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Research Paper

Early Mal-Adaptive Schemas and Defense Mechanisms in Patients with Obsessive Compulsive Disorder, With and Without History of Childhood Sexual Abuse

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ABSTRACT

Background: Preliminary evidence suggests childhood sexual abuse to play a role in obsessive-compulsive disorder (OCD). However, literature does not talk sufficiently anything about whether exposure to sexual abuse in childhood shall impact the person's maladaptive schema, defense mechanisms in context of obsessive-compulsive disorder. **Objective:** The study aimed to examine mal-adaptive schemas and defense mechanisms in patients with obsessive compulsive disorder, with and without history of childhood sexual abuse(N=30). We hypothesized that there would be no significant difference between maladaptive schemas, defense mechanism in patients of obsessive- compulsive disorder with and without history of childhood sexual. **Method:** Assessments of childhood sexual abuse, OCD symptomatology, and related variables were completed in a sample of OCD patients from both inpatient and outpatient. Student t test was used for analysis of data. **Results:** Result shows significant difference on schema defectiveness or shame. On défense styles of patients with OCD with and without CSA significant difference was found on projection, intellectualization, splitting self, splitting others and devaluation self. **Conclusion:** Schema of defectiveness/ shame is predominant early maladaptive schema in patients of OCD with CSA. intellectualization, projection, splitting self, splitting others and devaluation self are the major defenses that are significantly more used by patients of OCD with CSA.

Keywords: *Childhood Sexual Abuse, Obsessive-Compulsive Disorder, Maladaptive Schema, Defense Mechanisms.*

National Institute of Mental Health defines obsessive-compulsive disorder (OCD) as a common, chronic, and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and/or behaviours (compulsions) that he or she feels the urge to repeat over and over. The clinical phenomena associated with OCD, such as persistent unwanted aggressive, horrific or sexual thoughts accompanied by ritualistic

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behaviors have been known in the psychiatric literature for more than two centuries (Himmelhoch, Levine, & Gershon, 2001). Freud (1909) suggested that OCD symptoms are the result of the unsuccessful functioning of defense mechanisms characteristic of the anal-sadistic psychosexual developmental stage. In an attempt to resolve the conflict between unacceptable, unconscious sexual or aggressive impulses and the demands of conscience ego, individuals suffering from OCD use undoing (i.e., neutralizing unacceptable ideas by compulsive acts) and reaction formation (i.e., unconsciously developing attitudes and behaviors that are opposite of unacceptable repressed desires and impulses). Pierre Janet (1903) in his work Les Obsessions et la Psychasthenia (Obsessions and Psychasthenia), identified three stages of OCD. The first stage included the psychasthenic state or the obsessive personality. This was followed by a forced agitations stage comprising of tics and rituals. Finally, there is the deepest and final stage of psychasthenic illness in which the individual lacks sufficient psychological tension (a form of nervous energy) to complete higher level mental activities, leading to the activation of primitive psychological operations such as obsessions and compulsions.

OCD and Maladaptive schemas

Early maladaptive schemas (EMSs) are among the most important components of cognitive theory of psychological disorders (Young, Klosko, & Weishaar, 2003). These schemas represent core beliefs about self and others and mislead external information process into a dysfunctional way (Galhardo, & Cunha, 2006). Ji Eun Kim et al.,2014 in their study found that Patients with OCD had significantly higher scores for schemas related to defectiveness/shame, social isolation/alienation, and failure than did normal controls. Of the five OCD symptom dimensions, the sexual/religious dimension was only significantly correlated with schemas such as vulnerability to harm or illness and enmeshment/undeveloped self. (Rachman, 2002) proposed that compulsive behaviour develops as a means of coping with anxiety. The relationship between anxiety and intrusive thought is reciprocal; as anxiety increases in this loop, intrusive thoughts increase well. Interpretations of the intrusion significantly lead to increased anxiety, and these further increases subsequent intrusion.

Défense mechanisms in OCD

One of the most important duties of ego is to provide individual's psychological homeostasis; that is why Défense mechanisms are among the most important functions of ego. Andrews et al. noted the definition of Défense mechanisms by Anna Freud as "the ways and means by which the ego wards off unpleasure and anxiety, and exercises control over impulsive behaviour, affects and instinctive urges". A patient who suffers obsessive compulsive disorder follows an unconscious goal by doing compulsive acts. The goal is to prevent a happening or to experience a particular event. At the same time a second goal is involved that is the violation of a happened event (Freud, 1996). Andrews et al. observed significantly more usage of immature style in OCD patients. Pollock and Andrews also found that two immature defenses, acting out and projection, were used more by OCD patients compared to normal controls. In another study done by Ruhollah Shabanpour et al. found that in addition to these two immature defenses, devaluation, autistic fantasy, splitting and rationalization are also used more by patients with OCD.

