhood Traumas, and Dissociative Experiences

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ABSTRACT

Background: Obsessive compulsive symptoms (OCS), along with dissociative experiences (DE) are frequently acknowledged as coping strategies in individuals with childhood traumas (CT). Examining these relationships can highlight how early life traumatic events contribute to the emergence of psychopathologies in adulthood. In this study we aimed to investigate the associations between CT, OCS, and DE, and also examined whether DE and CT had a predictive value on OCS in a non-clinical sample of adults.

Methods: Three hundred eighty-eight participants (80.7% females, %83.8 university graduates, 55.4% married individuals) between the age of 18-66 years (M=29.09, SD=7.43 years) and with no current psychiatric diagnosis or treatment were evaluated via socio-demographic information form, Padua Inventory (PI), Dissociative Experiences Scale (DES) and Childhood Traumas Questionnaire (CTQ).

Results: Significant positive associations between CT, DE and OCS were observed. Multiple hierarchical regression analysis revealed CT and DE as predictors of adulthood OCS; and additionally, DE had a stronger predictive value with 28% of the variance whereas CTQ scores predicted approximately 3%.

Conclusion: Early life adversities may be related to emotional dysregulation, which could subsequently be associated with adult psychopathologies and dissociative experiences, suggesting a possible mediating pathway. In order to propose definite causal relations, future studies with longitudinal designs focusing particularly on the timing, duration, and subtypes of early trauma and the appearance of symptoms in adulthood are needed.

Keywords: Childhood traumas, Dissociative experiences, Obsessive Compulsive Symptoms.

Introduction

Obsessive compulsive symptoms (OCS) may not entirely comply with the diagnosis criteria of obsessive compulsive disorder; still, they are highly similar in terms of frequency, and cause of stress on individuals, even in non-clinical settings.[1,2] Previous studies have indicated that exposure to early traumas, including emotional, physical, and sexual abuse, as well as emotional and physical neglect, are widespread and are risk factors for the development and maintenance of OCS in adult life. [2,3]

In a clinical study conducted by Khosravani et al. (2017), it was discovered that greater exposure to childhood traumas (CT) was found associated with increased OCS, such as contamination, feelings of responsibility for harm, unacceptable thoughts, and the need for symmetry.[4] Kroska et al., (2018) examined a non-clinical sample of adults and similarly observed a significant positive correlation between levels of CT and OCS severity.[5] Childhood sexual abuse has been associated with contamination/washing symptoms [6], unacceptable thoughts [4], aggressive obsessions

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and total scores of OCS[8], physical abuse was associated with shameful thoughts[9] cleaning compulsions, religious and contamination obsessions [7], emotional abuse was associated with aggressive sexual obsessions, control compulsions [7] and the severity of OCS [10], physical neglect was associated counting compulsions [7] and OCS in general. [11] And lastly, emotional neglect in childhood was associated with somatic obsessions as well as hoarding obsessions and compulsion symptoms in adulthood. [7]

Several studies reported a significant association between CT and dissociative experiences (DE). [12,13] According to Wilgus et al. (2016), childhood sexual abuse and emotional neglect scores predicted 34% of the dissociation scores among university students.[14] Another study found that women who had both sexual and physical abuse in childhood were at a 106-fold higher risk of reaching high levels of dissociation.[15] Another study also reported a positive association between adverse childhood experiences and dissociation and predictive value. [16]

As recent research reveals that psychiatric conditions are not limited to clinical diagnoses and may be common among non-clinical populations as well, there exists a need for the investigation of subclinical symptoms. Psychopathologies such as OCS[2], dissociative experiences [17], and exposure to any type of neglect or abuse in childhood [18] are outstanding examples. The current study contributes not only to psychopathologies such as OCS and DE, but also examines their association with CT; and therefore, indicates the importance of early life experiences in adult psychopathologies. In this study we aimed to investigate the relationship between CT total scores and along with its subtypes, such as emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect and all the subtypes of OCS, like impulses, cleaning, control, rumination, and precision. And this research also examined whether DE and its subtypes of absorption, amnesia, depersonalization/derealization and CT had a predictive value on OCS within a non-clinical sample of adults.

