

Original Article

The relationship between the quality of life of patients with recurrent aphthous stomatitis with their childhood traumas and dissociative experiences

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Abstract

Aim: We aimed to evaluate childhood traumas and dissociative experiences which we think may be predisposing factors in patients with recurrent aphthous stomatitis (RAS).

Materials and Methods: The sample of the study consisted of 60 volunteer patients over the age of 18 (30 RAS patients and 30 control groups) who applied to the otolaryngology clinic. A Personal Information Form was prepared in line with main objective of the study, Childhood Traumas Questionnaire (CTQ), Dissociative Experiences Scale (DES), Hospital Anxiety and Depression Scale (HADS), Brief Symptom Inventory (BSI), and Quality of Life Scale-Short Form-36 (QLS36) were implemented on patients through face-to-face interviews.

Results: Brief symptom scale total score of RAS cases ($\bar{x}=45.64\pm 43.22$) was compared to the control group ($\bar{x}=37.62\pm 22.58$), short symptom scale sub-dimension depression score ($\bar{x}=12.17\pm 11.21$) was compared to the control group ($\bar{x}=11.52\pm 5.74$), age traumas scale total score ($\bar{x}=70.59\pm 43.22$) from the control group ($\bar{x}=68.74\pm 10.60$), dissociative experiences scale total score ($\bar{x}=14.30\pm 7.30$) from the control group ($\bar{x}=11.02\pm 1.24$) and quality of life scale general health perception score ($\bar{x}=52.25\pm 12.58$) was significantly higher than the control group ($\bar{x}=51.29\pm 11.87$) ($p<.05$). RAS was closely associated with psychiatric symptoms induced by traumas, somatization, anxiety and depression clinically.

Conclusion: RAS is an important disease having negative effects on the quality of life and is closely associated with depressive symptoms. This study results found a positive relationship between the childhood traumas and dissociative experiences in RAS cases. Childhood traumas and dissociative experiences can be considered as a predisposing factor in patients with RAS.

Keywords: Recurrent aphthous stomatitis, childhood traumas, dissociative experiences, hospital depression and anxiety, quality of life

INTRODUCTION

Recurrent aphthous stomatitis (RAS) is the ulcerative lesion of the oral mucosa. The Greek word of aphtha, which means burning, inflaming and inflammation, was used by Hippocrates for the first time [1]. RAS, which is one of the most common oral

ulcerative diseases in the world, affects 10-20% of the population but its incidence changes between 5-50% based on ethnic and socioeconomic groups [2]. Approximately 50% of women and 40% of men experience RAS twice or more throughout their lives [3].

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RAS starts during childhood and adolescence and is clinically seen as minor, major and herpetiform aphthae. The Minor RAS type forms more than 70% of RAS. Minor RAS is small, superficial aphthae confined to an erythematous halo and covered with grey-white pseudomembrane. These lesions heal within 10-14 days without leaving a scar. Major RAS lesions are 1-3 cm in size, painful and continue up to 6 weeks and end leaving a scar. The major type forms approximately 20% of all RAS [1]. Herpetiform type is the least common type and is characterized by multiple painful herpetiform lesions in the size of a needle. Many factors such as bacterial and viral factors, mental traumas, some unhealthy food, smoking cigarette, medicament reactions, immune system disorders, systematical disorders, hormonal imbalances, stress experiences, predispositional factors and genetic predispositions take part in the etiopathogenesis of RAS. Negative emotional factors due to stress take part as a fundamental element in the development of RAS episodes [2]. It was determined that there is a significant increase in the frequency of aphthous ulcers of students during exam periods compared to their actual life period where they do not have any stressors as an example to stressful life events [4]. It is reported that some patients with RAS benefit from antidepressant treatment [5]. RAS is a public health problem that must be underlined due to its high prevalence among society and its negative effects on the quality of life [6,7].

Objective concepts such as morbidity and mortality are addressed in the assessment of diseases. However, the patient is a whole physically, mentally and socially and must be addressed holistically [1]. As the findings show that the treatment of these cases can be completed successfully as a result of the holistic evaluation of clinical cases physically, mentally and socially, the concept of quality of life has become one of the main study subjects [8]. The RAS disease can be accompanied by some psychiatric symptoms (somatization, anxiety, depression) and the quality of life of patients can be negatively affected [9].

