




Psychache and Suicidal History in Patients with Obsessive-Compulsive Disorder

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Purpose: Suicide is an important cause of death in patients diagnosed with obsessive-compulsive disorder (OCD) as well as other psychiatric disorders. Early determining of risk factors provides an opportunity for intervention. The mediating effect of psychological pain (also known as psychache) on suicide has been shown in various disorders but has not been investigated in patients with OCD. In this study, we aimed to show the relationship between psychological pain and other clinical variables and suicide in OCD patients.

Patients and methods: This cross-sectional study consisted of 67 patients diagnosed with OCD according to DSM-5 criteria with no comorbid psychiatric diagnosis who applied to the psychiatric outpatient clinic of Çukurova University Faculty of Medicine and 63 healthy controls. Among the OCD patients, 12 had previous suicide attempts. In addition to the sociodemographic data form, participants filled out the Yale-Brown Obsessive Compulsive Scale (YBOCS), the Psychache Scale (PS), the Beck Scale for Suicidal Ideation (BSIS), and the Hamilton Depression Scale (HDS).

Results: OCD group's median obsession, compulsion, and the total scores of YBOCS, and the mean PS scores were higher than the control group. There was no difference between the socio-demographic variables of OCD patients with and without previous suicide attempts such as age, gender, years of education, place of residence, marital, and occupational status. The median scores of obsession, avoidance, global severity, and indecisiveness subdimensions of YBOCS, the mean BSIS and PS scores, the rates of current aggressive, current contamination, and the past religious obsessions were higher in the suicidal group. There were moderately significant relationships in the same direction between the PS, BSIS, and total YBOCS scores. Multivariate regression analysis demonstrated that only the PS scores predicted previous suicide attempts.

Conclusion: Our results demonstrated that current aggressive, current contamination, past religious obsessions, and the higher psychological pain are related to previous suicide attempts in OCD patients. Our regression analysis supports Shneidman's hypothesis: there would be no suicide without psychache. Relieving psychache in OCD patients may reduce suicide attempts even if there is no diagnosis of comorbid depression.

Keywords: obsessive compulsive disorder, suicide, psychological pain, psychache

Introduction

Obsessive-compulsive disorder (OCD) is characterized by a chronic course, reduced functionality, generally partial response to existing treatment methods, and causing disability.¹ OCD's prevalence is approximately 2% in the United States.² The negative consequences of OCD, such as decreased quality of life, and frequent psychiatric comorbidities, have often been focused on, but the relationship between OCD and suicide has not been adequately addressed.³

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Suicide is a major public health problem in all communities, characterized by processes that can range from thinking of death, desire to die, or not to find life worth living to the planning, undertaking and completing the attempt.⁴ Psychiatric disorders are important risk factors for suicide. Suicide-related studies have often focused on mood disorders, psychotic disorders, substance use disorders, and personality disorders.⁵ Previous studies reported that the history of suicide attempts was 3–4%, and the completed suicide rates were lower than 1% in patients with OCD.^{6,7} However, recent studies have shown that there are higher risks of suicide attempts and death as a result of suicide in OCD patients than healthy individuals.⁸

Suicide risk factors in patients with OCD were, until recently, an often neglected area where there was not enough data.^{1,5} Research has shown that comorbid mood disorders have mediating effects on suicide in OCD.⁹ A significant relationship was found between being single, family history of suicide attempts, childhood trauma, comorbidity of posttraumatic stress disorder, low socioeconomic level, and lack of religious activities and suicidal thoughts and attempts.^{1,5,10}

Studies on the relationship between obsessions and compulsions to suicidal behavior have not yielded a common result. Previous studies revealed that sexual, aggressive,^{11–13} symmetry/order,¹ and religious obsessions and compulsions⁵ were related to suicidal thoughts and suicide attempts. Although Dhyani et al¹⁴ stated that patients with OCD usually attempt suicide by poisoning, there is no common opinion on the method of suicide.

