CASE REPORT

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Childhood Sexual Abuse and Homicidal Obsessions

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ABSTRACT As the psychiatric sequel of childhood sexual abuse, it has been associated with various psychiatric disorders such as eating disorders, depression, post-traumatic stress disorder, and borderline personality disorder. In recent years, the link between obsessive compulsive disorder (OCD) and childhood trauma has been studied more intensely. It is known that traumatic events experienced in childhood, which is a vulnerable and unprotected period, will lead to neurobiological changes and lay the groundwork for psychiatric disorders in adulthood. In the case of a 37-year-old female who required hospitalization due to homicidal obsessions; the course, severity of obsessions and its relationship with the sexual trauma experienced in childhood will be discussed. It has been shown that childhood trauma can progress with higher impulsivity in individuals with OCD. In the case we shared the main problem that made us think of emergency hospitalization was the homicidal obsessions of our patient.

Keywords: Obsessive compulsive disorder; childhood trauma; homicidal obsessions

In recent years, the link between obsessive compulsive disorder (OCD) and childhood trauma has been studied more intensely. Research has focused on the effects of childhood trauma and the clinical course of OCD, its incidence, prevalence, the severity of the OCD symptomatology, and comorbidity.[1]

Traumatic events in the defenseless and vulnerable period of childhood cause neurobiological changes and are known to set the ground for psychiatric disorders in adulthood.[2] The disorders mainly related to childhood trauma are dissociative disorders, anxiety disorders, borderline personality disorder, antisocial personality disorder, alcohol and substance use disorders, and depression. OCD, characterized by disturbing, recurrent and anxiety-provoking thoughts which disrupt social functioning is shown to be possibly associated with childhood trauma, too.[1,3]

Childhood trauma does not just set the ground for psychiatric disorders but at the same time it affects the intensity, incidence and progression of the disorder.[4]

There is no case report investigating the link between obsessions and homicidal obsessions which are associated with childhood sexual trauma in OCD. The aim of this case report is to view the possible relationship between childhood sexual trauma and the progression of obsessions and their severity in a 37-year old female patient admitted to our in-patient clinic with homicidal obsessions.

CASE REPORT

A 37-year old female, primary school graduate who is unemployed and have two sons and one daughter was admitted to the in-patient clinic with "thoughts about killing her daughter". Patient consent has been taken.

The patient stated that 1.5 years ago, complaints of unhappiness, loss of interest, and low energy had begun and exacerbated over time; then loss of sleep and appetite were added to the original complaints, and in the last 2-3 months, thoughts about killing her daughter began. She could not rid her mind of these thoughts, and these thoughts were exhausting. She

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has declared that she loves her daughter immensely and would never wish harming her. The patient has applied to the psychiatry department for prevention of these thoughts. Because she has thoughts of killing her child in her mind, she believes she is a bad mother and she cannot perform her maternal duties. To overcome such disturbing thoughts, she refrains from being alone with the child and calls her mother to stay with her when her husband is at work. She felt hopeless and desperate due to thoughts about the girl and had suicidal thoughts for 2-3 months. In fact, she stated that she thought about how to die by suicide in the last few days.

The patient's history included no psychiatric attendance, no alcohol/substance use or history of psychotropic medication use. Psychiatric examination found open consciousness, oriented, cooperative, with normal speech amount and tone of voice, mood was depressive, affect was consistent with mood and she had obsessive and suicidal/homicidal thoughts.

The planned treatment was explained to the patient and relatives, considering the suicidal and homicidal thoughts of the patient, she was admitted to the ward.

Initial treatment administered a pharmacotherapeutic regime of 50 mg oral sertraline once per day, with 5 mg oral tablet olanzapine for impulse control and regulation before bed and 0.5 mg lorazepam oral soluble tables three times per day as anxiolytic.