The number of epidemiological studies on the frequency, severity and duration of psychiatric symptoms of patients with RAS is quite limited. The experiences of childhood traumas might affect psychological functions in adulthood. Relevant studies have shown that mental traumas experienced during childhood have a major effect on the formation of dissociation [10-13]. Dissociative experiences induced by traumas cause splitting the individuals' personality structures that are closely associated with their mental and behavioral characteristics. Dissociation, as an adjustment reaction to normal dynamics of life, prevents losing the inspection and control mechanisms related to individuals' lives at a certain level. Dissociation turns into a permanent mechanism that creates the feeling of despair mentally even when the individual has physical control [14].

The uncertainty regarding the etiopathogenesis of RAS is still existing today. Therefore, the aim of this study was to examine the quality of life, childhood traumas, anxiety, depression and dissociative experiences of patients and to determine the relationship between them. Thus, a possible relationship between

the variables will help us to understand the etiology of the disease and contribute to arranging new dimensions in treatment approaches.

MATERIAL AND METHOD

Study design

The sample of the study included 60 voluntary patients (30 patients with RAS and 30 in the control group) aged older than 18 years who applied to Otorhinolaryngology clinic between November 2018 and February 2019 and who were diagnosed with RAS. The patients included in the study had a complaint of RAS that continued for at least 15 days and symptomatically received drug therapy. The participants were selected using the convenience sampling method among nonstochastic sampling methods. The patients underwent otorhinolaryngology examination and the detailed anamnesis including clinical features of the patients was taken. In-mouth and oral mucosal regions were examined in detail. The patients who had an acute infection such as leucoplasia or gingivitis in addition to oral aphtha and who voluntarily agreed to participate in the study were excluded from the study. The approval of the local Scientific Study and Publishing Ethics Committee with the protocol number 2018/22-7 and the informed consent of all patients were obtained before the study was conducted.

Measures

The participants were implemented a Personal Information Form, the Hospital Anxiety and Depression Scale (HADS), Brief Symptom Inventory, Childhood Trauma Questionnaire, Dissociative Experiences Scale and Quality of Life Scale (SF36).

2.2.1. Personal Information Form: The personal information form developed by the researcher included 11 questions to determine sociodemographic characteristics of voluntary patients with RAS. Information about the patients' sex, age, marital status, the existence of chronic diseases, and previously receiving psychiatric treatment were obtained with this form.

Hospital Anxiety and Depression Scale: HADS is a commonly used scale that is filled by the patient in the hospital environment to scan the anxiety and depression symptoms. Its Turkish validity and reliability were carried out by Aydemir et al. [15]. It has 14 items and two subdimensions as HADS-A (Anxiety, 7 questions) and HADS-D (Depression, 7 questions). The cutoff point of the anxiety subdimension is 10 while the cutoff point of the depression subdimension is 7. Accordingly, those with a higher score than these are considered at risk. The Cronbach's alpha coefficient was found 0.85 for the anxiety subdimension and 0.77 for the depression subdimension in its reliability study. The internal consistency coefficient was found 0.84 for the anxiety subdimension and 0.86 for the depression subdimension in this study.

The Dissociative Experiences Scale: This self-reporting scale, which was developed by Bernstein et al. and includes 28 items, ranks dissociative experiences quantitatively. Its Turkish validity and reliability were carried out by Sar et al. [16]. It is not a diagnostic tool and is used to scan chronic dissociative disorders. The participants' grades between 0-100, and the mean of the total

scores obtained is calculated and the result is obtained. Scores higher than 30 indicate the existence of at least one dissociative disorder. In relation to the reliability of the scale, the Cronbach's alpha coefficient was =0.91 and the test-retest correlation was $r=0.78$ in its Turkish validity and reliability study, and these values were found to be high. The internal consistency coefficient of the scale was determined to be 0.78 in this study.