Materials And Method

Participants and procedure

This study has been conducted via an online survey. Initially, 426 adult volunteers participated in the study. After the exclusion of individuals with a current psychiatric diagnosis or treatment (based on self-report alone), the final sample size was reduced to 388 participants (313 females, 75 males). All participants provided informed consent and contact information for the lead researcher was also provided for further connection.

Measures

Socio-demographic Information Form: Demographic questions were age, sex, education, socioeconomic level and marital status of the participants.

Padua Inventory (PI): Padua Inventory,[19] a self-report scale examining OCS in five subdimensions such as rumination, cleaning, control, impulses, and precision was used. The Turkish adaptation was conducted by Beşiroğlu et al. (2005). In the present study, reliability was between 0.83 and 0.95 (see Table 2). [20]

Childhood Traumas Questionnaire (CTQ): Childhood Traumas Questionnaire, [21] a 28 item self-assessment questionnaire, evaluated individuals' experiences of abuse and neglect with its 5 subdimensions of emotional, physical, sexual abuse and emotional, physical neglect before the age of 20. The Turkish adaptation study of the questionnaire was

Table 1. Comparison of scales according to gender, marital status and education level.

Clinical measures	Female (*n*=313) Mean±SD	Male (*n*=75) Mean±SD	t	p	Married (*n*=215) Mean±SD	Single (*n*=173) Mean±SD	t	p	Under Collage Educated (*n*=63) Mean±SD	Collage Educated (*n*=325) Mean±SD	t	p
CTQ-EA	8.73±4.27	7.77±4.32	1.748	0.081	9.33±4.66	0.11±4.28	7.013	<0.001*	0.25±4.29	8.66±4.40	0.753	0.472
CTQ-PA	6.67±3.71	6.85±4.80	-0.360	0.719	7.13±4.35	0.11±3.93	3.129	0.026*	0.22±3.94	6.66±3.83	0.628	0.534
CTQ-SA	6.92±4.04	6.32±3.54	1.188	0.236	7.34±4.61	0.10±3.95	5.764	0.001	0.23±3.95	6.73±3.91	0.438	0.895
CTQ-EN	11.88±5.47	11.03±5.68	1.198	0.232	12.60±5.47	0.18±5.51	1.614	0.186	0.46±5.51	11.38±5.30	0.146	0.017
CTQ-PN	10.72±1.88	11.19±2.56	-1.502	0.136	10.89±2.09	0.20±2.03	1.491	0.226	0.36±2.03	10.81±1.94	0.491	0.226
CTQ-Total	1.80±0.61	1.74±0.67	0.735	0.464	1.78±0.62	1.63±0.51	6.923	<0.001*	1.96±0.62	1.76±0.63	0.424	0.242
PI-C	11.60±7.96	10.69±9.68	0.753	0.453	11.50±8.61	0.15±9.83	0.810	0.489	0.41±8.32	11.16±8.30	0.921	0.399
PI-R	14.11±9.65	14.17±10.62	-0.049	0.961	14.43±9.84	0.17±9.82	1.005	0.136	0.42±9.83	14.54±9.97	0.885	0.158
PI-CO	8.61±8.10	10.69±9.17	-1.945	0.053	9.29±8.67	0.12±8.34	0.287	0.835	0.33±8.36	9.04±8.40	0.455	0.635
PI-I	5.85±5.92	6.64±6.38	-1.019	0.309	6.07±6.21	0.08±6.00	0.860	0.462	0.19±6.02	6.03±5.91	0.036	0.965
PI-P	3.50±4.55	4.83±5.42	-2.175	0.030*	3.30±4.28	0.05±4.75	2.669	0.047	3.76±4.75	3.74±4.63	0.236	0.011*
PI-Total	1.06±0.68	1.14±0.83	-0.780	0.437	1.08±0.71	1.06±0.68	0.850	0.467	2.57±7.81	1.08±0.72	0.332	0.725
DES-DD	2.13±2.02	2.38±2.23	-0.884	0.379	2.11±2.12	0.03±2.05	0.510	0.675	0.10±2.17	2.05±2.02	0.914	0.021*
DES-DA	1.71±1.74	2.35±2.32	-2.230	0.028*	1.70±1.86	0.02±1.87	1.106	0.371	0.09±1.88	1.67±1.81	0.200	<0.001*
DES-A	3.44±2.23	3.71±2.41	-0.941	0.347	3.37±2.31	0.04±2.26	1.372	0.251	0.15±2.23	3.37±2.25	0.451	0.012*
DES-Total	2.55±1.87	2.91±2.13	-1.365	0.175	2.75±1.86	2.62±1.93	1.106	0.346	0.23±1.90	2.48±1.93	0.938	0.003*