Childhood sexual abuse in OCD

The formerly widespread tendency to be little the extent and effects of childhood sexual abuse (CSA) was exemplified in Freud's dismissal of his women patients' accounts as

sexual fantasy. Perhaps for that reason, as well as methodological difficulties, research of long-term psychological consequences of CSA has been sparse. This tendency has recently given way to extensive study of the short- and long-term mental effects of CSA, as reports of high prevalence of CSA in the general population have continue to emerge. The frequency of cases of a single CSA event occurring before the age of 18 is reported to range from 5% to 75% among women, and from 3% to 30% among men in the population at large. Recent studies suggest that sexual abuse in childhood will have both short-and long-term mental effects. Immediate effects of CSA might include anxiety, guilt, anger and hostility, irregular sexual behaviour, substance abuse, and learning disorders. In the long term, CSA is a risk factor for the emergence of adult psychopathology such as borderline personality disorder, eating disorders, somatization disorder, and depression. Although early psychoanalytic literature suggests a specific and close linkage between CSA and obsessive-compulsive disorder (OCD), this was hardly examined by a rigorous scientific method (Caspi et al., 2008).

REVIEW OF LITERATURE

Maladaptive schemas and OCD

In a study by Shariatzadeh, M. (2017) as Relationship between early maladaptive schemas and symptom dimensions in patients with obsessive compulsive disorder and concluded that patients with OCD had significantly higher schema related to defectiveness/shame, social isolation/alienation, and failure than did normal controls, with regard to the relationship between early maladaptive schemas and clinical symptoms concluded that maladaptive schemas play important role in the formation of psychopathology in individuals.

Afsaneh Yoosef et al. (2016) conducted a study and purpose of the study was to comparing early maladaptive schemas which are active in patients suffering from obsessive-compulsive disorder concluded as the dominant and specific early maladaptive schemas of OCD are Defectiveness/Shame, Mistrust/Abuse, and Emotional Deprivation Schemas.

Hakan Atalay et al. (2008) found that the patients with OCD have most of the early maladaptive schemas including social isolation, vulnerability and pessimism.

Nicola Thiel et al. (2014) conducted study in which EMS, schema modes, depression and traumatic childhood experiences were measured and demonstrated that higher scores on the EMS named failure and emotional inhibition and depressive symptom severity at pre-treatment were significantly related to poor outcome and explained a high percentage of the variance in OC symptoms at posttreatment. No influence on the treatment outcome was observed for schema modes, other EMS or other covariates.

Ulrich Voderholzer et al. (2014) investigated early maladaptive schemas (EMS), schema modes and childhood traumas in patients suffering from obsessive-compulsive disorder (OCD) suggested that there might be typical schema patterns associated with OCD and ED.
Sabine Wilhelm et al. (2015) conducted study to identify mechanisms of change in individuals with moderately severe obsessive-compulsive disorder (OCD) receiving cognitive therapy (CT). Perfectionism and certainty obsessive beliefs and maladaptive schemas related to dependency and incompetence significantly mediated (improved) treatment response.

The study was carried out by Fatih Kizilagac (2019) with OCD patients, enmeshment/undeveloped self, abandonment, failure, pessimism, vulnerability to harm or illness, emotional deprivation, social isolation/alienation, defectiveness/shame, approval seeking, insufficient self-control/self-discipline, self-sacrifice, and punitiveness schema scores were found significantly higher.

Defense mechanisms and OCD

Heidari Nasab (2006) found that clinical group suffered immature defense style more than the normal group. His findings also revealed that those who suffered obsessive compulsive disorder used acting out, somatization, splitting and violation more than normal people; and anxious patient used somatization and passive aggression more than normal people; but they used humor less than normal people.

Sarah E. Romans et al. (1999) conduct study in which the psychological Défense styles of women who reported childhood sexual abuse were assessed and compared to those of women without childhood sexual abuse. Results were as women reporting childhood sexual abuse showed more immature Défense styles, and those who experienced the most severe childhood sexual abuse showed the most immature styles. Coping styles are likely to be a major mechanism through which childhood sexual abuse increases rates of later psychological problems.

Ruhollah Shabanpour et al. (2012) found that adult patients suffering from obsessive-compulsive disorder (OCD) uses more immature and less mature styles.