Psychological pain (also known as psychache) is the process of mental suffering, a state of emotional unease caused by negative emotions such as shame, grief, anger, and despair that arise as a result of the hindrance of the individual's basic needs.^{15,16} Shneidman¹⁷ concluded that there would be no suicide without psychological pain as a result of his review of suicide notes. Studies about Shneidman's model stated that psychological pain provides the relationship between depression and suicidal ideation and lifelong suicide attempts, and that psychological pain has a catalyst effect on suicide risk factors.^{18,19} The effect of psychological pain on suicidality has been shown in different groups like students,²⁰ prisoners,²¹ homeless,¹⁸ and depressed patients.²² The researchers revealed the effect of psychological pain on suicide in patients with depressive disorder,²³ bipolar disorder,²⁴ and schizophrenia²⁵ in the Turkish population.

Although Brown et al³ reported the similarity of obsession-related stress to psychological pain recently, to the best of our knowledge, there is no study about psychache in patients with OCD. Determining risk factors for suicide in patients with OCD will provide an opportunity for early intervention and help to prevent possible deaths. Based on the Rudd's Fluid Vulnerability theory of suicide, it can be concluded that chronic pain caused by OCD may be a risk factor for suicide, similar to psychological pain.²⁶ In this study, we aimed to determine the relationship between psychological pain, previous suicide attempts and obsessions, compulsions, and sociodemographic variables in patients with OCD.

Materials and Methods

Sample

Cukurova University Faculty of Medicine (CUSM) Non-Interventional Clinical Research Ethics Committee approved the study. All participants signed an informed consent form before the interviews. The study was conducted in accordance with the Declaration of Helsinki. The first author conducted psychiatric interviews based on diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5).²⁷ Eighty-two patients who were treated in outpatient clinics of the Department of Psychiatry of CUSM formed the OCD group. The control group consisted of 74 healthy volunteers who were compatible with the patients in terms of variables such as age, gender, marital status, and educational level. All participants were older than 18 and literate. Exclusion criteria were comorbid mental retardation, cognitive impairment, and psychotic disorders. We also excluded 15 patients from the OCD group and 11 subjects from the control group who were diagnosed with depression according to DSM-5²⁷ or had a total score of 7 or above on the Hamilton Depression Scale (HDS)²⁸ considering the confounding effects of depression on suicide. The final analysis included 67 patients with OCD and 63 healthy controls.

Power Analysis

With a moderate effect size (Cohen's $d = 0.50$), 0.80 power, and 0.05 error ($p = 0.05$), we calculated the sample size for the study to be 128 with the G Power program (version 3.1).²⁹ Accordingly, we concluded that a sample consisting of 130 individuals has adequate power.

Procedure

In addition to the sociodemographic data form, the participants filled out the Beck Scale for Suicidal Ideation (BSIS),

the Hamilton Depression Rating Scale (HDS), the Yale-Brown Obsessive Compulsive Scale (YBOCS), and the Psychache Scale (PS). Approximately 60–90 mins were given to each patient for a clinical interview and filling out the scales. The interviewer (first author) explained the points that the participants did not understand.

Measures

The Beck Scale for Suicidal Ideation (BSIS)

It is a five-section scale developed to evaluate the severity of suicidal ideation. The total score is obtained from the arithmetic sum of the scores from sub-sections. The highest score is 38, and high scores indicate the seriousness of suicidal ideation.³⁰ In the Turkish validity and reliability study, Cronbach's alpha value was 0.84.³¹

The Hamilton Depression Scale (HDS)

HDS is developed to assess the severity of depressive symptoms. This 17-item scale is filled by the clinician.²⁸ Scores between 0–7 indicate no depression.³² In the Turkish validity and reliability study, Cronbach's alpha value was 0.75.³³

The Yale-Brown Obsessive Compulsive Scale (YBOCS)

It is a semi-structured scale consisting of 19 items that evaluate the types and severity of obsessive-compulsive symptoms. The items are rated from 0 to 4 on this Likert-type scale. The total score is obtained by calculating only the first ten items (except items 1b and 6b). High scores indicate increased disorder severity. The first five questions are related to obsessive symptoms, and the next five are related to compulsions. Symptoms are evaluated regarding how much they occupy the person's time, prevent normal functioning, induce distress, are actively resisted, and can be controlled by the patient. Items 11–16 evaluate the insight, avoidance, indecisiveness, pathological responsibility, pathological slowness, and pathological doubting, respectively. Items 17 and 18 are scored on the interviewer's comment on disorder severity and global improvement. Item 19 evaluates the reliability of the scores. The symptom checklist next to the scale helps to determine the types of obsessions and compulsions as current and past.³⁴ In the Turkish validity and reliability study, and the Cronbach's alpha value was 0.81 in the internal consistency.³⁵