SD: Standard deviation, t: Independent samples t-test; CTQ Total: Childhood Traumas Questionnaire total score; CTQ-EA: Childhood Traumas Questionnaire -Emotional Abuse subdimension, CTQ-PA: Childhood Traumas Questionnaire-Physical Abuse; CTQ-SA: Childhood Traumas Questionnaire-Sexual Abuse; CTQ-EN: Childhood Traumas Questionnaire -Emotional Neglect; CTQ-PN: Childhood Traumas Questionnaire-Physical Neglect; PI Total: Padua Inventory total score; PI-C: Padua Inventory- Cleaning subdimension; PI-R: Padua Inventory-Rumination; PI-CO: Padua Inventory-Control; PI-I: Padua Inventory Impulses; PI-P: Padua Inventory Precision; DES Total: Dissociative Experiences Scale total score; DES-DD: Dissociative Experiences Scale - Derealization/ Depersonalization subdimension; DES-AM: Dissociative Experiences Scale-Dissociative Amnesia; DES-AB: Dissociative Experiences Scale- Absorption subdimension, *: p<0.05, **: p<0.001

conducted by Şar, et al. (2012) and was reported to have a Cronbach's alpha of 0.95 (see Table 2). [22]

Dissociative Experiences Scale (DES): Dissociative Experiences Scale, **23** a self-assessment scale with 28 items, which scans dissociative experience (such as, derealization/depersonalization, dissociative amnesia, and absorption) and their severity, was used. The Cronbach's alpha of the scale was found 0.98 in the Turkish adaptation study by Yargic et al. (1995). The Cronbach's alpha was between 0.87 and 0.95 in this study (see Table 2). [24]

Data Analysis

Descriptive analysis, Pearson correlation, stepwise and multiple hierarchical linear regression analysis were performed on data via SPSS 26. Stepwise logistic regression analyses were performed to identify determinants of OCS which is measured by PI. Block variables were identified as the total scores of CTQ and DES scores. The variables were added in a block only if the difference in the ANOVA analyses had a significance of $p<0.05$, have a significant and higher correlation than 0.20, and have an acceptable range of tolerance and

Table 2. Descriptive statistics and reliability analysis of scales

	Mean±SD	Range	Z Scores	Cronbach's alpha
CTQ-Emotional Abuse	8.55±4.29	5-25	0.204*	0.85
CTQ -Physical Abuse	6.71±3.93	5-25	0.338*	0.93
CTQ -Sexual Abuse	6.81±3.95	5-25	0.336*	0.94
CTQ -Emotional Neglect	11.71±5.51	5-25	0.130*	0.95
CTQ-Physical Neglect	10.81±2.03	5-20	0.283*	0.61
CTQ-Total	45.68±14.18	27-108	0.129*	0.92
PI-Cleaning	11.43±8.32	0-40	0.115*	0.89
PI-Rumination	14.12±9.83	0-40	0.111*	0.92
PI-Control	9.02±8.35	0-32	0.149*	0.93
PI-Impulses	6.01±6.00	0-28	0.167*	0.83
PI-Precision	3.76±4.75	0-24	0.214*	0.83
PI-Total	44.33±29.31	0-145	0.117*	0.95
DES-Depersonalization/Derealization	2.17±2.06	0-10	0.160*	0.87
DES-Dissociative Amnesia	1.84±1.88	0-7	0.174*	0.89
DES-Absorption	3.48±2.26	0-10	0.080*	0.90
DES-Total	26.21±1933	0-89	0.099*	0.95

SD: Standard deviation, CTQ Total: Childhood Traumas Questionnaire total score; PI Total: Padua Inventory total score; DES Total: Dissociative Experiences Scale total score, *: $p<0.05$, **: $p<0.001$

VIF. All the analyses accepted a value of $p<0.05$ to explore significant relationships.