Hamidi F. (2010) conducted study and aimed at comparing beliefs and defense mechanism in patients with obsessive compulsive disorder and normal individuals and results showed that there was a significant difference between two groups in their irrational beliefs and defense mechanisms.

Childhood Sexual Abuse (CSA) and OCD

Caspi, A et al. (2008) examined the association of CSA and obsessive-compulsive disorder (OCD) in adults. A significantly higher frequency of CSA involving physical contact was found among the OCD.

Sabrina Boger et al. (2020) investigated the relationship between childhood maltreatment and OCD she concluded that Childhood maltreatment was highly prevalent among OCD patients and childhood trauma survivors still show higher OCD symptom severity after treatment. Therefore, childhood maltreatment should be considered in psychological interventions in individuals with OCD.

Mathews CA. et al. (2008) examined the relationship between childhood trauma. There was a small but significant association between obsessive-compulsive symptoms and childhood trauma, sexual abuse and conscientiousness, suggesting that an indirect role for childhood trauma in the development of obsessive-compulsive symptoms may also exist.

Rationale for current study

Childhood Sexual abuse has been seen playing role in obsessive compulsive disorder. Also, people with the mental illness do have schemas which are irrational and unhelpful. However, literature does not talk sufficiently anything about whether exposure to sexual

abuse in childhood shall impact the person's maladaptive schema, and defense mechanisms in context of obsessive-compulsive disorder. Once we establish whether or not there is any relationship between them, it shall help in the implication of psychotherapeutic intervention in the sense that apart from just mere challenging the cognitions, we can help mediate and heal the impact of childhood sexual abuse. This will also help building up understanding and insight in the patient so that the causation of irrational thoughts and acts can be well understood by them in context of their own life incidences.

METHODOLOGY

Aim

To examine early mal-adaptive schemas and defense mechanisms in patients with obsessive compulsive disorder, with and without history of childhood sexual abuse.

Objectives

- To compare severity of illness in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.
- To compare maladaptive schemas in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.
- To compare defense mechanisms in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.

Hypothesis (Null Hypothesis)

- There would be no significant difference between maladaptive schemas in patients of obsessive- compulsive disorder with and without history of childhood sexual abuse.
- There would be no significant difference defense mechanisms in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.

Venue of the Study: The study was conducted at Central Institute of Psychiatry, Kanke, Ranchi.

Study Design: Cross sectional hospital-based study.

Sampling Technique: Purposive hospital based.

Sampling/Designing

Purposive sampling has been used; 30 patients selected from both the in-patient and out-patient clinical population, diagnosed with obsessive compulsive disorder as per the ICD-10 (DCR) WHO (1993). 15 patients selected for experimental group with history of childhood sexual abuse and 15 patients selected for control group with no history of childhood sexual abuse.

Inclusion Criteria for OCD patients with Childhood Sexual Abuse:

- Patients diagnosed with Obsessive-compulsive disorder, Mixed Obsessional thought and acts (predominantly having obsession of dirt and contamination with washing compulsion) according to ICD-10 (DCR) WHO (1993) diagnostic criteria.
- Participants in the age group between 18-50 years.
- Both male and female.
- Those who can comprehend Hindi and English language.

- Patients in with cut-off score of 8 or higher in Sexual Abuse domain of CTQ and those in control group with a score less than 8.
- Those who gave the informed consent.

Inclusion Criteria for OCD patients without childhood sexual abuse:

- Age and sex variables matched to patients of obsessive-compulsive disorder with childhood sexual abuse.
- Patients with a score of 7 and below on sexual abuse domain of CTQ test.
- Those who can comprehend Hindi and English language.
- Those who gave informed consent.

Exclusion Criteria for patient of OCD with and without Childhood Sexual Abuse:

- Patients with a history of major physical and neurological disorders.
- Patients with history of co-morbid psychiatric disorders except mild to moderate depression (on BDI score should 1-29) and anxiety (on HAM-A score should 1-24).
- Patients with substance use disorder except nicotine and caffeine use disorder.