The Psychache Scale (PS)

The PS is based on Shneidman's definition of chronic, nonspecific psychological pain resulting from failure to

meet vital psychological needs. It is a self-report scale consisting of 13 questions. The first nine items evaluate the frequency of psychache (eg, item 5: my pain makes my life seem dark), and the next four evaluate its intensity (eg, item 12: my pain is making me fall apart). The answers to the five-point Likert-type questions range from "never" to "always" or from "strongly agree" to "strongly disagree." High scores indicate that the intensity and the frequency of psychological pain increases.³⁶ PS has been shown to distinguish depressive patients with and without previous suicide attempts, successfully. In the Turkish validity and reliability study, the Cronbach's alpha value was 0.98.²³

Statistical Analysis

We showed descriptive statistics as mean \pm standard deviation or as median and interquartile ranges according to the distribution of data. We summarized categorical variables as number and percentage and compared between the groups using the Fisher Exact or chi-square tests. We compared continuous variables with the independent samples *t*-test when data were normally distributed, and the Mann Whitney *U*-test otherwise. The Spearman's rho correlation coefficient was used to assess the relationship between the scale scores when the data were not normally distributed. We used univariate and multivariate logistic regression models to investigate the risk factors affecting suicide attempts (dependent variable), and results were given as 95% confidence interval (CI) with odds ratio (OR). We used the Jamovi (Version 1.0.7) and JASP (Version 0.11.1) programs for statistical analysis and considered a value of $p < 0.05$ statistically significant.

Results

Table 1 compares the sociodemographic characteristics of OCD and control groups. Age, sex, years of education, place of residence, marital, and occupational status showed similar distribution by groups ($p > 0.05$ for each).

Table 2 compares the scale scores between the groups. The total obsession and compulsion scores and the median total score of the YBOCS of the OCD group were significantly higher than the control group ($p < 0.001$). The median scores of insight, avoidance, indecisiveness, pathological responsibility, pathological slowness, pathological doubting, global severity, global improvement, and reliability sub-dimensions of YBOCS were significantly higher in the OCD group ($p < 0.05$ for each). We also found that the mean total scores of HDS and PS of the OCD group were significantly higher ($p < 0.001$ for each).

Table 1 Sociodemographic Characteristics of Groups

	Diagnosis		p
	OCD (N=67)	Control (N=63)	
Age, Mean \pm SD	36.1 \pm 11.7	33.2 \pm 13.3	0.184 ^Σ
Sex (%)			0.236 ^Ω
Female	43 (64.2)	33 (52.4)	
Male	24 (35.8)	30 (47.6)	
Years of education (median [IQR])	12.0 [5.0–14.0]	11.0 [8.0–15.0]	0.329 ^B
Place of residence (%)			0.276 ^Ω
Urban	33 (49.3)	38 (60.3)	
Rural	34 (50.7)	25 (39.7)	
Marital status (%)			0.914 ^Ω
Single	41 (61.2)	37 (58.7)	
Married	26 (38.8)	26 (41.3)	
Occupational status (%)			0.377 ^Ω
Unemployed	36 (53.7)	28 (44.4)	
Employed	31 (46.3)	35 (55.6)	

Notes: ^ΣIndependent samples *t*-test. Descriptive statistics are given as Mean \pm SD. ^BMann Whitney *U*-test. Descriptive statistics are given as median [IQR]. ^ΩPearson Chi-Square test. Descriptive statistics are given as number (%).

Abbreviations: SD, Standard Deviation; IQR, Interquartile Range.

Table 3 compares sociodemographic characteristics and the BSIS, HDS, YBOCS, and PS scores of OCD patients according to the presence of suicide attempts. The sociodemographic characteristics of OCD patients

were similar according to the presence of suicide attempts ($p > 0.05$ for each). The total obsession and YBOCS total scores of the OCD patients who had a history of attempted suicide were significantly higher ($p = 0.007$ and $p = 0.028$, respectively). The avoidance, indecisiveness, and global severity scores of OCD patients who had a history of attempted suicide were significantly higher ($p = 0.009$, $p = 0.038$ and $p = 0.021$, respectively). Finally, the BSIS and PS scores of OCD patients who had suicide attempts were also significantly higher ($p < 0.001$ for each).