2.2.4. Childhood Traumas Questionnaire: It was developed by Bernstein et al. and its Turkish adaptation, validity and reliability studies were carried out by Sar and Ozturk [17]. It is a self-reporting measurement tool that is useful for the retrospective and quantitative evaluation of abuse and neglect experiences before the age of 20. It has 28 items. Each item is scored between 1-5. It has five subdimensions (sexual abuse, physical abuse, emotional abuse and emotional neglect, physical neglect) and a total score of childhood traumas including all five subdimensions. All subdimension scores change between 5-25, and the total score changes between 25-125. Higher scores indicate that the individual experienced a high level of abuse and neglect. The Cronbach's alpha value of the scale was 0.93. The internal consistency coefficient of the scale was determined to be 0.82 in this study.

Brief Symptom Inventory: It is a five-point Likert type self-evaluation inventory developed by Derogotis to scan general psychopathological symptoms of individuals. It is a multi-dimensional symptom screening scale that was developed to detect psychological symptoms that may arise in various psychiatric and medical patients like normal samples. It was adapted to Turkish by Sahin and Durak and includes the subdimensions of anxiety, depression, negative self, somatization and hostility, and three global indexes [18]. Higher scores obtained from the subdimensions indicate the frequency of psychological symptoms of individuals. Three global indexes have different scoring methods and are named the Discomfort Seriousness Index, Symptom Total Index and Symptom Discomfort Index based on their scoring methods. The Discomfort Seriousness Index shows the level of stress. This value changes between 0 and 4. This score is obtained by dividing the total subdimension score by 53. The Symptom Total Index is the total score obtained by taking all positive values except items scored as 0, as one. This score changes between 0 and 53. The Symptom Discomfort Index is obtained by dividing the total subdimension score by the total symptom score. The Cronbach's alpha coefficients of the scale for an adult sample was .87 and was .94 in this study.

The Quality of Life Scale Short Form-36: The SF-36 was developed by Rand Corporation in 1992 and its Turkish validity and reliability studies were carried out by Kocyigit et al. [19]. It has 36 items and is used to examine individuals' health status and quality of life. It has eight subdimensions as physical function, physical role difficulty, evaluation role difficulty, energy, mental health, pain, social functionality and general health perception. Each subdimension has a total score instead of one single total score for the whole scale. Each subdimension is scored between 0-100. SF-36 has a positive scoring and the quality of life-related to health increases as the score of each subdimension increases.

The internal consistency between the items of the scale is 0.88, between subdimensions is 0.84 while the internal consistency coefficient between items was 0.67 and between the subdimensions was 0.70 in this study.

Statistical analysis

Data were analyzed using the SPSS 22.0 program. Descriptive statistics such as frequency distribution, mean, standard deviation were used to define the sample, and the correlation analysis was performed to determine the direction and level of the relationship between the variables. The significance level was regarded as 95% to determine the differences in the analyses.

RESULTS

The findings related to sociodemographic characteristics, brief symptom inventory, childhood traumas, dissociative experiences, quality of life (SF-36) and hospital anxiety and depression data of 30 patients with RAS were presented in this section.

Characteristics of the study groups

According to Table 1, 56.7% of the patients with RAS were female and 43.3% were male. Of the participants, 53.3% were aged between 20 and 30 while 46.7% were aged between 31 and 40. Of the participants, 60% were married and 40% were single. Of the participants, 33.3% were primary school graduates, 36.7% were high school graduates and 30% were university graduates. Among the participants, 73.4% were employed and 26.6% were unemployed. Of the participants, 80% did not receive psychiatric treatment and 90% did not receive psychological help. A total of 90% of the participants did not have a chronic disease.

Table 1. Demographic characteristics of the participants

Variables	RAS Group	Control Group
Sex		
Female, n (%)	17 (56.70)	22 (73.3)
Male n (%)	13 (43.30)	8 (26.7)
Age		
20-30 years old, n (%)	16 (53.30)	22 (73.3)
31-40 years old, n (%)	14 (46.70)	8 (26.7)
Marital Status		
Married, n (%)	18 (60.00)	10 (36.6)
Single, n (%)	12 (40.00)	20 (63.4)
Educational Level		
Primary school, n (%)	10 (33.30)	4 (13.4)
High school, n (%)	11 (36.70)	11 (36.4)
University, n (%)	9 (30.00)	15 (50.2)
Employment status		
Employed, n (%)	22 (73.40)	17 (56.7)
Unemployed, n (%)	8 (26.60)	13 (43.3)
Going to a Psychiatrist		
No, n (%)	24 (80.00)	26 (86.7)
Yes, n (%)	6 (20.00)	4 (13.3)
Chronic Disease		
No, n (%)	27 (90.00)	23 (76.7)
Yes, n (%)	3 (10.00)	7 (23.3)

