

SHORT REPORT

## History of childhood trauma and disruptive behaviors in the medical setting

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### Abstract

**Objective.** In this study, we examined relationships between five types of childhood trauma and 17 disruptive behaviors in the medical setting. **Methods.** Using a cross-sectional consecutive sample of 394 internal medicine outpatients, we surveyed participants about five types of childhood trauma (i.e. witnessing of violence, physical neglect, emotional abuse, physical abuse, and sexual abuse) and 17 disruptive behaviors in the medical setting (e.g., yelling, cursing, threatening medical personnel). **Results.** Initial correlations indicated relationships between four of the five forms of childhood trauma and the number of different disruptive behaviors endorsed. However, using multiple regression analysis, only witnessing violence and physical abuse remained independent predictors of disruptive behaviors in the medical setting. **Conclusions.** Individuals with childhood histories of witnessing violence and/or physical abuse are at-risk for perpetrating various disruptive behaviors in the medical setting.

**Key Words:** Aggression, disruptive behavior, emotional abuse, medical setting, physical abuse, physical neglect, sexual abuse, witnessing violence

### Introduction

Relationships between trauma in childhood and aggression in adulthood have been previously confirmed. For example, in a study of over 17,000 members of a health maintenance organization, Anda and colleagues found that aggression-related domains in adulthood increased in a graded fashion according to the number of childhood adversities experienced [1]. In a sample of 95 adult males, Rosenbach found that physical and sexual abuse related to elevated aggression scores [2]. In a meta-analysis of studies of children exposed to domestic violence, Jacobus found statistically significant relationships with moderate effects for externalizing behaviors [3]. Ford and colleagues examined data from the National Survey of Adolescents and found associations between childhood trauma and delinquency [4]. Using a prospective design, Widom and colleagues found relationships between child abuse and neglect, and aggression in

adulthood – a relationship that was particularly specific among men [5]. In a study examining multiple types of violence, Seifert reported relationships between childhood trauma and aggression [6]. In an Egyptian study, Mansour and colleagues reported associations between moderate-to-severe abuse in childhood and impulsivity and aggression in adulthood [7]. There are also a number of studies relating maltreatment in childhood to intimate partner violence (e.g., [8–10]). Through this sampling of various studies, which have examined different populations with various methodologies and measures, a diffuse but consistent relationship continually emerges between maltreatment in childhood and aggressive behavior in adulthood. However, we are unaware of any studies that have examined traumatic experiences in childhood and relationships with a unique form of aggression in adulthood – disruptive behaviors

in the medical setting, which is the focus of the present study.

## Method

### Participants

Participants were males and females, ages 18 years or older, being seen at an internal medicine outpatient clinic for non-emergent medical care. The outpatient clinic is staffed by both faculty and residents in the department of internal medicine, and is located in a mid-sized, mid-western US city. The majority of patients recruited for this study were seen by resident providers. We excluded individuals with compromising medical (e.g., severe pain), intellectual (e.g., mental retardation), cognitive (e.g., dementia), or psychiatric symptoms (e.g., psychotic) – i.e., symptoms of a severity that would preclude the candidate's ability to successfully complete a survey.

At the outset, 441 individuals were approached and 401 agreed to participate (90.9%). Of these, 394 completed relevant study measures, of which 64.5% were female and 34.5% male, ranging in age from 18 to 92 years ( $M = 53.38$ ,  $SD = 16.23$ ). Most participants were White/Caucasian (89.6%); however, 6.3% of participants were African-American, 1.5% Asian, 1.5% Hispanic, 0.5% Native American, 0.3% Other, and 0.3% had missing data. With regard to educational attainment, all but 7.6% had at least graduated high school whereas 26.5% had earned at least a bachelor's degree.

### Procedure

During clinic hours, one of the authors (SF) positioned himself in the lobby of the outpatient clinic, approached incoming patients, and informally assessed exclusion criteria. With potential candidates, the recruiter reviewed the focus of the project and then invited each to participate. Each participant was asked to complete a four-page survey, which took about 10 min. Participants were asked to place completed surveys into sealed envelopes and then into a collection box in the lobby.

The survey consisted of three sections. In the first section, we asked participants about demographic information (e.g., sex, age, marital status, racial/ethnic origin, and educational level).

