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The relationship between childhood traumatic experiences and death anxiety: The mediating role of obsessive beliefs

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Abstract
Introduction: For many people, death anxiety brings a lot of fear and panic, and it is very important to investigate the factors influencing its formation and continuation. The purpose of this study was to explore the mediating role of obsessive beliefs in the relationship between traumatic childhood experiences and death anxiety in adulthood.

Materials and Methods: The present study employed a descriptive-correlational design and structural equation modeling. The statistical population comprised Iranian adults residing in Mashhad, Iran in 2022, of whom 340 individuals were selected as the research sample through convenient sampling. Data were collected online using the Templer Death Anxiety Scale (TDAS), Childhood Trauma Questionnaire (CTQ), and the Obsessive Beliefs Questionnaire (OBQ-44). The data were analyzed utilizing the Pearson correlation method and structural equation analysis through SPSS version 26 and AMOS version 24.

Results: The results revealed a significant correlation ($P < 0.01$) between traumatic childhood experiences and obsessive beliefs, indicating a noteworthy association with death anxiety. The results of structural equation modeling also demonstrated a satisfactory fit for the model in this study. Furthermore, the mediating role of obsessive beliefs in the relationship between traumatic childhood experiences and death anxiety was found to be significant, with a $\chi2/df \leq 3$ and a significance level of 0.001.

Conclusion: According to the findings, traumatic childhood experiences can predict and affect death anxiety through interaction with obsessive beliefs.

Keywords: Death anxiety, Obsessive beliefs, Traumatic childhood experiences

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Introduction

One of the most vulnerable groups in society is children. Among the harms that threaten children is childhood traumatic experiences, which unfortunately do not receive much attention in society (1). Childhood traumatic experiences refer to any physical, emotional, or sexual abuse, neglect of children's basic needs,

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and exploitation of children. The World Health Organization defines childhood trauma as including all types of emotional, physical, and emotional abuse, sexual abuse, neglect, and exploitation that jeopardize children's health, survival, thriving, and dignity (2).

Childhood traumatic experiences include all types of negative behaviors and neglect, posing a significant public health concern in the United States (3). In Iran, a study by Mikaeili and Zamanloo conducted to assess the prevalence of these traumatic experiences, revealed that approximately 32.35% of children had been exposed to childhood traumatic experiences, indicating a considerable percentage of such incidents. Moreover, the highest rates of these experiences were related to emotional abuse, emotional neglect, physical abuse, and physical neglect, respectively (4). Childhood traumatic experiences leave many consequences for humans. These experiences are encoded as a multiplex network of information or a fear structure in memory (5). The consequences of childhood traumatic experiences include low resilience, underdeveloped relationships, unusual social behaviors (6), the formation of obsessive beliefs (7), deficits in emotion regulation, distractibility, defiance of orders (8), and death anxiety (9).

Anxiety is a primitive emotion that preserves human survival and keeps people safe from all threats, thus maintaining human security and well-being (10). Death anxiety is one type of anxiety. Existential psychologists have stated that this kind of anxiety is experienced in the existential depth of each person and is not so related to the conscious level of people's personalities but rather is a conscious or unconscious psychological state that arises as a result of a defense mechanism and can be stimulated by being threatened by death and endangered survival (11,12).

Several studies have explored the connection between childhood traumatic experiences and death anxiety. They showed that exposure to traumatic experiences can predict death-related thoughts later in life. The results of another study stated that childhood abuse and mistreatment can lead to a threefold increase in the likelihood of developing anxiety problems such as death anxiety (13,14). The results of Lähdepuro et al.'s study showed that childhood traumatic experiences such as emotional neglect and physical harm can be associated with increased symptoms of death anxiety in adulthood (12). Obsessive beliefs are another consequence of childhood traumatic experiences. Based on the American Psychological Association's definition, obsessive beliefs refer to a pervasive pattern of preoccupation with orderliness, perfectionism, and mental control that begins in early adulthood and leads to a loss of flexibility, openness, and efficacy over time (15).

In this regard, the results of Pinciotti et al.'s study indicate that a history of traumatic experiences in childhood may result in an excessive sense of responsibility and obsessive control of various thoughts to prevent re-experiencing emotions resulting from traumatic experiences (16). Also, the results of Şar et al.'s study showed that individuals who were exposed to childhood traumatic experiences experienced more fear compared to others and developed obsessive beliefs to reduce this fear (17). n another study, the results showed that childhood traumatic experiences can lead to the formation and continuation of obsessive beliefs and obsessive-compulsive disorder through interaction with the emotion of shame (18).