According to the comparison of the scale scores of the RAS and control groups in Table 2, the brief symptom scale total score of the RAS cases ($\bar{x}=45.64\pm 43.22$) was significantly higher than the control group ($\bar{x}=37.62\pm 22.58$) ($t=2.36, p<.05$). Brief symptom scale subscale depression score of RAS cases ($\bar{x}=12.17\pm 11.21$) was significantly higher than the control group ($\bar{x}=11.52\pm 5.74$) ($t=2.36, p<.05$). The childhood traumas scale total score of RAS cases ($\bar{x}=70.59\pm 43.22$) was significantly higher than the control group ($\bar{x}=68.74\pm 10.60$) ($t=1.25, p<.05$). Childhood traumas scale sub-dimension physical neglect score of RAS cases ($\bar{x}=14.63\pm 2.87$) was significantly higher than the control group ($\bar{x}=14.35\pm 1.27$) ($t=0.94, p<.05$). Dissociative experiences scale total score of RAS cases ($\bar{x}=14.30\pm 7.30$) was significantly higher than the control group ($\bar{x}=11.02\pm 1.24$) ($t=1.84, p<.05$). Hospital anxiety and depression scale subscale scores of RAS cases ($\bar{x}=12.28\pm 3.37$) were significantly higher than the control group ($\bar{x}=10.10\pm 3.52$) ($t=2.54, p<.05$). Hospital anxiety and depression scale sub-dimension hospital depression score of RAS cases ($\bar{x}=9.50\pm 2.32$) was significantly higher than the control group

($\bar{x}=8.98\pm 4.74$) ($t=3.28, p<.05$). Quality of life scale general health perception score of RAS cases ($\bar{x}=52.25\pm 12.58$) was significantly higher than the control group ($\bar{x}=51.29\pm 11.87$) ($t=1.12, p<.05$).

According to Table 2, the total score on the Brief Symptom Inventory was $\bar{x}=45.64\pm 43.22$, and the highest subdimension score was on depression with $\bar{x}=12.17\pm 11.21$. Additionally, the total score on the Childhood Traumas Questionnaire was $\bar{x}=70.59\pm 9.35$, the highest score was obtained on the neglect subdimension with $\bar{x}=20.78\pm 4.07$ while the lowest score was obtained on the sexual abuse subdimension with 08.40 ± 1.18 . The Dissociative Experiences Scale score was $\bar{x}=14.30\pm 7.30$. The subdimension scores of the HADS were $\bar{x}=12.28\pm 3.37$ in the hospital anxiety and $\bar{x}=9.50\pm 2.32$ in the hospital depression. Lastly, the subdimension scores of the Quality of Life Scale were $\bar{x}=60.61\pm 18.17$ in physical function, $\bar{x}=55.99\pm 21.62$ in physical role difficulty, $\bar{x}=47.89\pm 24.52$ in emotional role difficulty, $\bar{x}=58.70\pm 10.42$ in energy, $\bar{x}=42.63\pm 11.71$ in mental health, $\bar{x}=70.91\pm 11.28$ in social functionality, $\bar{x}=50.98\pm 22.45$ in pain and $\bar{x}=52.25\pm 12.58$ in general health perception.