Table 4 compares obsession and compulsion types (current and the past) according to the presence of suicide attempts in patients with OCD. The rates of current aggressive, current contamination, and past religious obsessions of OCD patients who had a history of attempted suicide higher ($p < 0.001$, $p = 0.020$ and $p = 0.024$, respectively).

Table 5 shows the correlations between the scales. There were moderately significant correlations between BSIS and PS, total obsession, compulsion scores, and YBOCS total scores of OCD patients ($p < 0.05$ for each) in the same direction. There were also moderately significant correlations between PS scores and total obsession, compulsion, and total scores of YBOCS in the same direction ($p < 0.05$ for each).

In **Table 6**, we investigated the risk factors for suicide attempts with univariate and multiple logistic regression models. The univariate logistic regression model revealed that the effect of current aggressive, contamination, and

Table 2 Comparison of Scale Scores by Groups

	Diagnosis		p
	OCD (N=67)	Control (N=63)	
Total Obsession Score (median [IQR])	10.0 [6.5–12.0]	0.0 [0.0–0.0]	<0.001^B
Total Compulsion Score (median [IQR])	8.0 [4.0–12.0]	0.0 [0.0–0.0]	<0.001^B
YBOCS Total Score (median [IQR])	18.0 [10.0–23.0]	0.0 [0.0–0.0]	<0.001^B
Insight (median [IQR])	0.0 [0.0–1.0]	0.0 [0.0–0.0]	<0.001^B
Avoidance (median [IQR])	1.0 [0.5–2.0]	0.0 [0.0–0.0]	<0.001^B
Indecisiveness (median [IQR])	1.0 [0.0–2.0]	0.0 [0.0–1.0]	<0.001^B
Pathological Responsibility (median [IQR])	0.0 [0.0–0.0]	0.0 [0.0–0.0]	0.019^B
Pathological Slowness (median [IQR])	1.0 [0.0–2.0]	0.0 [0.0–0.0]	<0.001^B
Pathological Doubting (median [IQR])	1.0 [0.0–1.0]	0.0 [0.0–0.0]	<0.001^B
Global Severity (median [IQR])	3.0 [1.5–4.0]	0.0 [0.0–0.0]	<0.001^B
Global Improvement (median [IQR])	4.0 [3.5–5.0]	6.0 [6.0–6.0]	<0.001^B
Reliability (median [IQR])	1.0 [1.0–1.0]	0.0 [0.0–0.0]	<0.001^B
Hamilton Depression Scale, Mean \pm SD	4.5 \pm 2.0	2.5 \pm 1.9	<0.001^Σ
Psychache Scale, Mean \pm SD	37.6 \pm 15.3	23.6 \pm 7.1	<0.001^Σ

Notes: ^ΣIndependent samples *t*-test. Descriptive statistics are given as Mean \pm SD. ^BMann Whitney *U*-test. Descriptive statistics are given as median [IQR]. *p* values in bold are statistically significant ($p < 0.05$).

Abbreviations: YBOCS, Yale-Brown Obsessive Compulsive Scale; SD, Standard Deviation; IQR, Interquartile Range.

Table 3 Sociodemographic Characteristics and Scale Scores of OCD Patients According to the Presence of Suicide Attempts