Results

Sample characteristics and group differences

The mean age of the sample (n=388) was 29.09±7.43 years (range between 18 to 66). The majority were females (80.1%; n=313), married (54.1%; n=215) individuals with university education (83.8%; n=325). The samples' mean of the total years of education was 15.84, SD=3.60. Before proceeding with the regression analysis, it was confirmed that there was no evidence of a multiple linear relationship between the predictor variables (CTQ-DES) and the predicted (PI) (Tolerance for DES=1.000, VIF=1.000 and Tolerance for CTQ=0.853, VIF=1.172). Table 1 and 2 show the mean group differences of self-report measures regarding gender, education level and marital status and the mean scores, ranges, standard deviation values, z scores and Cronbach's alpha of the scales, respectively.

Preliminary results

A positive and significant correlation was observed between the total PI scores and the total scores of CTQ ($r=0.345$, $p<0.001$) and DES

(r=0.532, p<0.001). All results provided evidence that regression analysis can be performed with the relevant predictors and then correlation analysis was applied to determine the independent variables. Table 3, 4 and 5 show the Pearson correlations between OCS, CTQ and DE and the subdimensions.

Relationship between specific OCS and specific CT

More specifically, it was found that the cleaning subdimension of PI was weakly and positively correlated with the CTQ subdimensions, such as sexual (r=0.112, p<0.001) emotional (r=0.130, p<0.001) and physical abuse (r=0.136, p<0.001). The rumination subdimension of PI was significantly associated with all the subdimensions of CTQ such as emotional abuse (r=0.398, p<0.001), physical abuse (r=0.349, p<0.001), sexual abuse (r=0.170, p=0.001), emotional (r=0.297, p<0.001) and physical neglect (r=0.308, p<0.001). The control subdimension of PI was found to be significantly and positively associated with emotional abuse (r=0.281, p<0.001), physical abuse (r=0.322, p<0.001), emotional (r=0.143, p=0.005) and physical neglect (r=0.280, p<0.001). Similarly, the impulses subdimension of PI displayed significantly positive correlations with emotional abuse (r=0.377, p<0.001), physical abuse (r=0.368, p<0.001), sexual abuse (r=0.152, p=0.003), emotional (r=0.268, p<0.001) and physical neglect (r=0.242, p<0.001) subdimensions of CTQ. Lastly, the precision dimension of PI was found to be significantly and positively associated with emotional abuse (r=0.216, p<0.001), physical abuse (r=0.259, p<0.001), emotional (r=0.137, p=0.001) and physical neglect (r=0.234, p<0.001).

Relationship between specific OCS and specific DE

In addition to the significant and positive relationships between the total scores of PI and DES, further specific associations were found. The cleaning subdimension of PI was found to significantly and positively associated with depersonalization/derealization (r=0.210, p<0.001), amnesia (r=0.248, p<0.001) and absorption (r=0.288, p=0.001) subdimensions of DES.

Similarly, the rumination subdimension of PI was found to be significantly and positively associated with all of the dimensions of DES such as depersonalization/derealization (r=0.415, p<0.001), amnesia (r=0.330, p<0.001) and absorption (r=0.520, p=0.001).The control dimension of PI was found to significantly and positively associated with depersonalization/derealization (r=0.346, p<0.001), amnesia (r=0.372, p<0.001) and absorption (r=0.439, p<0.001) subdimension of DES. The impulses subdimension of PI displayed significantly positive correlations with depersonalization/derealization (r=0.451, p<0.001), amnesia (r=0.373, p<0.001) and absorption (r=0.519, p<0.001) subdimensions of DES. Lastly, the precision dimension of PI was found to significantly and positively associated with depersonalization/derealization (r=0.369, p<0.001), amnesia (r=0.378, p<0.001) and absorption (r=0.475, p<0.001) dimension of DES.