Table 2. Comparison of RAS and control group scale scores

Scale	Dimension	RAS Group		Control Group		t	p
		\bar{x}	sd	\bar{x}	sd		
Brief Symptom Inventory	Total	45.64	43.22	37.62	22.58	2.36	.04
	Anxiety	9.90	11.27	8.21	4.36	1.01	.03
	Depression	12.17	11.21	11.52	5.74	0.91	.04
	Negative Self	9.39	11.36	8.58	4.95	0.97	.04
	Somatization	6.79	5.72	6.32	3.42	1.08	.03
	Hostility	7.40	6.87	7.10	3.75	2.01	.05
Childhood Traumas Questionnaire	Total	70.59	9.35	68.74	10.60	1.25	.02
	Emotional Abuse	10.52	3.01	10.01	3.82	0.83	.04
	Physical Abuse	11.27	3.92	11.23	3.58	1.27	.05
	Physical Neglect	14.63	2.87	14.35	1.27	0.94	.04
	Emotional Neglect	20.78	4.07	19.29	3.57	1.85	.05
	Sexual Abuse	8.40	1.18	8.01	2.45	1.74	.04
Dissociative Experiences	Total Score	14.30	7.30	11.02	1.24	1.84	.04
Hospital Anxiety and Depression Scale	Hospital Anxiety	12.28	3.37	10.10	3.52	2.54	.05
	Hospital Depression	9.50	2.32	8.98	4.74	3.28	.04
The Quality of Life Scale	Physical Function	60.61	18.17	62.52	7.85	2.75	.05
	Physical Role Difficulty	55.99	21.62	54.65	13.25	3.85	.04
	Emotional Role Difficulty	47.89	24.52	46.74	12.68	0.87	.03
	Energy/Liveliness/Vitality	58.70	10.42	57.21	15.25	1.45	.02
	Mental Health	42.63	11.71	41.31	10.85	2.98	.05
	Social Functionality	70.91	11.28	68.87	10.36	2.58	.04
	Pain	50.98	22.45	59.23	21.34	2.36	.03
	General Health Perception	52.25	12.58	51.29	11.87	1.12	.05

According to Table 3, no significant correlation was found between the RAS group quality of life subdimensions and brief symptoms, childhood traumas, dissociative experiences and hospital anxiety and depression total scores and subdimensions ($p>.05$). However, a negative and significant correlation was found between the physical functions subdimension of the quality of life and brief symptom total score ($r=-.43^*$) and anxiety ($r=-.53^{**}$), negative self

($r=-.37^*$), somatization ($r=-.54^{**}$), discomfort seriousness index ($r=-.43^*$) and symptom total index ($r=-.40^*$) ($p<.05$). Additionally, a positive significant correlation was found between the pain subdimension of the quality of life and somatization ($r=.38^*$) and dissociative experiences ($r=.42^*$) while a negative correlation was found with physical abuse ($r=-.45^*$) ($p<.05$).

Table 3. Correlation analysis findings of the RAS group

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	
1	1																										
2	.96**	1																									
3	.98**	.92**	1																								
4	.94**	.88**	.90**	1																							
5	.77**	.74**	.74**	.57**	1																						
6	.93**	.84**	.89**	.88**	.65**	1																					
7	1.00**	.96**	.98**	.94**	.77**	.93**	1																				
8	.72**	.68**	.75**	.60**	.66**	.64**	.72**	1																			
9	.42*	.38*	.34	.46*	.27	.49**	.42*	-.22	1																		
10	-.17	-.19	-.18	-.14	-.04	-.17	-.16	-.08	-.14	1																	
11	-.11	-.19	-.09	-.11	.09	-.13	-.11	-.01	-.09	.71**	1																
12	-.09	-.12	-.07	-.11	.05	-.13	-.09	-.02	-.16	.51**	.49**	1															
13	-.07	-.03	-.11	-.05	-.11	-.05	-.07	-.05	-.05	.68**	.18	-.10	1														
14	-.06	-.05	-.08	-.003	-.11	-.07	-.06	-.06	.01	.42*	-.10	-.23	.58**	1													
15	-.23	-.24	-.28	-.26	-.03	-.16	-.23	-.17	-.12	.43*	.52**	.22	.26	-.41*	1												
16	.60**	.62**	.58**	.56**	.39*	.57**	.60**	.43*	.28	-.12	-.30	-.33	.30	.13	-.13	1											
17	-.69**	-.63**	-.64**	-.70**	-.41*	-.75**	-.69**	-.44*	-.54*	.12	.05	.16	-.07	.13	.02	-.56*	1										
18	.04	.06	-.03	.10	.06	-.01	.04	.15	.04	-.13	-.15	-.13	-.02	.02	-.13	.08	-.02	1									
19	-.26	-.27	-.24	-.33	-.17	-.14	-.27	-.08	-.07	-.03	-.15	.20	-.13	.03	-.10	-.20	.09	.11	1								
20	-.43*	-.53**	-.33	-.37*	-.54**	-.23	-.43*	-.40*	-.04	.10	.05	.04	.06	.11	.03	-.18	.22	-.17	.32	1							
21	-.23	-.25	-.18	-.23	-.10	-.25	-.23	-.07	-.29	.16	-.001	.02	.16	.33	-.11	-.36	.23	-.20	.33	.09	1						
22	-.12	-.07	-.07	-.22	.03	-.17	-.12	.03	-.34	.13	-.09	.15	.14	.15	.03	-.31	.30	-.12	.41*	.10	.66**	1					
23	-.10	-.09	-.10	-.07	-.26	-.01	-.10	-.05	.03	-.29	-.36	.14	-.36	-.07	-.34	-.13	.04	.11	.74**	.17	.04	.06	1				
24	-.24	-.23	-.21	-.25	-.14	-.23	-.24	.01	-.18	.09	.08	.36*	-.19	-.06	-.03	-.23	-.01	.12	.74**	-.01	.10	.21	.55**	1			
25	-.09	.01	-.21	-.10	.03	-.10	-.09	-.20	.29	.09	-.08	.21	.08	.01	-.002	.02	.04	.30	.24	-.12	-.21	.05	.12	.14	1		
26	.25	.24	.21	.09	.38*	.36	.25	.21	.21	-.33	-.22	-.45*	.001	-.12	.11	.42*	-.19	-.003	-.11	-.15	-.26	-.24	-.24	-.38*	.05	1	