Regarding the relationship between obsessive beliefs and death anxiety, the results indicate a very strong correlation between death anxiety and obsessive beliefs (19). Additionally, Menzies et al. stated that various subgroups of obsessions and related beliefs are associated with death anxiety during the COVID-19 pandemic (20).

As mentioned, based on the literature of the present study, childhood traumatic experiences play a major role in shaping the components of obsessive beliefs and death anxiety. Also, the components of obsessive beliefs and death anxiety have a significant relationship with each other. Given the very high importance of the death anxiety variable and accurately identifying the effective factors in its formation and continuity, as well as examining the contribution and effect size of each variable and the apparent and hidden relationships between them, the present study considers childhood traumatic experiences and obsessive beliefs together. Therefore, this study aims to address the existing research gap by answering the question of whether obsessive beliefs play a role in the relationship between childhood traumatic experiences and death anxiety.

Materials and Methods

The method of this research was applied in terms of purpose, quantitative in terms of data,

and "correlation using structural equation analysis" in terms of the relationship between variables. The statistical population of this study encompassed all Iranian adults aged 18 to 50 years residing in Mashhad, Iran in 2022 who had suitable access to the Internet and virtual space at the time of sampling. Employing the statistical method used in the research, considering a 25% dropout rate, an effect size of 0.15, and a test power of 95%, as determined by G-power software, a minimum sample size of 300 individuals was initially set. However, to enhance the similarity of the current sample to the target population, improve the test power, and increase the generalizability of the results, a total of 340 individuals were selected using the convenience sampling method.

Given the COVID-19 pandemic circumstances and the lack of physical access to individuals, sampling was conducted through an online questionnaire. The inclusion criteria included having at least a secondary level of education, no history of acute medical or psychiatric problems (as reported by the individuals themselves), and willingness to participate in the research. For exclusion criteria, individuals with a history of any traumatic event or injury within the past six months were excluded from the study. Additionally, incomplete questionnaire submissions were also considered a reason for exclusion from the study.

Research instruments

A) Demographic Checklist: It includes personal information including gender, age, level of education, marital status, history of physical, and ways to reconnect to receive research findings were received.

B) Templer Death Anxiety Scale (TDAS): This questionnaire consisted of 15 items and was developed in 1970 by Templer to measure death anxiety. Respondents indicate their response to each item with either "yes" or "no". Scores range from 0 to 15, where scores between 0 to 7 indicate low death anxiety and scores between 8 to 15 represent high death anxiety (21). Studies on the validity and reliability of the Death Anxiety Scale show that the reliability and validity of this instrument are acceptable. This questionnaire is used worldwide to measure death anxiety and is a standard questionnaire. In the original culture, the reflection coefficient of the scale was 0.83, and its concurrent validity was reported to be 0.27 based on the correlation with the apparent anxiety scale and 0.40 with the depression scale (22). Rajabi and Bohrani have normalized this scale in Iran, reporting a reliability coefficient of 0.62 and an internal consistency coefficient of 0.73. The validity was examined using the Death Anxiety Scale and the Apparent Anxiety Scale, yielding correlation coefficients of 0.40 and 0.43, respectively (23).

C) The Childhood Trauma Questionnaire (CTQ): This scale, developed by Bernstein and colleagues in 2003, was designed to assess childhood trauma and related damages. It functions as a screening tool to identify individuals who have undergone childhood abuse and neglect, assessing five types of childhood maltreatment: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect. The Childhood Trauma Scale consists of 28 questions, with 25 items focusing on the main components of the questionnaire and an additional three questions aimed at identifying individuals who deny their childhood difficulties. The questionnaire is rated on a five-point Likert scale from 1 to 5. Therefore, the score range for each individual across the entire questionnaire falls between 25 and 125. Higher scores on the questionnaire indicate more significant trauma or damage, while lower scores signify less childhood trauma or lower levels of damage. The Cronbach's alpha value for the dimensions of emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect among a group of adolescents was reported as 0.87, 0.86, 0.95, 0.89, and 0.78, respectively (24). In a study conducted in Iran by Ebrahimi et al. the Cronbach's alpha coefficients for the five components ranged from 0.81 to 0.98, and the test-retest reliability was reported as 0.94 (25).