Relationship between specific CT and specific DE

According to the Pearson correlations, it was found that the emotional, physical, and sexual abuse subdimensions of CTQ were positively correlated with the depersonalization/derealization, amnesia, and absorption subdimensions of DES. The emotional abuse subdimension of CTQ

Table 3. Pearson correlations between childhood traumas and obsessive compulsive symptoms

	1	2	3	4	5	6	7	8	9	10	11	12
1 CTQ-EA	1											
2 CTQ-PA	.718**	1										
3 CTQ-SA	.435**	.361**	1									
4 CTQ-EN	.598**	.428**	.312**	1								
5 CTQ-PN	.437**	.479**	.109*	.315**	1							
6 CTQ-TS	.853**	.757**	.598**	.832**	.475**	1						
7 PI-C	.112*	.130*	.136**	.039	.088	.107*	1					
8 PI-R	.398**	.349**	.170**	.297**	.308*	.390**	.377**	1				
9 PI-CO	.281**	.322**	.089	.143**	.280*	.260**	.435**	.638**	1			
10 PI-I	.377**	.368**	.152**	.268**	.242*	.360**	.358**	.618**	.520**	1		
11 PI-P	.216**	.259**	.076	.137**	.234**	.220**	.445**	.624**	.654**	.562**	1	
12 PI-TS	.358**	.362**	.164**	.229**	.295**	.345**	.679**	.852**	.834**	.753**	.799**	1

CTQ-EA: Childhood Traumas Questionnaire -Emotional Abuse subdimension, CTQ-PA: Childhood Traumas Questionnaire-Physical Abuse; CTQ-SA: Childhood Traumas Questionnaire-Sexual Abuse; CTQ-EN: Childhood Traumas Questionnaire - Emotional Neglect; CTQ-PN: Childhood Traumas Questionnaire- Physical Neglect; CTQ TS: Childhood Traumas Questionnaire total score; PI-C: Padua Inventory- Cleaning subdimension; PI-R: Padua Inventory-Rumination; PI-CO: Padua Inventory-Control; PI-I: Padua Inventory Impulses; PI-P: Padua Inventory Precision; PI TS: Padua Inventory total score; *: p<0.05, **: p<0.001

Table 4. Pearson correlations between obsessive compulsive symptoms and dissociative experiences

	1	2	3	4	5	6	7	8	9	10
1 PI-C	1									
2 PI-R	.377**	1								
3 PI-CO	.435**	.638**	1							
4 PI-I	.358**	.618**	.520**	1						
5 PI-P	.445**	.624**	.654**	.562**	1					
6 PI-TS	.679**	.852**	.834**	.753**	.799**	1				
7 DES-DD	.210**	.415**	.346**	.451**	.369**	.451**	1			
8 DES-AM	.248**	.330*	.372*	.373*	.378**	.425**	.802**	1		
9 DES-AB	.288**	.520*	.439**	.519**	.475**	.565**	.807**	.794**	1	
10 DES-TS	.279**	.472**	.422**	.493**	.488**	.532**	.923**	.905**	.954**	1

PI-C: Padua Inventory- Cleaning subdimension; PI-R: Padua Inventory-Rumination; PI-CO: Padua Inventory-Control; PI-I: Padua Inventory Impulses; PI-P: Padua Inventory Precision; PI TS: Padua Inventory total score; DES-DD: Dissociative Experiences Scale - Derealization/ Depersonalization subdimension; DES-AM: Dissociative Experiences Scale- Dissociative Amnesia; DES-AB: Dissociative Experiences Scale- Absorption subdimension DES TS: Dissociative Experiences Scale total score; *: p<0.05, **: p<0.001

showed significant and positive associations with the depersonalization/derealization (r=0.339, p<0.001), amnesia (r=0.303, p<0.001) and absorption (r=0.340, p=0.001) subdimensions of DES. The physical abuse subdimension of CTQ was found to be significantly positive associations with the depersonalization/derealization (r=0.278, p<0.001), amnesia (r=0.263, p<0.001) and

absorption (r=0.265, p=0.001) subdimensions of DES.