1: Brief Symptom (Total); 2:Anxiety; 3:Depression; 4:Negative Self; 5:Somatization; 6: Hostility; 7: Discomfort Seriousness Index; 8: Symptom Total Index; 9: Symptom Discomfort Index; 10: Childhood Traumas (Total); 11: Emotional Abuse; 12: Physical Abuse; 13: Physical Neglect; 14: Emotional Neglect; 15: Sexual Abuse; 16: Dissociative Experiences (Total); 17: Hospital Anxiety; 18: Hospital Depression; 19: Physical Function; 20: Physical Role Difficulty; 21: Emotional Role Difficulty; 22: Energy/Liveliness/Vitality; 23: Mental Health; 24: Social Functionality; 25: Pain; 26: General Health Perception

DISCUSSION

RAS is an important disease characterized by recurrent ulcerations and oral mucosa and its etiology is not known certainly. The findings obtained from the analyses of the study, which was conducted to examine the relationships between the quality of life, psychopathological symptoms, childhood traumas and dissociative experiences, were discussed in line with the literature. It was found in this study that most of the participants were female, aged between 20 and 30, married, high school graduates and employed. A similar study has reported that RAS is seen in both sexes but it is more common among women [20]. Similar to the literature, more than half of the patients with RAS were women in this study.

The mean scores on the Brief Symptom Inventory, Hospital Depression and Anxiety Scale, Childhood Trauma Questionnaire, and Dissociative Experiences Scales, which were used to determine the mental states of the patients in this study, were high. Most patients did not receive psychiatric treatment and psychological support before. Since the participants' score on the depression subdimension of the Hospital Depression and Anxiety Scale indicated the existence of at least one depressive disorder, the patients need to receive professional support to eliminate depressive symptoms. The most common mental disorders in physical diseases are anxiety and depression, and they often co-exist [21]. A study conducted with 34 patients with Behçet's disease and 43 healthy individuals determined that the depression and anxiety scores of the patients were high [22]. A study, which was conducted to determine the relationship between recurrent aphthous stomatitis with oral mucosal lesions similar to Behçet's disease and psychiatric comorbidity and depression, determined that most patients experienced depressive disorders at least once [23]. A study by Gavi et al. conducted with 110 patients with RAS revealed that there was a high-level correlation between anxiety and depression symptoms and RAS symptoms [24]. Another study conducted with 50 individuals of whom 25 were patients with RAS and 25 were in the control group found that the patients with RAS had more psychiatric symptoms than the control group [25]. A study, which included patients with RAS, determined that hospital depression was higher compared to non-clinical cases, and there was a positive correlation between the diagnosis of RAS and psychological changes [26]. A study conducted with 50 patients with RAS and 25 individuals in the control group revealed that stressful experiences are triggering for the formation of chronic ulcers and the patients with RAS had more anxiety and depression symptoms than the control group [27]. The findings of this study indicate that RAS has a positive correlation with depression and anxiety in parallel with the relevant literature.