Tools

- **Informed Consent Form:** It is to be developed for the current purpose. Which will contain details about Purpose of the research, Type of Research, Participant selection, Voluntary Participation, Procedures and Protocol, Duration, Benefits, Confidentiality, Sharing the Results, Right to Refuse or Withdraw, Alternatives to Participating, Who to Contact, and Certificate of Consent.
- **Socio-demographic data sheet:** This has consisted all the socio demographic details regarding the patient as name, fathers name, address, age, sex, marital status, religion, education, occupation, family income, habitat, family type, with clinical details as HOPI, history of past illness, treatment history (medical & psychological), family history, personal history, pre-morbid personality, MSE, and Diagnosis (ICD-10).
- **Yale–Brown Obsessive Compulsive Scale: (Y-BOCS) (Wayne K. Goodman,1989):** The Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) comprises a Symptom Checklist and Severity Scale to consecutively rate obsessions and compulsions. The Symptom Checklist includes 54 common obsessions and compulsive behaviors, which are grouped according to thematic content (eg, contamination and aggression) or behavioral expression (eg, checking and washing). Symptoms that are endorsed over the past week are then globally rated by the clinician using a five- point scale ranging from 0 (none) to 4 (extreme) across five dimensions: (1) time/frequency, (2) interference, (3) distress, (4) resistance, and (5) degree of control (see Table 1). Obsessive and compulsive symptom severity are rated separately (scores range from 0 to 25) with these scores summed to create a total OCD severity score (range, 0–50). The Y-BOCS also includes single-item ratings of insight, avoidance, indecisiveness, responsibility, pervasive slowness, and doubting on the 0–4-point scale, but these ratings are not included in severity scores and are less often used. The following score clusters approximately map onto symptom severity: mild symptoms (0–13), moderate symptoms (14–25), moderate–severe symptoms (26–34), and severe symptoms (35– 40).
- **Hamilton rating scale for Depression. (HAM-D) (Max Hamilton,1960)** 17 item rating scale to access presence and severity of depressive states in patients diagnosed

with depression. 9 items are scored 0-4, whereas the further 8 are scored 0-2, as these represent variables which do not lend themselves to quantitative rating. (0= absent, 1= doubtful, or slight, 2= mild, 3= moderate, 4= severe. 0= absent, 1= doubtful or slight, 2= clearly present). Item 18- 21 are not regarded as measuring the intensity of depression and are commonly omitted.

- **Hamilton Anxiety scale (HAM-A) (Hamilton,1997):** Hamilton developed this scale in 1997 to quantify the severity of anxiety symptomatology. It consists of 14 items, each defined by series of symptoms. Each item is rated on 5-point rating scale from 0 (not present), 1, 2, 3, to 4(sever). This instrument developed to assess and quantify symptom severity among patients with anxiety neurosis. Inter-rater reliability has reported as an Intra class Correlation Coefficient of 0.74–0.96 (Bruss et al., 1994).
- **Childhood trauma Questionnaire (CTQ-SF):** (David P. Bernstein, 1996) It is a retrospective device for childhood maltreatment and can be used in both adolescent and adult populations. It takes only five minutes to administer, can be administered to a large group of individuals. This test has 28 questions is based on five factors Emotional abuse, Emotional neglect, physical abuse, sexual abuse and physical neglect. Based on five points rating scale. Reliability Cronbach alpha= 0.77
- **Young Schema Questionnaire-short form (YSQ -S3)** (Young & Brown, 2003) Six-point rating scale, reliability 0.80 Cronbach alpha, 75 items with five domains and their sub domains as follows.YSQ-SF3 was developed by Jeffrey Young (1990, 2003). The scale proposes 18 subscales grouped into five schema domains as follow: Rejection, impaired autonomy and performance, impaired limits, other-directedness, over vigilance, and inhibition. The subscales are consecutively: Abandonment/instab ility, mistrust/abuse, emotional deprivation, defectiveness/shame, social isolation/ali enation, dependence/incompetence, vulnerability to harm and illness, enmeshme nt/undeveloped self, failure, entitlement/grandiosity, insufficient self-control/self-discipline, subjugation, self-sacrifice, approval-seeking/recognition-seeking, negativi ty/pessimism, emotional inhibition, un-relenting standards/hyper-criticalness, and punitiveness. The questionnaire consists of 90 items that are rated on a 6-point Likert-type scale (1 = entirely untrue of me, 6 = describes me perfectly). As each subscale consists of 5 items, the score obtained on the subscales varies between 5 and 30.
- **Defense style questionare-60 (DSQ-60) (Trijsburg, Bond & Drapeau, 2003.)** It's a Self-report questionnaire. Reliability with Cronbach's alpha = .72 makes it reliable tool to use. The Defense Style Questionnaire is the most widely used self-report questionnaire for the assessment of defenses (Bond, 2004). The 60-item version of the scale assesses 30 defense mechanisms and this 60-item version was derived from previous versions of the Defense Style Questionnaire.

