The Effect of Denial of Childhood Trauma on the Self-Report of Suicidality on Psychiatric Inpatients

Dayna Kline

Lehigh Valley Health Network: Research Scholar Program

Abstract

Childhood trauma is an overwhelming tragedy in our world today; from physical and emotional abuse and neglect to sexual abuse. Children who experience these tragic events suffer not only throughout the years that the abuse occurs but throughout their entire life and adulthood. They may experience personality changes, depression, and even suicidal ideations (Li, Wang, Hou, Wang, Liu, Wang, 2013). One way to deal with the negative effects of their childhood is to deny its occurrence. Denial exists in many different situations whether it is denial of death, illness or even a traumatizing event (Simon & Hales, 2012). Freud believed that individuals used denial to cope with unbearable situations and even the feelings associated with those situations; whereas Kubler-Ross believed denial was a natural stage of the healing process that all individuals experienced (Telford, Kralick & Koch, 2006). However, both theorists encompass the idea that denial is a way to hide from reality. We wanted to investigate if individuals from a psychiatric inpatient unit who deny their childhood trauma will also minimize their suicidality, trying to suppress their feelings of the past. Results indicated that suicidality was minimized in patients who also denied their childhood trauma. Additionally, we found that self-esteem provides a more accurate measure of psychiatric inpatients' suicidality rate rather than asking patients for a self-report of their suicidality.

The Effect of Denial of Childhood Trauma on the Self-Report of Suicidality on Psychiatric Inpatients

Childhood trauma is a major problem which exists in our world for many years. Past research has shown that on average 28-32% of primary and elementary school students suffer from child neglect growing up (Li et al., 2013). Unfortunately, that is only the reported cases of childhood trauma while many cases may go unnoticed. Not only does childhood trauma affect the child's emotional and physical needs at the time in which it occurs, it has neurological effects as well. Abused and neglected children tend to show more signs of behavioral and emotional problems which are related to the size of the amygdala in their brain (Petersen, Joseph & Feit, 2014). This decrease in the amygdala size puts individuals at risk for a much harder time dealing with internalizing problems, anxiety and emotional reactivity. Additionally, adults have been found to have a decreased size of their hippocampus region when they had experience childhood physical and sexual abuse. The hippocampus plays a vital role in learning and memory causing individuals who were abused to lack the ability of formulating and storing new memories. Nevertheless, both Mehta and colleagues (2009) and Sheridan and colleagues (2012) found that individuals who were abused as children had a much physically smaller brain. This shows that childhood trauma does not only affect the child's physical and emotional aspect but also the neurobiological aspect as well.

Not only is childhood trauma influential on the neuropathology of an individual's brain but it has a long withstanding effect on the individual's personality as well. Trauma exposure often leads individuals to psychopathology including ADHD, depression which may lead to suicidal thoughts, anxiety and even personality disorders in adolescence and adulthood, with each type of trauma having various outcomes (Li et al., 2013). For example, sexual and physical

abuse is linked with borderline personality disorder, physical abuse is linked with antisocial personality disorder and emotional trauma is related to poor impulse control and interpersonal behavior. While none of these outcomes are certain in every individual who experiences childhood trauma, they are very common among the amount of individuals who get abused or neglected in some way as a child.

Individuals have various ways of dealing with trauma. Depending on the individual, one may cope with using different mechanisms such as alcohol, drugs or medication. However, some individuals cope with their trauma through denial. Freud defined denial as "the refusal to acknowledge the existence of an unbearable situation or the feelings associated with it," (Telford, Kralik & Koch, 2006). Individuals who have experienced trauma as a child may be inclined to deny that trauma ever happened creating a psychological protection from the event(s) (Tse). It is also a way to both implicitly and explicitly avoid the confrontation of dealing with the reality of the traumatizing event. Kubler-Ross believed the denial was a form of grief (Telford, Kralik & Koch, 2006). When dealing with a painful situation, mainly death, one of the first stages is denial that death ever took place. According to Kubler-Ross, this type of denial is natural for human beings to have when dealing with a mournful situation. Some studies agree with Freud and Kubler-Ross that denial may be useful and healthy early on in stages of life-threatening situations; however, if denial remains over a long period of time it may become dangerous causing pathological grief. Constant behaviors of denial in illnesses inevitably lead to poorer illness management and higher levels of distress and depression.