RAS negatively affects the quality of life at a certain level since it cannot be completely treated, has a chronic course, and has not one single ideal treatment method. The SF-36 is the most commonly used scale to determine the quality of life of patients with RAS, which is a multisystemic disease. It was found that the patients' scores on the physical function, physical role difficulty, emotional role difficulty, mental health, pain and general health perception

subdimensions of the Quality of Life Scale were lower compared to the cutoff points. Cardoso et al. conducted a study on 22 patients with RAS and 22 individuals in the control group and revealed that the quality of life of patients with RAS was lower than the control group [28]. Another study conducted with 53 patients with RAS determined that RAS significantly decreased the quality of life of individuals by negatively affecting their oral health [29]. The study by Eren et al. conducted with 54 patients with Behçet's disease determined that the scores on physical function, physical role difficulty, general health and social function subdimensions of the quality of life were low [30]. Another study on the quality of life of patients with Behçet's disease and RAS found low values on all of the subdimensions of the SF-36 [31]. Dhopte et al. state that the diagnosis of RAS is a fundamental determinant factor for the quality of life and emphasize that practices for improving the living standards of these patients will contribute to the positive development of the treatment process [27].

Another finding obtained in this study is that there is a significant correlation between the patients' quality of life subdimension scores and brief symptom, childhood traumas, dissociative experiences, hospital anxiety and depression total scores. The variables do not affect the quality of life of the patients together. However, a positive correlation was found between the pain subdimension of the Quality of Life Scale and the somatization subdimension of the Brief Symptom Inventory and dissociative experiences. According to this finding, the somatization symptoms increase as the patients' pain increases. Studies conducted with a clinic sampling revealed that patients with dissociative disorder experienced somatization disorder more often and severe, and the consultation ratios and hospitalization due to medical reasons were high and determined that the severity of somatization in these patients increased as the severity of dissociative experiences increased [32, 33].

No study on the childhood traumas and dissociative experiences of patients with RAS was found in the literature. This situation makes this study more important. It is known that individuals experience conditions like depression, anxiety and hostility because of experiencing physical abuse in childhood, and its permanent or long-lasting effects continue throughout their life [34]. The number of studies that examine childhood traumas on the formation of most psychiatric disorders has been increasing in recent years and the relationships between childhood traumas and different psychiatric disorders (dissociative disorders, somatic symptom disorders, sleep disorders, personality disorders, obsessive-compulsive, anxiety and depression) have been determined [35, 36].

RAS is an important disease that must be paid attention to and examined since it has negative effects on the quality of life and is closely associated with some psychiatric symptoms (somatization, anxiety, depression) [37]. It is stated that stress-originated experiences like anxiety and depression are significantly associated with the quality of life in patients with RAS instead of personality structures and defense mechanisms [29]. Stress experiences may also lead to the onset of new RAS episodes in patients with a history of RAS. In general, it is seen that psychological stressors

have a stronger relationship with RAS episodes compared to physical stress factors [38]. The emergence of cumulative scientific facts about the relationship between RAS and mental disorders emphasizes the importance of the need for evaluating these cases with a multidisciplinary perspective.

CONCLUSION

RAS is an important disease having negative effects on the quality of life and is closely associated with depressive symptoms. According to the results of this study, most of the patients with RAS show depressive symptoms. This study results found a positive relationship between the childhood traumas and dissociative experiences in RAS cases. Childhood traumas and dissociative experiences can be considered as a predisposing factor in patients with RAS. In order to reveal the relationship between RAS and childhood traumas, dissociative experiences and depression more comprehensively, studies with larger samples should be conducted. Patients with RAS should be investigated in terms of childhood trauma and treatment should be approached multidisciplinary. Mental evaluation should be an essential part of the examination of patients with RAS. The cooperation between otorhinolaryngology and psychiatry-psychology will have significant effects on patients' treatments and quality of life.

Conflict of interests

The authors declare that there is no conflict of interest in the study.

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Ethical approval

Approval was obtained from the Scientific Research and Publication Ethics Committee of İnönü University on 04.12.2018 with the decision number 2018/22-7.

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