Procedure

Patients with obsessive-compulsive disorder meeting the inclusion/ exclusion criteria were recruited from outpatient department of Central Institute of Psychiatry. The samples were selected Purposively. The written informed consent was taken from the patients following which socio- demographic and clinical information has been collected using structured socio-demographic and clinical datasheet. Yale–Brown Obsessive Compulsive Scale, was applied to confirm the diagnosis and severity, followed with administration of Childhood Trauma Questionnaire (CTQ) to select patients with scoring above cut of 8 in domain of

sexual abuse in CTQ was taken as experimental group and others those below cutoff 8 in CTQ was taken as control group. Both the groups of the patients were assessed by administering Young Schema Questionnaire (YSQ), Defense style questionnaire (DSQ).

Statistical Analysis

The results obtained were analysed by using the computer software program, Statistical Package for Social Sciences version 25.0 (SPSS-25.0) for windows ®, with different parametric, and non-parametric measures being used. Description of the sample characteristics was done using descriptive statistics to calculate percentage, mean and standard deviation. Other socio demographic variables and clinical variables were compared across three groups using independent t-test and chi-square test.

RESULTS

The study was conducted in Central Institute of Psychiatry. Patients with a diagnosis of obsessive-compulsive disorder as per the ICD-10 (DCR) WHO (1993) were selected and assessed for Childhood Sexual Abuse using sexual abuse domains of CTQ and 15 patients of OCD with CSA and 15 patients without CSA were taken-up for the study.

Table 1: Comparison of socio-demographic variables (discrete) of OCD patient with and without CSA.

Variables		OCD with CSA N (%)	OCD without CSA N (%)	df	χ^2	Fisher's exact test	p
Gender	Male	8 (28.6%)	4 (14.3%)	1	0.778	.459	0.459
	Female	8 (28.6%)	8 (28.6%)				
Place of habitat	Urban	9 (32.1%)	5 (17.9%)	1	0.583	.704	0.704
	Rural	7 (25.0%)	7 (25.0%)				
Educational Qualification	Primary	5 (0%)	3 (3.6%)	4	6.052	.213	0.178
	High school	6 (17.9%)	2 (10.7%)				
	Inter	3 (21.4%)	6 (7.1%)				
	Graduate	2 (10.7%)	0 (21.4%)				
	Post graduate	0 (7.1%)	1 (0%)				
Socio-Economic status	Lower	0 (0.0%)	1 (3.6%)	2	1.458	.707	0.707
	Middle	15 (3.6%)	10 (3.6%)				
	Higher	1 (53.6%)	1 (35.7%)				
Religion	Hindu	14(50.0%)	12(42.9%)	2	1.615	1.000	1.000
	Muslim	1(3.6%)	0 (0.0%)				
	Others	1(3.6%)	0 (0.0%)				
Marital status	Married	6(21.4%)	6(21.4%)	2	2.139	.341	0.341
	Unmarried	10(35.7%)	5(17.9%)				
Type of family	Nuclear	12(42.9%)	7 (25.0%)	2	1.781	.517	0.517
	Joint	4 (14.3%)	4 (14.3%)				

P= NS (Not significant)

Table 1: shows the comparison of socio-demographic variables which were of discrete type. Chi-square was applied to compute the data. Analysis of the table revealed that there was no any significant difference found between gender, domicile, educational qualification, marital

status, religion, socio- economic status, type of family it can be said that the two groups were matched on the above-mentioned variables.

Table 2: Comparison of socio-demographic and clinical variables (continuous) of OCD patient with and without CSA.

variables	OCD with CSA Mean ± SD	OCD without CSA Mean ± SD	Df	t	p
Age	26.69 ± 7.9	28.25 ± 7.82	26	-.518	.609
No of family members	5.81 ± 3.52	6.25 ± 3.91	26	-.310	.759
Duration of illness	7.09 ± 6.23	4.583 ± 3.82	26	1.229	.230
Age of onset	19.63 ± 6.20	23.58 ± 5.53	26	-1.748	.092

P= NS (Not significant)

Table-2 shows the comparison of age, numbers of family members, duration of illness, age of onset between the patient of OCD with and without childhood sexual abuse and using t-test (for continuous variable) as applicable. Result shows no significant difference found between the mean of both groups.

Table 4: Comparison of Schemas of OCD patient with and without CSA.