	Suicide		P
	Absent (N=55)	Present (N=12)	
Age, Mean \pm SD	36.0 \pm 11.5	36.8 \pm 13.3	0.862 Σ
Sex (%)			0.999 Ω
Female	35 (63.6)	8 (66.7)	
Male	20 (36.4)	4 (33.3)	
Years of education (median [IQR])	12.0 [5.0–14.0]	12.0 [5.0–14.0]	0.737 ^B
Place of residence (%)			0.311 Ω
Urban	25 (45.5)	8 (66.7)	
Rural	30 (54.5)	4 (33.3)	
Marital status (%)			0.999 Ω
Single	34 (61.8)	7 (58.3)	
Married	21 (38.2)	5 (41.7)	
Occupational status (%)			0.545 Ω
Unemployed	31 (56.4)	5 (41.7)	
Employed	24 (43.6)	7 (58.3)	
Age of first symptoms, Mean \pm SD	20.1 \pm 7.9	17.4 \pm 8.8	0.339 Σ
Age of first treatment, Mean \pm SD	26.3 \pm 9.9	28.2 \pm 7.5	0.458 Σ
Total Obsession Score (median [IQR])	9.0 [5.0–12.0]	11.5 [10.0–15.0]	0.007^B
Total Compulsion Score (median [IQR])	8.0 [4.0–11.0]	11.5 [7.5–13.0]	0.172 ^B
YBOCS Total Score (median [IQR])	16.0 [10.0–23.0]	23.5 [17.2–28.0]	0.028^B
Insight (median [IQR])	0.0 [0.0–1.0]	0.5 [0.0–2.0]	0.276 ^B
Avoidance (median [IQR])	1.0 [0.0–2.0]	2.0 [2.0–3.0]	0.009^B
Indecisiveness (median [IQR])	1.0 [0.0–2.0]	2.0 [1.0–2.0]	0.038^B
Pathological responsibility (median [IQR])	0.0 [0.0–0.0]	0.0 [0.0–0.0]	0.543 ^B
Pathological slowness (median [IQR])	1.0 [0.0–2.0]	2.0 [1.0–2.0]	0.264 ^B
Pathological doubting (median [IQR])	1.0 [0.0–1.0]	0.0 [0.0–1.0]	0.138 ^B
Global Severity (median [IQR])	2.0 [1.0–3.0]	4.0 [2.8–4.0]	0.021^B
Global Improvement (median [IQR])	5.0 [3.0–5.5]	4.0 [4.0–5.0]	0.390 ^B
Reliability (median [IQR])	1.0 [1.0–1.0]	1.0 [1.0–1.0]	0.673 ^B
Hamilton Depression Scale, Mean \pm SD	4.5 \pm 2.0	4.8 \pm 1.7	0.537 Σ
BSIS, (median [IQR])	0.0 [0.0–0.0]	2.0 [2.0–4.8]	<0.001^B
Psychache Scale, Mean \pm SD	33.9 \pm 14.2	54.3 \pm 6.7	<0.001Σ

Notes: Σ Independent samples t-test. Descriptive statistics are given as Mean \pm SD. ^BMann Whitney U-test. Descriptive statistics are given as median [IQR]. Ω Pearson Chi-Square/Fisher Exact test. Descriptive statistics are given as number (%). p values in bold are statistically significant (p<0.05).

Abbreviations: YBOCS, Yale-Brown Obsessive Compulsive Scale; BSIS, Beck Scale for Suicidal Ideation; SD, Standard Deviation; IQR, Interquartile Range.

past religious obsessions, the BSIS, and PS scores, avoidance, indecisiveness, and global severity subdimensions of the YBOCS were significant on suicide attempts (p < 0.05 for

each). The multivariate logistic regression analysis showed that only the PS score was predicting previous suicide attempts significantly (p = 0.043).

Table 4 Comparison of Obsession and Compulsion Types of OCD Patients According to the Presence of Suicide Attempts

	Suicide		p
	Absent (n=55)	Present (n=12)	
Aggressive (%)			
Current	8 (14.5)	9 (75.0)	<0.001
Past	16 (29.1)	6 (50.0)	0.187
Contamination (%)			
Current	29 (52.7)	11 (91.7)	0.020
Past	40 (72.7)	11 (91.7)	0.267
Sexual (%)			
Current	12 (21.8)	5 (41.7)	0.164
Past	14 (25.5)	5 (41.7)	0.299
Hoarding/Saving (%)			
Current	2 (3.6)	0 (0.0)	0.999
Past	2 (3.6)	1 (8.3)	0.452
Religious (%)			
Current	13 (23.6)	2 (16.7)	0.721
Past	19 (34.5)	9 (75.0)	0.024
Symmetry (%)			
Current	10 (18.2)	0 (0.0)	0.188
Past	14 (25.5)	2 (16.7)	0.716
Somatic (%)			
Current	9 (16.4)	2 (16.7)	0.999
Past	10 (18.2)	2 (16.7)	0.999
Cleaning/Washing (%)			
Current	28 (50.9)	8 (66.7)	0.501
Past	42 (76.4)	8 (66.7)	0.483
Checking (%)			
Current	23 (41.8)	4 (33.3)	0.749
Past	32 (58.2)	4 (33.3)	0.213
Repeating Rituals (%)			
Current	14 (25.5)	2 (16.7)	0.716
Past	16 (29.1)	2 (16.7)	0.490
Counting (%)			
Current	13 (23.6)	6 (50.0)	0.084
Past	19 (34.5)	6 (50.0)	0.341
Ordering/Arranging (%)			
Current	3 (5.5)	0 (0.0)	0.999
Past	4 (7.3)	0 (0.0)	0.999
Hoarding/Collecting (%)			
Current	0 (0.0)	1 (8.3)	0.179
Past	0 (0.0)	1 (8.3)	0.179