D) The Obsessive Beliefs Questionnaire (OBQ-44): This scale was developed by the Cognitive Working Group on Obsessive-Compulsive Disorder (OCD) in 2001 to assess illness-related dimensions within the cognitive domain of individuals diagnosed with OCD. Comprising 44 items, this scale is graded on a 7-point Likert spectrum from "completely disagree" to "completely agree." It encompasses three cognitive components: responsibility/threat estimation, perfectionism/certainty, and importance/control of thoughts. Research conducted by this group in 2003 and 2005 indicated strong internal consistency ($\alpha = 0.80$) and excellent test-retest reliability of this scale,

affirming the three components of obsessive beliefs (26). Shams et al. investigated the Persian version in Iran, assessing its validity and reliability. They reported Cronbach's alpha coefficients of 0.92 for the total scale, 0.85 for the responsibility/threat estimation subscale, 0.85 for the perfectionism/certainty subscale, and 0.82 for the importance/control of thoughts subscale. Additionally, test-retest reliability using a 5 to 14-day interval showed coefficients of 0.82 for the total questionnaire, 0.87 for the responsibility/threat estimation subscale, 0.79 for the perfectionism/certainty subscale, and 0.82 for the importance/control of thoughts subscale (27).The research data were collected from all interested adults who volunteered to participate in the study through an online questionnaire (Google Form) shared on Instagram, Telegram, and WhatsApp from January to February 2022. Therefore, the research link was widely distributed, and individuals who expressed interest and met the necessary criteria for participating were invited to complete the questionnaire at their convenience. Respondents were asked to register their email addresses at the beginning of the form to prevent duplicate responses, ensuring that duplicate data could be excluded from the analysis. For data analysis, Structural Equation Modeling (SEM) was employed. The analysis was conducted using SPSS version 26 and AMOS version 24.

Results

First, the demographic characteristics of the study sample were examined. Among the 340 participants, 98 (28.8%) were male, and 242 (71.2%) were female. The participants' mean age was 32.29 ± 8.91 years (18 to 50). Fifty individuals (14.7%) had a high school diploma, 10 individuals (2.2%) had an associate degree, 141 individuals (41.5%) had a bachelor's degree, and 139 individuals (40.9%) had a master's degree or higher. Additionally, among them, 217 individuals (63.8%) were single, and 123 (36.2%) were married.

Table 1. Results of Pearson correlation test to examine the relationship between research variables

Variable	M	SD	1	2	3	4	5	6	7	8	9
Childhood traumatic experience											
1. Physical abuse	10.28	0.85	1								
2. Sexual abuse	0.49	0.4	***0.74	1							
3. Emotional abuse	0.98	0.61	***0.62	***0.43	1						
4. Physical neglect	1.09	1.13	***0.73	***0.60	***0.53	1					
5. Emotional neglect	1.67	1.14	***0.61	***0.37	***0.58	***0.48	1				
6. A sense of responsibility for harm and damage	3.23	1.1	***0.58	***0.43	***0.52	***0.51	***0.49	1			
7. Perfectionism	2.65	0.99	***0.52	***0.36	***0.48	***0.46	***0.46	***0.96	1		
8. Importance/control of thoughts	3.24	2.12	***0.60	***0.45	***0.53	***0.53	***0.48	***0.98	***0.89	1	
9. Death anxiety	0.97	0.81	***0.51	***0.43	***0.49	***0.48	***0.46	***0.62	***0.60	***0.61	1

Table 1 presents a strong relationship between the death anxiety variable and all components of childhood traumatic experiences variables, as well as obsessive beliefs variables (*P*> 0.01). The suggested research model was examined using Structural Equation Modeling (SEM). Before that, assumptions of normality, multicollinearity, and independence of errors were investigated. One of the important assumptions of the structural equation model is the normal distribution of the variables. Skewness and kurtosis coefficients are used to examine the normality of the variables. Considering these indices fall within the range of +1 and -1, the distribution of variables in the research is normal. Tolerance statistics and Variance Inflation Factor (VIF) were utilized to examine multicollinearity. Given that the values obtained for the independent variables were all greater than 0.4, there was no significant multicollinearity between the independent variables. On the other hand, the value obtained for the Durbin-Watson test was 2.33, falling within the acceptable range (1.5 to 2.5) and indicating the independence and lack of correlation of error values.

As observed in Table 2, the overall effect of childhood traumatic experiences pathways to

obsessive beliefs (0.71), childhood traumatic experiences to death anxiety (0.36), and obsessive beliefs to death anxiety (0.37) was significant. Bootstrapping was done using AMOS software to determine the relevance of the indirect path; the findings are shown in Table 3.