Variables	OCD with CSA Mean ± SD	OCD without CSA Mean ± SD	Df	t	P
Emotional deprivation	1.19 ± 1.167	.92 ± 1.443	26	.549	.588
YSQ abandonment	.94 ± 1.389	.42 ± .669	26	1.195	.243
YSQ mistrust or abuse	1.25 ± 1.342	.92 ± 1.379	26	.643	.526
YSQ social isolation	1.69 ± 1.493	.83 ± 1.267	26	1.595	.123
YSQ defectiveness or shame	1.56 ± 1.459	.42 ± .793	26	2.454	**.021***
YSQ social undesirability	1.50 ± 1.932	.75 ± 1.357	26	1.147	.262
YSQ dependence or incompetence	1.27 ± 1.335	.92 ± .996	26	.755	.458
YSQ vulnerability to harm others	1.31 ± 1.302	2.00 ± 1.348	26	-1.362	.185
YSQ enmeshment	1.19 ± 1.167	.83 ± 1.267	26	1.581	.126
YSQ subjugation	1.13 ± 1.628	75 ± .965	26	.708	.485
YSQ Self sacrifice	.63 ± .806	.83 ± 1.193	26	-.552	.586
YSQ emotional inhibition	1.00 ± 1.211	.75± 1.215	26	.540	.594
YSQ unrelenting standard	1.19 ± 1.601	.75 ± 1.422	26	.750	.460
YSQ entitlement	1.38± 1.408	.83± 1.030	26	1.124	.271
YSQ insufficient self-control	1.50 ± 1.633	1.33 ± 1.670	26	.265	.793

**p≤0.05 (2-Tailed)*

Table-4: shows comparison of schemas of OCD patient with and without CSA using student t-test. According to the analysis of result, there is significant difference on domain of defectiveness or shame ($p<0.05$) where, mean of patients of OCD with CSA is 1.56 ± 1.459 and mean of patients of OCD without CSA is .42 ± .793

Table 6: Comparison of Défense style of OCD patient with and without CSA.

Variables	OCD with CSA Mean ± SD	OCD without CSA Mean ± SD	t	df	P
DSQ altruism	12.56 ± 3.182	13.67 ± 3.025	-.826	26	.416
DSQ passive aggressive	9.31 ± 3.979	7.17 ± 3.407	1.195	26	.243
DSQ suppression	9.19 ± 2.994	7.92 ± 2.539	1.499	26	.146
DSQ sublimation	6.19 ± 3.082	7.33 ± 2.708	-1.024	26	.315
DSQ splitting other	8.38 ± 2.778	8.25 ± 3.223	.110	26	.913
DSQ rationalization	8.31 ± 3.135	9.00 ± 3.330	-.559	26	.581
DSQ humour	4.31 ± 2.750	5.83 ± 2.290	-1.552	26	.133
DSQ projection	9.94 ± 4.711	6.33 ± 2.741	2.361	26	**.026***
DSQ reaction formation	10.56 ± 2.476	9.83 ± 2.657	.748	26	.461
DSQ self-observation	10.50 ± 3.502	15.75 ± 16.006	-1.279	26	.212
DSQ denial	9.13 ± 2.895	8.83 ± 3.33	.248	26	.806
DSQ devaluation of others	4.88 ± 2.655	6.92 ± 3.919	-1.645	26	.112
DSQ projective identification	8.81 ± 3.060	7.67 ± 1.875	1.143	26	.263
DSQ dissociation	5.31 ± 2.024	4.58 ± 2.712	.816	26	.422
DSQ self-assertion	10.44 (3.949)	9.25 ± 3.467	.829	26	.415
DSQ omnipotence	4.06 ± 2.294	4.50 ± 2.393	-.490	26	.628
DSQ acting out	10.25 ± 3.512	8.75 ± 3.494	1.121	26	.273
DSQ fantasy	5.56 ± 3.502	7.50 ± 3.371	-1.472	26	.153
DSQ withdrawal	7.50 ± 4.844	9.25 ± 4.751	-.954	26	.349
DSQ intellectualization	10.94 ± 3.021	8.50 ± 2.680	2.215	26	**.036***
DSQ splitting self	6.75 ± 1.949	9.08 ± 1.505	-3.442	26	**.002***
DSQ displacement	8.25 ± 3.173	6.92 ± 2.746	1.164	26	.255
DSQ repression	6.00 ± 3.204	6.58 ± 1.832	-.564	26	.578
DSQ splitting others	8.63 ± 1.746	11.17 ± 2.791	-2.960	26	**.006***
DSQ idealization	8.19 ± 2.536	8.58 ± 2.429	-.416	26	.681
DSQ anticipation	9.63 ± 2.363	9.50 ± 2.393	.138	26	.891
DSQ help rejecting	10.44 ± 2.366	8.25 ± 3.137	2.107	26	**.045***
DSQ affiliation	9.81 ± 2.949	8.83 ± 3.353	.820	26	.420
DSQ isolation	9.44 ± 3.140	9.58 ± 2.575	-.313	26	.897
DSQ devaluation self	10.75 ± 4.107	7.42 ± 4.252	2.094	26	**.046***