Notes: Fisher Exact test. Descriptive statistics are given as number (%). p values in bold are statistically significant ($p < 0.05$).

Table 5 The Relationship Between BSIS, YBOCS and PS Scores of OCD Patients

		r	p
Beck Scale for Suicidal Ideation	– Psychache Scale	0.533	<0.001**
Beck Scale for Suicidal Ideation	– Total Obsession Score	0.372	0.002**
Beck Scale for Suicidal Ideation	– Total Compulsion Score	0.247	0.044**
Beck Scale for Suicidal Ideation	– Total YBOCS Score	0.339	0.005**
Psychache Scale	– Total Obsession Score	0.455	<0.001**
Psychache Scale	– Total Compulsion Score	0.394	<0.001**
Psychache Scale	– Total YBOCS Score	0.462	<0.001**

Notes: **Spearman's Rho Correlation Coefficient. p values in bold are statistically significant ($p < 0.05$).

Abbreviation: YBOCS, Yale-Brown Obsessive Compulsive Scale.

Discussion

According to the World Health Organization (WHO), about 800 000 people die due to suicide every year,³⁷ and suicide is a preventable cause of death. Therefore, suicidal ideation and attempts have an important place in OCD, as in other psychiatric disorders. The most important outcome of this study is determining the relationship between suicide and psychological pain in patients with OCD.

One of the most important theories put forward to prevent suicide and determine its predictors is the psychache theory.³⁸ Psychache was investigated in many suicide-related studies after Shneidman's¹⁷ pioneering definition. Verrocchio et al³⁹ considered psychache as an important risk factor for suicide independent of the diagnosis of mental disorders. The mediating effect of psychache was demonstrated between perfectionism and suicidal ideations,⁴⁰ between general distress and suicidal ideations,¹⁹ and between childhood traumas and suicidal ideations.⁴¹ Montemarano et al⁴² conducted a 4-year follow-up study that supported Shneidman's model and pointed out that other factors were increasing the risk for suicide only when they were associated with psychache. In the Turkish population, previous studies revealed that the average PS score of patients with major depressive disorder

Table 6 Univariate and Multiple Logistic Regression Analysis of Factors Affecting Suicide Attempts

	Univariate LR		Multiple LR	
	OR [95% CI]	p-value	Or [95% CI]	p-value
Aggressive ^a : Absent vs present	17.62 [3.91–79.5]	< 0.001	2.53 [0.34–18.68]	0.362
Contamination ^a : Absent vs present	9.86 [1.19–81.71]	0.034	4.77 [0.30–76.48]	0.270
Religious ^b : Absent vs present	5.68 [1.37–23.52]	0.016	4.05 [0.55–29.96]	0.171
BSIS	1.46 [1.05–2.03]	0.025	1.08 [0.81–1.43]	0.588
Psychache Scale	1.14 [1.06–1.23]	< 0.001	1.13 [1.00–1.27]	0.043
Avoidance	2.44 [1.20–4.99]	0.014	1.66 [0.36–7.68]	0.515
Indecisiveness	2.23 [1.01–4.92]	0.047	1.5 [0.39–5.81]	0.558
Global Severity	1.87 [1.08–3.24]	0.026	0.72 [0.22–2.41]	0.597

Notes: Dependent variable, Suicide attempt. p values in bold are statistically significant ($p < 0.05$). ^aCurrent; ^bPast.