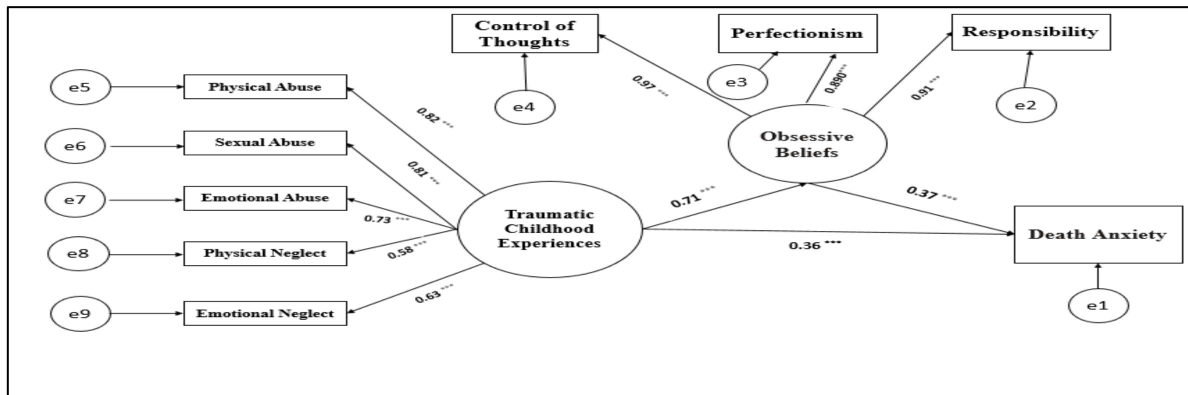

Figure .1 Final model (all relationships are significant at the *P*< 0.001 level)

Table 2. Measurement parameters of direct relationships

Path	Unstandardized Estimate	Standardized Estimate	Standard Error	Critical Ratio	P
Childhood traumatic experiences to obsessive beliefs	2.22	0.71	0.17	13.04	0.001
Childhood traumatic experiences to death anxiety	0.52	0.36	0.1	4.93	0.001
Obsessive beliefs to death anxiety	0.17	0.37	0.03	5.45	0.001

Table 3. Bootstrapping results to test indirect relationships

Path	Standard value	Standard Error	Lower bound	Upper bound	P
Childhood traumatic experiences to obsessive-compulsive symptom severity with shame mediating	0.27	0.06	0.15	0.40	0.001

As shown in Table 3, the path from childhood traumatic experiences to death anxiety with obsessive beliefs mediation (β= 0.27, *P*< 0.05) had a lower confidence interval of 0.15 and an upper limit of 0.40. Since zero was outside these confidence intervals, this mediating relationship was significant.

Obsessive beliefs played a mediating role in the relationship between childhood traumatic experiences and death anxiety. As Table 4 illustrates, the fitting indicators indicated that the model fits. Therefore, the final model had a desirable goodness of fit.

Table 4. Indices of goodness-of-fit for the final model of the research

Index	χ2	Df	χ2/df	RMSEA	GFI	AGFI	IFI	TLI	CFI	NFI
Desired value			≤2	≤0.08	≥0.90	≥0.90	≥0.90	≥0.90	≥0.90	≥0.90
Final model	31.29	15	2.08	0.05	0.97	0.94	0.99	0.98	0.99	0.98

Discussion

The purpose of this study was to ascertain how obsessive beliefs mediated the association between childhood traumatic experiences and death anxiety. The findings show that the relationship between childhood traumatic experiences and death anxiety is significant. This finding aligns to some extent with the results of Russell and Russell's research, which investigated psychological responses to traumatic experiences in U.S. soldiers with a sample of 464 participants (28). Also, it is consistent with the work of McKay et al. a review study examining the link between childhood trauma experiences and psychological disorders (29), and Lähdepuro et al.'s study which explored the impact of early stress experiences on 1,872 adult participants (12). All these studies, including the current research, converge on the association between childhood traumatic experiences and psychological distress. One explanation for this

finding is that traumatic experiences in childhood, depending on their intensity and frequency, affect an individual's memory, emotions, cognition, and physical senses and cause them harm. In individuals who experience childhood trauma, a kind of lack of self-confidence, self-blame, and lack of intrinsic self-worth is formed (30). Due to the occurrence of harm during childhood, these individuals may experience a kind of constant "vigilance" that, at any moment, an incident similar to that may happen, leading to the reactivation of negative emotions related to traumatic experiences.

As a result, the experience of fear and anxiety about death becomes inevitable. This fear and anxiety can lead to worrying that "something might happen to me, hurt me and destroy me". So, they are preoccupied with and excessively monitor their own and others' deaths and experience high levels of death anxiety in various life situations (26).

On the other hand, the results of the current study indicate a significant relationship between obsessive beliefs and death anxiety. This finding aligns to some extent with the outcomes of the study conducted by Verin et al. which examined the relationship between obsessive beliefs and death anxiety by examining a sample of 48 people from American society and similarly acknowledged the relationship between obsessive beliefs and death anxiety as the present study (31), and Menzies et al. who in two simultaneous studies on samples of 79 and 143 people examined the relationship between obsessive-compulsive disorder and death anxiety, consistent with the present study (20).