During patient assessments and interviews, the patient reported that when she was 10-years old, someone staying in their house who was 60-70 years of age stayed in the same room as her and sexually abused her and that she had never previously shared this information. She stated that this situation negatively affected her, however, she thought she had overcome it. There was no problem when her first 2 children were boys; however, after her daughter was born, she began to be afraid of "what if a similar event happened to my daughter". She explained that initially the fear that her daughter may be exposed to sexual harassment made her only unhappy and tense, but as her daughter grew these thoughts began to intensify. In order to deal with these thoughts, she warned her children not to come out of their rooms when guests came to the house and kept all the children together in the same room when an overnight guest came. The ridiculous thought that if she killed her child, it would protect her from such an event began 2-3 months previously and she stated that this thought had made life more difficult.

She stated that she felt better in hospital separated from her daughter as she could not do anything to her own daughter. She was monitored for 2 weeks with pharmacotherapy, psychotherapy and for suicidal/homicidal thoughts during this process. The patient was discharged with 100 mg sertraline, 5 mg olanzapine and regular outpatient follow-up was planned.

DISCUSSION

There are studies investigating the effects of emotional abuse, trauma, and harassment in the childhood period on obsessions among patients with OCD.[2,4-6]

Mathews et al. in a study of 938 students reported that trauma in the childhood period could directly and indirectly affect OCD symptoms.[2] A study in 2018 by Ay et al. researched the correlation of childhood period trauma with suicide in OCD patients. They found that aggression, sexual and religious obsessions and ritualistic compulsions were significantly higher among OCD individuals who had experienced childhood trauma.[7] Additionally, there was a moderate-level correlation between possibility of suicide and childhood trauma, possibility independent from depression or anxiety.

When carefully asked about the childhood period, it was learned that she had been exposed also to both emotional and physical abuse besides sexual abuse. History of voyeurism, touching the genital region and sexual harassment were revealed during the interviews with the patient. The patient accused the abusers who harassed her during her childhood for the intensity and frequency of homicidal thoughts about killing her daughter.

Though the basic form and content of obsessions and compulsions change from culture to culture, some differences are observed in prevalence.[8] There are differences in the prevalence of obsessions in dif-

ferent regions and different social classes. In our case, the patient's first two children were boys and after bearing a girl, anxiety and thoughts about killing her daughter developed and the patient's insistent emphasis on this may show the effect of cultural differences.

A study was conducted with 3,493 people in 2012 to evaluate the relationship of childhood sexual abuse with suicidal behavior, to test whether gender controls the relationship between childhood sexual abuse and psychiatric comorbidity, and to evaluate the relationship between childhood sexual abuse and healthcare use among middle-aged and older adults. In this study, the prevalence of childhood sexual abuse was 8.0% and revictimization prevalence was 1.9%. Revictimization was significantly associated with mixed anxiety and depression, generalized anxiety disorder, phobia, post-traumatic stress disorder, and suicidal ideation. In our case, our female patient may have identified with her own "victimization" and the sacrifice of her daughter and experienced the fear of being "re-victimization".[9]

It was shown that OCD individuals with childhood trauma may progress with high impulsivity, so the basic problem requiring emergency admission for our case was the homicidal thoughts of the patient.[1] The phenomenology of OCD is known to be affected by cultural and social factors, so the detailed assessment of childhood history for childhood trauma, especially for patients exposed to emotional/physical abuse, has great importance for the process.

Source of Finance

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Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: *Onur Hurşıtoğlu;* ***Design:*** *Şerif Bora Nazlı;* ***Control/Supervision:*** *Şerif Bora Nazlı;* ***Data Collection and/or Processing:*** *Şerif Bora Nazlı;* ***Analysis and/or Interpretation:*** *Onur Hurşıtoğlu;* ***Literature Review:*** *Onur Hurşıtoğlu, Şerif Bora Nazlı;* ***Writing the Article:*** *Şerif Bora Nazlı;* ***Critical Review:*** *Şerif Bora Nazlı;* ***References and Fundings:*** *Şerif Bora Nazlı;* ***Materials:*** *Şerif Bora Nazlı.*

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