The CTQ subdimension of sexual abuse was found to be significantly and positively associated with the depersonalization/derealization (r=0.244, p<0.001), amnesia (r=0.173, p<0.001) and absorption (r=0.200, p=0.001) subdimensions of DES. The emotional neglect subdimension of CTQ was found to be significantly and positively associated with the depersonalization/derealization (r=0.327, p<0.001), amnesia (r=0.251, p<0.001) and absorption (r=0.304, p=0.001) subdimensions of DES. Lastly, the physical neglect dimension CTQ was found to be correlated with the depersonalization/derealization (r=0.198, p<0.001), amnesia (r=0.197, p<0.001) and absorption (r=0.271, p<0.001) subdimensions of DES.

The regression analysis

The regression analysis revealed a significant relationship, indicating that CT and DE significantly predicted OCS. Consequently, DES scores accounted for approximately 28% of the variance ($F_{(1,387)}$ =152,185, p<0.001) in PI scores, whereas CTQ scores explained only 3% ($F_{(2,385)}$ =84,896, p<0.001).

Discussion

In this study, our findings indicated significant positive associations between primary variables, such as obsessive-compulsive symptoms, dissociation and childhood trauma. We observed that early life traumas and dissociative experiences in adulthood significantly predicted obsessive compulsive symptoms; and besides, dissociative experiences had a stronger predictive value on obsessive compulsive symptoms.

One of the strongest relationships was found between rumination and emotional abuse. This finding was supported by previous studies. [25-27] Although the correlational design of the study makes it hard to draw causal links, this particular association may be evaluated as an attempt established in early years of life for self-help in processing the traumatic event. This is also suggested by Domke et al. (2023), who states that emotional abuse and neglect can prevent a child from learning how to regulate emotions using adaptive strategies.[26] As a result, from early childhood, the individual might develop ineffective emotion regulation strategies like rumination. The following strongest relationships in the present study were between impulses and emotional-physical abuse. In a recent study which carried out an analysis of the mediating roles of impulsiveness and emotion regulation, positive associations were also reported.[28] We suggest that emotional dysregulation in general may play a role in adult psychopathologies following long exposures to abusive experiences in early life, suggesting a potential mediating role.

Although Pearson coefficients indicated weak relations, cleaning OCS showed the strongest significantly positive relationships with sexual abuse. This finding was supported by previous studies [29,30] and are generally explained as maladaptive behaviors or thoughts for coping with the "dirtiness" or "guilt", possibly related with childhood sexual abuse. At this point it is useful to mention mental contamination, which is defined as a feeling of internalized dirtiness, self-focused disgust or shame often leading to compulsive cleaning or washing. 31 In evaluating these results, it makes it clearer in understanding the need for a regulation of distress and relationship between early sexual abuse experiences and OCS, particularly cleaning. Surprisingly, we observed no

significant relationship between cleaning and neglect experiences in childhood. There exist contradictory findings in recent literature. [7,32,33] Among all early adverse experiences in life, neglect may be the hardest to detect and document. [34] An individual with a long exposure to neglect may end up in emotional dysregulation and develop maladaptive coping mechanisms. [35,36] Thus, different psychopathologies in adulthood may have emerged from overlooked and less recognized early traumas, such as neglect.

The symptoms of control and precision showed the strongest relationships with physical abuse. This finding may be the result of long exposure to unpredictable/ uncontrollable adult behavior and the emotional climate of the child's environment. In previous studies the underlying mechanism between early life adversities and obsessive-compulsive symptoms were also explained by how rituals might help in coping anxiety and environmental unpredictability [37] which is highly related to early life traumas. [38]

Our findings suggested that all obsessive-compulsive symptoms included in this study had the strongest relationship with dissociative absorption. According to Carlson & Putnam (1993), dissociative absorption was defined as the tendency for one's awareness to become so consumed in an internal or external stimulus that they get disconnected to their surroundings. [39] In line with several recent studies [40,41] our findings could be explained by individuals characterized by OCS were prone to score highly on absorption, as they tend to immerse themselves in obsessions or fully engage their attention in compulsive mental rituals. [42] Dissociative amnesia showed significantly positive correlations with total obsessive compulsive symptom scores, as well as cleaning, control, and precision subdimensions. Besides, derealization/ depersonalization was significantly and positively correlated with obsessive compulsive symptoms in general. Since current neurobiological knowledge associates OCD etiology with earlier-onset brain dysfunction [43-45] these findings tend to indicate a connection between the severities in dissociation, obsession and compulsions, based on early life difficulties in the absence of emotionally regulatory chances. Our findings were also supported with a recent study [46] in which the author explains the higher the dissociative amnesia is the more checking and control behaviors there are.