The explanation for this finding can be that the purpose of obsessive beliefs is to maintain a sense of certainty about the world and are used to reduce the sense of ambiguity. Obsessive beliefs may offer a temporary sense of calm in the short term. However, in the long run, a painful occurrence occurs. This is because the individual gets trapped in a "vicious cycle" where they lose control of their surroundings. Because of this inability, they become anxious and may even experience damage to their identity organization.

One of these ambiguous situations in human life is the time of their death. Humans do not even know about a minute after themselves in life, and this situation generates much anxiety. If someone wishes to control their death or the deaths of those around them, they may feel despair and hopelessness due to their inability to do so. This experience of death anxiety becomes increasingly irrational compared to the past with each passing moment (16,17).

The results also show that childhood traumatic experiences have a significant relationship with obsessive beliefs. This finding is consistent with studies by Pinciotti et al. (16) and Shirkhani et al. on a similar statistical population (adults living in Mashhad) (18), and Şar et al. on 184 people and a similar tool (CTQ) to the present study (17).

The above studies examined the relationship between obsessive beliefs and childhood traumatic experiences, are consistent. The explanation for this finding can be that childhood traumatic experiences, including experiences of rejection, lack of approval, and social deprivation, violate part of the individual's identity and leave the self-organization with a kind of void resulting from not being accepted and approved. This void, in turn, results in negative feelings towards oneself and a fragile self-concept. The person experiences a profound sense of inferiority, rejection, and shame (18).

These individuals are consistently concerned that they will experience further discretization in various situations, leading to negative personal judgments. This, in turn, results in an increased sense of defectiveness and a lack of self-worth. Individuals attempt to avoid this sense of worthlessness by employing obsessive thoughts and beliefs. Still, they fail to realize that the result of these avoidances is a failure in behavioral restraint. As a result, this worry not only does not decrease but also increases over time, and the experience of shame in the person becomes deeper. The increase in this shame, in turn, leads to an increase in obsessive beliefs and behaviors (31).

However, an important finding of this study was the mediating role of obsessive beliefs in the relationship between childhood traumatic experiences and death anxiety. This finding is somewhat consistent with the results of Moreton et al.'s review of studies examining death anxiety and psychiatric history, which reported a similar result to the present study regarding the relationship between childhood experiences and death anxiety (32).

In explaining the findings of this research, it can be said that during childhood, because the human personality has not yet been properly

and fully formed, children are very vulnerable to events around them. Traumatic experiences in childhood usually occur unexpectedly and create a psychological wound by instilling fear and terror. This wound lingers on the remaining psychological organization and jeopardizes life (20). The occurrence of traumatic childhood experiences leads to the loss of the individual's internal credibility, as they cannot control situations in the face of an assailant, causing their entire beliefs to collapse suddenly.

The loss of this credibility results in an internal gap, and unconsciously, the individual resorts to obsessive beliefs to compensate for this internal gap. These obsessive beliefs make the individual susceptible to various types of anxiety, and over time, they become so intense that they disrupt normal human functioning. Since these obsessive beliefs cannot be beneficial in all aspects of life, including the life and death of a person, this anxiety extends to various branches of individual health, and the person experiences a high level of death anxiety (33). The present study has limitations that warrant careful consideration when interpreting its findings. For instance, one limitation is using online questionnaires for data collection, necessitated by the COVID-19 pandemic and social distancing measures.

As a result, individuals who needed access to cyberspace and the Internet were not included in this study. Another limitation of this study is its sampling method, which employed convenience sampling. Additionally, the study did not assess the participants' psychiatric history. Therefore, it is suggested that future research should address these limitations.

Conclusion

The present study predicts death anxiety by demonstrating the mediating role of obsessive beliefs in the relationship between traumatic childhood experiences and anxiety. Therefore, interventions based on introducing preventive measures regarding parenting styles and the importance of childhood in reducing individuals' traumatic childhood experiences can have positive results. These interventions can be considered preventive and therapeutic programs to assist individuals in reducing and improving anxiety, especially death anxiety.

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Conflict of Interests

The authors declare no conflict of interest.

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Ethical Considerations

For confidentiality purposes, information obtained from the questionnaires was collected without including subjects' names and addresses, guaranteeing that respondents' identities remained confidential and accessible only to those involved in this study. Ensuring the trust and confidence of participants in contributing to the research and freely responding to the questionnaires was a primary consideration in this study.

Authors' Contributions

All authors equally contributed to preparing this article.

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