According to Robins (1981), 25% of psychiatric patients at risk for suicide deny having suicide ideations to their health professionals (Simon & Hales, 2012). This is because individuals who do not think they need help, or who are determined to kill themselves, look at mental health

professionals as an enemy and try to hide their true suicidal ideations. Therefore, the purpose of the present research is to determine if one's denial of their childhood trauma events (physical, emotional, sexual abuse and physical and emotional neglect) impacted their self-report of their suicidality rate. It was hypothesized that patients who denied their childhood trauma would also have a lower suicidality rate, indicating denial in their suicidality, compared to non-denying individuals.

Method

Participants

One hundred and forty six consecutively admitted psychiatric inpatients within three days of their admission were selected by the clinical staff of Dr. Karper or Amy Blitz, CRNP in the Lehigh Valley Hospital Muhlenberg: Inpatient Psychiatric Unit, BH2, Bethlehem, PA. Participants were chosen based on availability, cooperativeness and severity of disorder: excluded participants consisted of uncooperative or decompensated individuals. Participants consisted of mostly females with the majority being white, see table 1 for demographics.

Materials

Two instruments were used to assess the participants. The Personality Inventory for DSM-5: Adult (Krueger, Derringer, Markon, Watson, Skodol, 2013) is a 220 self-report questionnaire to measure the participants' personality. The PID-5 assesses participants' personality: negative affect ("I worry a lot about terrible things that might happen"), detachment ("I prefer not to get too close to people"), antagonism ("I'm good at making people do what I want them to do"), disinhibition ("Others see me as irresponsible") and psychoticism ("I often have ideas that are too unusual to explain to anyone"). This measure was scored on a 4-point Likert-type scale; 0 = very false or often false, 1 = sometimes false, 2 = sometimes true, 3 = very

true. The Childhood Trauma Questionnaire (Bernstein & Fink, 1998) is a 28 self-report questionnaire to measure the participants' childhood trauma: sexual abuse ("Someone tried to touch me in a sexual way, or tried to make me touch them"), physical abuse ("I was punished with a belt, a board, a cord, or some other hard object"), emotional abuse ("People in my family called me things like "stupid", "lazy" or "ugly"), emotional neglect ("There was someone in my family who helped me feel that I was important and special") and physical neglect ("I didn't have enough to eat"). Self-esteem was then measured by combining six of the questions on the PID-5 together ("I often feel like nothing I do really matters"). The higher the rating of self-esteem, the worse individuals thought about themselves. Suicidality was also measured by combining six of the questions on the PID-5 ("The future looks really hopeless to me") to create a suicidality score for each participant. Denial was then measured by three of the CTQ questions ("I had the perfect childhood"). Individuals who answered never true to very often true on these questions were considered to be either low, moderate or severe deniers of their childhood trauma.

Procedure

Patients were picked each day by Dr. Karper or an RN on the inpatient BH2 unit. They were chosen based on cooperativeness, severity of illness and patience; only those who the doctor or the RN thought would be a good fit to fill out the survey were chosen. Two of Dr. Karper's students would fill out the demographic information with the patients' birth date, the current date, the patients' room number and the survey number. The patients were told the survey was a measure of personality and childhood events that would help Dr. Karper better assist them. They were then asked if they would be willing to fill out the survey. If they agreed to fill it out they were given as much time as needed (usually 45-60 minutes). If they refused, they

were not penalized in any way. When the survey was finished Dr. Karper's students scored the survey appropriately and entered the data into the computer to be analyzed.

Results

A multiple regression in an analysis program, STATA, showed that for deniers both self-esteem and suicidality have a significant positive relationship with one another, F(1,177)=290.41, p<0.00; specifically the higher the participants' score on self-esteem (higher scores represents low self-esteem) the higher the suicidality level of participants.

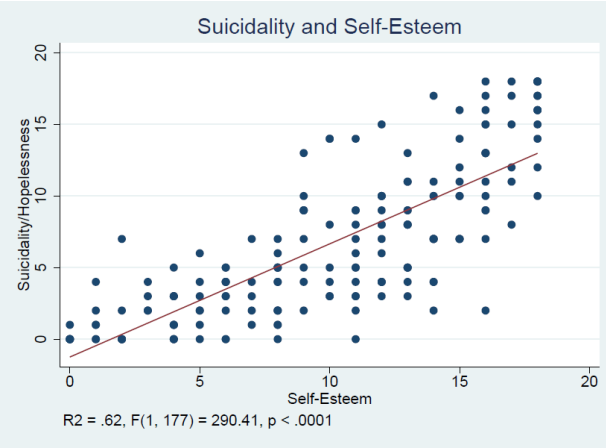

Figure 1 shows the significant relationship between suicidality and self-esteem. The higher the rating the worse self-esteem participants had.