In the second section, we explored five types of childhood trauma. Specifically, participants were asked if, "Prior to the age of 12, did you *ever* experience..." with yes/no response options. Individual items were: (1) the witnessing of violence (the first-hand observation of violence that did not directly

involve you); (2) physical neglect (not having your basic life needs met); (3) emotional abuse (verbal and nonverbal behaviors by another individual that were purposefully intended to hurt and control you, not kid or tease you); (4) physical abuse (any physical insult against you that would be considered inappropriate by either yourself or others and that left visible signs of damage on your body either temporarily or permanently or caused pain that persisted beyond the "punishment"); and (5) sexual abuse (any sexual activity against your will). Scores could range from 0 (none of the five types of childhood abuse/trauma) to 5 (all forms).

In the third section, using an author-developed questionnaire, we asked participants about 17 disruptive behaviors related to the medical setting. With yes/no response options, participants were asked, "In dealing with medical personnel (office staff, assistants, nurses, doctors), either in an inpatient or outpatient medical (non-psychiatric) setting, have you *ever*," with items such as, "Yelled or screamed at medical personnel," "Cussed at medical personnel," "Verbally threatened medical personnel," and "Threatened to hit or strike medical personnel." The Disruptive Behaviors Survey is shown as it appeared to respondents in Table I.

## Results

Of the 394 respondents, 153 (38.8%) indicated having witnessed violence as a child, 45 (11.4%) indicated having experienced physical neglect, 161 (40.9%) indicated having experienced emotional abuse, 106 (26.9%) indicated having experienced physical abuse, and 77 (19.5%) indicated having experienced sexual abuse. With regard to disruptive behaviors in the medical setting, the possible number of such behaviors respondents could endorse was 0–17, but the actual numbers endorsed were 0–11, with 51.0% of respondents not endorsing any of the 17 listed disruptive behaviors. Of the total sample, 9.1% endorsed one behavior, 20.3% endorsed two behaviors, 10.4% endorsed three behaviors, 5.6% endorsed four behaviors, and only 3.6% endorsed five or more behaviors. The mean number of different disruptive behaviors reported as a function of childhood trauma is reported in Table II. With the exception of sexual abuse, those who indicated each form of childhood trauma also reported a statistically significantly greater number of different forms of disruptive behavior in medical settings.

Because there was a fair degree of overlap in the endorsement of each type of childhood trauma, we performed a multiple regression analysis to determine which forms of childhood trauma were unique



of physical abuse. These traumatized individuals may act out their aggressive behavior in a medical setting, imperiling clinicians as well as staff and other patients. Put another way, for these individuals, the behavioral range of aggression in adulthood clearly extends to the medical setting. In addition, clinicians need to be sensitively considerate in their communication with these traumatized individuals to avoid unnecessarily provoking a confrontation. When such confrontations arise, clinicians need to have some sense of how to manage conflict, when possible.

Note that the percentage of women participants in this sample is higher than men participants. This directly reflects the gender utilization patterns in this clinic – i.e. women more frequently access services than men. This observed gender effect may have affected the reported frequencies of childhood traumas. For example, a greater proportion of men may have diminished the prevalence of sexual abuse and may have even increased the prevalence of physical abuse. How these possible changes would affect the data remains unknown, but should be appreciated.

In addition, the average age of the sample is 53 years, again very representative of an internal medicine clinic. Given the middle-age positioning of the sample, there is always the possibility of the under-reporting trauma through acceptance with time as well as the risks in any sample of denial, suppression, repression, and misinterpretation.

This study has a number of potential limitations, including the self-report nature of the data, the general inquiry about childhood trauma, the use of an unvalidated scale for disruptive behaviors in the medical setting because no such scale previously existed, and the exclusion of severely impaired patients. The latter process may have unintentionally excluded individuals with high levels of childhood trauma, although the number of candidates actually excluded was less than 10 individuals. However, the unique aspects of this study include examining issues through the types of inquiries typically initiated by clinicians, using a consecutive and large patient sample, and investigating a unique form of aggression. Findings indicate that witnessing violence and physical abuse in childhood are associated with the number of different disruptive behaviors in the medical setting—a relevant concern for clinicians in all types of treatment settings.

### Key points

- Trauma in childhood has previously been associated with various aggressive behaviors in adulthood. However, relationships between childhood trauma and disruptive behaviors in the medical setting have not been explored

- According to findings, with the exception of sexual abuse, the remaining forms of childhood trauma (i.e. witnessing violence, physical neglect, emotional abuse, physical abuse) demonstrated statistically significant relationships with disruptive behaviors in the medical setting
- Using multiple regression analysis to further tease out relationships, only witnessing violence and physical abuse remained statistically significant predictors of disruptive behaviors in the medical setting, suggesting that exposure to violence in childhood has far-reaching effects in adulthood that may extend to the medical treatment environment

### Acknowledgements

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### Statement of interest

None to declare.

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