In our study, another strong relation existed between derealization and depersonalization and PI subdimensions of rumination and impulses. According to DSM-5, depersonalization is defined as "a feeling of unreality or detachment from, or unfamiliarity with, one's whole self or aspects of the self" and derealization is defined as "a feeling of unreality or detachment from, or unfamiliarity with, the world". [47] In recent studies, the authors explain the relationship between dissociative amnesia and the rumination of constant checking/controlling as a way of insuring an accomplishment of a task. [41,48]

And finally, in our sample of adults, Pearson analyses showed strong positive relationships between early life traumatic experiences and current dissociative phenomena. Previous studies report similar findings. [49,50] The underlying mechanism of this relationship can be explained how dissociation, depersonalization/derealization, amnesia and absorption can serve as maladaptive coping mechanisms to detach from overwhelming emotions. [49,51] In this study, finding significant positive relationships between neglect and dissociation was an outstanding result. Although neglect can sometimes be hard to indicate and measure, these very early adverse

experiences in life create a major disadvantage in brain development and foundation, thus psychopathologies in adulthood. As Lanius (2015) states, when basic needs such as safety and care are unmet, dissociation may function as a coping mechanism, creating an internal distance from unsafe conditions and distressing experiences. [52]

The finding that dissociative experiences held a higher predictive value on symptoms of obsessions and compulsions compared to childhood trauma experiences was also considered important. In a recent study by Ojalehto (2020), it was found that experimental avoidance (defined as the unwillingness to expose oneself to unwanted internal experiences perceived as negative or threatening), was associated with the persistence of obsessive-compulsive symptoms. [53] This could be understood by considering a possible link between dissociative experiences acting as a form of distraction from trauma exposure and their potential role in mediating the relationship between early traumas and symptoms of obsessions and compulsions. As suggested by Kroska et al. (2018) this could create an experiential avoidance mechanism for individuals with trauma experiences. [5]

Practical Implications

This study provides some practical implications. First is the finding of significant associations between obsessive compulsive symptoms, dissociative experiences, and childhood traumas in a non-clinical sample, indicating the importance of early life experiences that appear in various psychopathologies. Second, although childhood traumas and dissociative experiences significantly predict obsessive compulsive symptoms in adulthood, dissociative experiences have a stronger predictive value on obsessive compulsive symptoms, indicating a possible early maladaptive coping in childhood.

Both obsessive, compulsive, and dissociative tendencies, functioning as maladaptive strategies, can potentially benefit from specific therapeutic interventions. These commonly involve identifying and challenging maladaptive thought patterns [43] as well as promoting the acceptance of thoughts and emotions and reducing experiential avoidance. [54,55]

Lastly, in order to propose definite causal relations, future studies with longitudinal designs focusing on the timing, duration, and subtypes of early trauma and the appearance of symptoms in adulthood are needed.

Limitations

Despite all contributions, conducting the study with self-report methods may have confounded the findings based on reporting errors, recall issues or biases, particularly for trauma-oriented questions. Besides, given the non-clinical sample, it is epidemiologically plausible that undiagnosed psychiatric conditions may still exist and would be more accurate if structured clinical interviews were conducted. Furthermore, based on the cross-sectional design of the study, no definite causality could be suggested. One other limitation of this study was the difficulty in measuring obsessive compulsive symptoms. Numerous questionaries share a common problem of similar definitions, subtypes, and severity; thus, one inventory alone may not have included wide range of symptoms. The moderate size of the sample as well as the online nature of the study should also be mentioned as restrictions.

Conclusion

OCD is a complex phenomenon with clinical and neurodevelopmental components, including genetic and neurobiological factors.[43,56] While a comprehensive analysis with causal considerations is beyond the scope of this study, our findings underscore the need for a more holistic approach. Future studies with longitudinal designs focusing on the particular features of early trauma, such as the timing, duration and the subtypes, and their associations with adulthood psychopathology are needed.

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