A one way analysis of variance showed that there was no difference in self-reported self-esteem between deniers and non-deniers, $F(1, 144) = 2.31$, $p=0.13$. Alternatively, it showed that suicidality was statistically significant between deniers and non-deniers, $F(1, 144) = 4.15$, $p=0.04$; specifically deniers (M= 5.61, SD= 4.54) minimized their suicidality more than non-deniers (M=7.56, SD= 5.44). A one way analysis of variance also showed that participants, whether deniers or non-deniers, did not differ in their report of their personality (n.s. for all personality domains). Another one way analysis of variance showed that participants who were deniers rated all types of childhood abuse lower than participants who were non-deniers, see table 2. This confirmed that deniers did significantly deny their childhood trauma compared to those who were not considered deniers.

Discussion

The intention of the present study was to determine if one's denial of their childhood trauma impacted the self-report of their suicidality rate. It was hypothesized that patients who denied their childhood trauma would also portray a lower suicidality rate, indicating minimization/denial in their suicidality, compared to non-denying individuals.

The results of the data support our contentions that when individuals denied their childhood trauma they also reported a lower suicidality rate, indicating minimization on their thoughts of suicidality. This shows that when an individual uses denial as a coping mechanism, they will not be reporting proper results on their suicidal ideations. This is very detrimental in clinical usage because mental health professionals will not be getting an accurate analysis of the patients' suicidality which can be life threatening. However, results show that participants did report accurately their personality and self-esteem. These findings show that individuals did not deny all aspects of themselves, only childhood trauma and the minimization of suicidality.

These findings lead to implications that should be taken into clinical consideration when dealing with psychiatric inpatients. Since inpatients properly report only their self-esteem, and as found self-esteem and suicidality are related, the best measure of psychiatric patients' suicidality rate would be to look at their self-esteem. If they report high levels of self-esteem their suicidality rate is low; however, if they report low levels of self-esteem their suicidality rate would be high. This clinical conclusion is very important for doctors to use when assisting a psychiatric inpatient. One cannot tell by looking at an individual whether they are denying certain information or if they are telling the truth; therefore, in order for a doctor to appropriately assess all patients' self-esteem should be used to measure suicidality in all appropriate psychiatric inpatients.

While this study proved our hypothesis to be correct, there were some limitations of the study. First, all participants were conveniently sampled and therefore these results may not be generalizable to all psychiatric patients; outpatients cannot be assumed to deny similarly to inpatients. While the subjects in this study were recruited from a population that was predominately Caucasian, future work might explore how culture, age, or gender might influence the expression of suicidality.

Table 1 *Ethnicity and Gender of Psychiatric Inpatient Participants*

Patient Race	Frequency	Percentage
White	133	83.13
Black	9	5.63
Hispanic	14	8.75
Asian	2	1.25
Middle Eastern	2	1.25

Gender	Frequency	Percentage
Female	112	70
Male	48	30

Table 2 *Mean, Standard Deviation and F-Statistic of Childhood Trauma Scores*

	Deniers M (SD)	Non-Deniers M (SD)	F-statistic
1. Emotional Abuse	10(6)	14 (6)	13.25**
2. Physical Abuse	8 (5)	11 (6)	6.53*
3. Sexual Abuse	8 (5)	11 (7)	8.22*
4. Physical Neglect	7 (3)	9 (6)	8.22**
5. Emotional Neglect	9 (6)	14 (6)	23.88**

Note: *= p-value is significant at the 0.01 level, ** = p-value is significant less than 0.001, the higher a mean the more severe a trauma

References

Bernstein, DP. & Fink, L. (1998). Childhood trauma questionnaire. A retrospective self-report. *The Psychological Corporation.*

Krueger, RF., Derringer, J., Markon, KE., Watson, D., & Skodol AE (2013). The Personality Inventory for DSM-5 (PID-5)—Adult. American Psychiatric Association.

Li, X., Wang, Z., Hou, Y., Wang, Y., Liu, J., & Wang, C. (2013). Effects of childhood trauma on personality in a sample of Chinese adolescents. *Child Abuse & Neglect.*

Petersen, AC., Joseph, J., & Feit, M. (2014). Consequences of child abuse and neglect. *New Directions in Child Abuse and Neglect Research*. Washington (DC): National Academies Press (US), *111-155.*

Simon, R. & Hales, R. (2012). Textbook of suicide assessment and management: Second edition. Arlington, VA: The American Psychiatric Publishing Company.

Telford, K., Kralik, D., & Koch, T. (2006). Acceptance and denial: Implications for people adapting to chronic illness: Literature Review. *The Authors Journal.* 457-464.

Tse, D. Denial in cancer patients. *Palliative Medicine Grand Round.*