**p≤0.05 (2-Tailed)*

Table-6 shows comparison of défense styles of patients with OCD with and without CSA using student t-test. Table also shows the value of mean, SD and t values of the variable. According to the analysis of result, there is significant difference found on défenses of - projection ($p<0.05$) where, mean and SD of patients with OCD with CSA is 9.94 (± 4.711) and mean of patients of OCD without CSA 6.33 (± 2.741)); intellectualization ($p<0.05$) where, mean and SD of patients of OCD with CSA is 10.94 (± 3.021)and patients of OCD without CSA 8.50 (± 2.680); splitting self ($p<0.05$) where, mean and SD of patients with OCD with CSA is 6.75 (± 1.949) and mean and SD of patients with OCD without CSA 9.08 (± 1.505); splitting others ($p<0.05$) where, mean and SD of patients of OCD with CSA 8.63 (± 1.746) and mean and SD of patients with OCD without CSA is 11.17 ± 2.791; and devaluation self ($p<0.05$) where mean of patients of OCD with CSA is 10.75 ± 4.107 and patients of OCD without CSA is 7.42 ± 4.252.

DISCUSSION

General considerations

The present study was designed to compare severity of illness, maladaptive schemas and défense mechanisms in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse. The results showed that there was a significant difference between two groups in their irrational beliefs and defense mechanisms. The findings of that study generally confirmed the findings of other studies.

Socio-demographic and clinical variables characteristics

The salient socio-demographic features of this study group patients of OCD with and without CSA were noted as mean age and standard deviation of patient with CSA is 26.69 (± 7.93) and mean and standard deviation of patient without sexual abuse is 28.25 (± 7.829) comprising 28.6% male and female 28.6% of patients of OCD with CSA whereas, 14% male and 28.6 % female in OCD without sexual abuse. The literature on gender-related differences in OCD is relatively sparse. Most previous studies have reported a female predominance or roughly equal gender distribution (Cillicilli et al.,2004). However, in current study there is no significant age difference between groups, there are both male and female patient from both urban and rural habitat, no significant difference in education of both the groups, in both groups mostly the patients are unmarried and belongs to middle socio-economic status, from nuclear family. There is no difference between onset of illness in current study however previous literatures suggests that Years of education and marital status are reflective of the general socio-demographic scenario in India, where largely men form the workforce and are more socio-economically advantageous for the family. This often leads to disparities in treatment seeking behaviors between the genders. More males being single could be because of earlier onset of illness and subsequent disability. These findings are echoed by other studies on OCD patients from India (Cherian et al., 2014).

Comparison of severity of illness in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.

Prior research has suggested an increased prevalence of childhood abuse and neglect among patients with OCD, and that it is associated with both increased OCD symptom severity and worse treatment outcomes. However, earlier research is limited by small sample sizes and inconsistent findings. only few studies have examined whether the experience of maltreatment is related to the severity of OCD symptoms. Results from studies in subclinical samples have mostly supported such a link. Higher levels of childhood maltreatment were associated with increased OCD symptom severity in two large college student samples (Kroska, & O'Hara, 2018) as well as in a general population sample (Briggs & Price, 2009). However, in the latter study this link was fully mediated by current levels of anxiety and depression. With respect to clinical samples of patients with OCD, the results have been less clear. In a study including 120 patients with OCD, childhood trauma was associated with higher OCD symptom severity (Semiz, Inanc, & Bezgin, 2014). This was particularly the case for sexual, physical and emotional abuse, and emotional neglect. However, these findings did not control for multiple testing or potentially confounding factors such as anxiety or depression. Conversely, a number of studies involving patients with OCD have not found a relationship between levels of childhood maltreatment and OCD severity (Visser et al., 2014). However, according to the present study there is no significant difference between the severity of obsessive-compulsive symptom between the patient of OCD with sexual abuse and patient of OCD without sexual abuse. The result is supported by above given some of the studies.

Comparison of maladaptive schemas in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.