Abbreviations: OR, Odds Ratio; LR, Logistic regression; CI, Confidence Interval; BSIS, Beck Scale for Suicidal Ideation.

was 43.98 ± 11.43 ,²³ 45.88 ± 10.44 of patients with bipolar disorder²⁴ and 37.6 ± 14.28 of patients with schizophrenia.²⁵ We found the mean score of PS as 37.6 ± 15.3 in the OCD and 23.6 ± 7.1 in the control group. The PS scores of the patients with OCD who had previous suicide attempts were significantly higher than those who had not (54.3 ± 6.7 and 33.9 ± 14.2 , respectively). Besides, there was a significant positive correlation between YBOCS, BSIS, and PS. These data suggest that the severity of psychache and suicidal thoughts may increase as the severity of the OCD increases. Although the OCD patients included in our study were not diagnosed with comorbid depression, the association of psychological pain with suicide attempts supports the hypothesis that psychache is independent of the diagnosis.³⁹ Our results also suggest that relieving psychache in patients with OCD may help to reduce suicide risk.

The results of the studies on the relationship between OCD symptoms and suicide risk differ. Repeating and trust seeking compulsions,⁹ symmetry/order obsessions and compulsions,¹ and sexual/religious obsessions⁵ have been reported to be more frequent in patients with OCD who had previous suicide attempts and suicidal ideation. We found current aggressive, sexual obsessions, and past religious obsessions to be more frequent in OCD patients with previous suicide attempts. Kamath et al⁹ have found higher YBOCS obsession subscale scores in patients with OCD who had suicidal ideation and previous suicide attempts. Brown et al³ have determined a one-way relationship between OCD symptoms and suicidal ideation in a 6-year follow-up study. According to Brown et al,³ as the severity of OCD symptoms increased, the severity of suicidal ideation increased, but suicidal ideation did not affect OCD symptoms over the years. We found higher scores in avoidance, indecisiveness, global severity, and total obsession

subdimensions of YBOCS, and also higher BSIS, PS, and total YBOCS scores in OCD patients with a history of previous suicide attempts. Hollander et al⁴³ reported suicide behaviors that did not result in death in approximately 15% of OCD patients. In subsequent studies, Kamath et al⁹ reported past suicidal ideation in 59% of patients with OCD, current suicidal ideation in 28%, and suicide attempt history in 27%.⁴⁴ These rates are three times higher than healthy individuals and are similar to other mental disorders such as bipolar disorder, schizophrenia, major depressive disorder, alcohol use disorder, and personality disorders.⁴⁴ In a multicenter study, the rate of suicide attempts was 14.6% in OCD patients.⁴⁵ We found lifetime suicide attempts to be 17.9% in OCD patients. We also found suicidal thoughts and lifetime suicide attempts to be significantly higher in the OCD group than the controls. Other comorbid mental disorders, especially mood disorders,⁹ personality disorders, and behavioral disorders affect the risk of suicide in OCD.^{43,46} Considering the confounding effects on suicide, we did not include patients with comorbid mental disorders in our study. Suicide attempts rates would be expected to be higher if patients diagnosed with comorbid mental disorders, particularly major depression, were included in the study.

Family history of suicide attempts, being single, and low socioeconomic status are sociodemographic variables related to suicide in patients with OCD.^{1,5} We did not find any significant relationship between sociodemographic variables and previous suicide attempts. There were also no relationships between the previous suicide attempts and the age of first symptoms and treatment. These data suggest that psychological pain rather than sociodemographic variables may be more important in the relationship between OCD and suicidality.

Our study has some strengths and limitations. We questioned whether patients had attempted suicide lifelong but did not classify suicide attempts as past and current. We also did not investigate the method and the severity of suicide attempts. Investigating a possible relationship between the level of psychological pain and the severity of suicide attempts in patients with OCD may be of interest for future studies. Follow-up studies may show more clearly the change in the level of psychological pain during the course OCD and whether it affects suicidal ideation. Only the inclusion of patients admitted to the psychiatry clinics of a tertiary clinic may limit the generalization of our results. Finally, the fact that we did not question hopelessness, which is an important risk factor for suicide, can be considered as another limitation of our study. The most important strength of our study is the direct evaluation of the relationship between psychological pain and suicide in OCD and the first demonstration of this relationship.

Conclusion

In conclusion, it is crucial to relieve the obsessions and compulsions because the severity of OCD can trigger suicidal ideation, but not only typical symptoms, but also attention to clinical variables such as psychological pain and tolerance to psychological pain will help to prevent suicide attempts and possible deaths in patients with OCD.

Disclosure

The authors report no conflicts of interest in this work

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