Beck proposed that negative childhood experiences, such as physical and emotional neglect, and physical, emotional, and sexual abuse, make a person more vulnerable to depression later in life. Childhood maltreatment showed a positive relationship with EMSs; this finding agrees with Young's (1999) model of EMS development. In present study the result shows the difference between the patient of OCD with sexual abuse and the patient of OCD without sexual abuse with respect to schema defectiveness/shame which shows that this schema is more predominantly present in patient of OCD with sexual abuse. Young et al. (2003) had also proposed that schema of Defectiveness/ Shame is one of the result schemas from early traumatic or victimisation experiences of an interpersonal nature. Previous evidence also supported that maladaptive schema are linked to a variety of psychological disorders commonly presented in people with histories of interpersonal trauma including adult depression and anxiety (O'Dougherty Wright, Crawford, & Del Castillo, 2009).

Comparison of defense mechanisms in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse.

Défense's are thought to underlie and contribute to self-organization and impact how individuals interact with and experience their environment. Clinically, defensive functioning is thought to mediate between stress or conflict and subsequent symptom formation and functioning (Perry and Hoglend, 1998). It is only when defenses are used too rigidly or at an age-inappropriate level that they are thought to result in pathological behaviour and further distress. Défense's appear to mediate among stress, symptom presentation, and level of functioning (Perry et al., 1998). The current findings indicate that there is significant difference found on defense style of patient of OCD with and without sexual abuse. According to the results obtained, the patients of OCD with sexual abuse use more defenses of *intellectualization, projection, splitting self, splitting others* and *devaluation self* as compared to the patients of OCD without sexual abuse. A previous study, in a community sample of women, found that those with a history of CSA used more immature level defenses like *projection* than those without a history of CSA (Romans et al., 1999). Abuse severity was also related to the use of projection as a defense among other defense styles. Study performed by Pollock and Andrews (1989) also indicated towards *acting out* and *projection* used more by OCD patients compared to normal controls. Ruhollah Shabanpour et al., (2012) found that in addition to those two immature defenses, *devaluation of self* and *splitting* are also used more by patients with OCD. Murdoch etal., 2014 in his study found the association between sexual trauma and self-efficacy such that men who report greater levels of rape myth acceptance and devaluation of emotions would have a stronger association between sexual trauma and self-efficacy compared with men who report lower levels.

SUMMARY & CONCLUSION

Summary

The present study was designed to compare severity of illness, maladaptive schemas, attachment styles and défense mechanisms in patients of obsessive-compulsive disorder with and without history of childhood sexual abuse. Study also determines relationship of maladaptive schemas, attachment styles and défense mechanism in the two groups.

Patients with obsessive-compulsive disorder meeting the inclusion/ exclusion criteria were recruited from outpatient department of Central Institute of Psychiatry using purposive sampling technique. The written informed consent was taken from the patients following

which socio- demographic and clinical information has been. A total of 30 patients meeting inclusion/ exclusion criteria were recruited, 15 patients with childhood sexual abuse in one group and other 15 patients without childhood sexual abuse in another group. Childhood Trauma Questionnaire (CTQ) was applied to select patients with scoring above cut-off of 8 in domain of sexual abuse in CTQ have been taken as patient with CSA and others those below cut-off 8 in CTQ has been taken as group of patients without CSA. Yale–Brown Obsessive Compulsive was applied to establish the diagnosis of obsessive-compulsive disorder, severity of symptoms and to ascertain current and past symptoms.

- There is significant difference between patients of OCD with CSA and the patients of OCD without CSA with respect to schema defectiveness/shame which shows that this schema is significantly more predominantly present in patients of OCD with CSA.
- The patients of OCD with CSA use significantly more defenses of intellectualization, projection, splitting self, splitting others and devaluation self as compared to the patients of OCD without CSA.

CONCLUSION

In patients of OCD with CSA schema defectiveness/ shame is manifested as early maladaptive schema. Intellectualization, projection, splitting self, splitting others and devaluation self are the major defenses that are significantly used by those patients.

Limitations & Future Directions

Limitations

No study is devoid of limitations. The current study had certain loopholes as mentioned below:

- A small sample of 30 participants, 15 patients and 15 controls, was studied. A bigger
- sample size could yield more generalizable and reliable results.
- The population studied was restricted to a small geographical area in Ranchi which
- might not be representative of the population of our country or the world.

Future directions

- Future studies may include a larger sample size for increasing generalizability of findings.
- Drawing samples from varied geographical locations can further increase generalizability.

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Conflict of Interest

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