



The role of disgust propensity and trait guilt in OCD symptoms: A multiple regression model in a clinical sample



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ABSTRACT

The relationship between disgust propensity (DP) and obsessive-compulsive disorder (OCD), particularly with contamination-related OCD symptoms, has been widely recognized. The relationship between trait guilt (TG) and OCD has been less investigated, although some studies have explored the role of guilt in OCD, and found that it may precede, motivate or be a consequence of OCD symptoms. The present study analyzed the role of TG and DP in OCD, focusing on different types of OCD symptoms. Dimensional self-report measures of DP, TG and OCD were administered to a clinical sample (98 OCD patients), and measures of depression and anxiety were also included as control variables. At a bivariate level, DP was moderately correlated with only the *Contamination* and *Symmetry* dimensions of OCD. There were weak but significant correlations between TG and the *Responsibility for harm and mistakes* and *Unacceptable thoughts* OCD dimensions only. Results from subsequent hierarchical regression analyses indicated that DP was predictive of contamination and symmetry OCD symptoms above and beyond depression and anxiety. Unexpectedly, TG did not significantly predict any OCD symptom. Theoretical implications and directions for future research are discussed.

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1. Introduction

Obsessive compulsive disorder (OCD) is characterized by the occurrence of persistent thoughts, urges, or images that are experienced as intrusive and unwanted (i.e., obsessions), and compulsive actions that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation (DSM-5; American Psychiatric Association [APA], 2013).

A small number of studies have explored the role of guilt in OCD (Shafraan, Watkins, & Charman, 1996; Steketee, White, & Quay, 1991). For example, it has been suggested that the fear of guilt for acting irresponsibly may lead to OCD symptoms (Gangemi, Mancini, & van den Hout, 2007; Mancini, D'Olimpio, & Cieri, 2004; Mancini & Gangemi, 2004), and OCD patients consistently report more guilt than healthy controls (Shafraan et al., 1996). Although some authors have suggested that the association between guilt and OCD is specific for patients with obsessions about responsibility for causing harm or

making mistakes (Foa, Amir, Bogert, Molnar, & Prezworsky, 2001; Foa, Sacks, Tolin, Prezworsky, & Amir, 2002; Salkovskis et al., 2000), other studies have demonstrated a positive association between guilt and OCD symptoms in patients with contamination obsessions (Menziez, Harries, Cumming, & Einstein, 2000; Sica, Taylor, Arrindell, & Sanavio, 2006; Taylor et al., 2010; Tolin, Brady, & Hannan, 2008). However, one of the main limitations of these studies was that they analyzed different features of guilt (e.g. fear of guilt, and guilt avoidance), and only a few of them specifically explored the construct of trait guilt (TG)—a personality predisposition to experience guilt extending beyond immediate circumstances. In a recent study of a large Italian community sample (Melli et al., in press), TG emerged as a predictor of contamination-related OCD symptoms, independent of anxiety and depression. Unfortunately, this study did not consider any other symptom dimension. Consistently, D'Olimpio et al. (2013) found that OCD patients were more prone to feelings of guilt than both non-clinical participants and anxious patients.

Research on OCD has also investigated the role played by disgust propensity (DP)—an individual's predisposition to experience disgust (David et al., 2009; Olatunji, Sawchuk, Lohr, & de Jong, 2004; Olatunji, Williams, Lohr, & Sawchuk, 2005; Schienle, Stark, Walter, & Vaitl, 2003). A number of correlational studies have found significant positive associations between measures of DP and washing rituals in OCD (Cougale, Lee,

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Horowitz, Wolitzky-Taylor, & Telch, 2008; David et al., 2009; Olatunji, 2010; Olatunji et al., 2005; Sawchuk, Olatunji, & De Jong, 2006; Schienle et al., 2003; Tolin, Woods, & Abramowitz, 2006) and DP emerged as a predictor of washing and checking behaviors in non-clinical samples (Mancini, Gragnani, & D'Olimpio, 2001; Nicholson & Barnes-Holmes, 2012; Olatunji, 2010; Olatunji et al., 2004). These results suggested that DP could be involved in the development and maintenance of OCD symptoms (Olatunji et al., 2004). For instance, a study using structural equation modeling demonstrated a linear relationship between high DP and fear of contamination in OCD (Moretz & McKay, 2008) and implicit measures of DP have also been shown to predict obsessive-compulsive symptoms (Nicholson & Barnes-Holmes, 2012). These results are consistent with previous findings in both non-clinical and clinical samples (c.f. Olatunji, 2010), and support the claim that DP is an important affective factor underlying fear of contamination. Other authors reported that DP also predicts checking compulsions (Berle et al., 2012; Mancini et al., 2001; Schienle et al., 2003, Thorpe, Patel, & Simonds, 2003).

Although independent lines of research suggest that both TG and DP contribute to OCD, only two recent studies considered these variables together and hypothesized that they may be related to one another. D'Olimpio et al. (2013) found that OCD patients had a high propensity to experience feelings of both guilt and disgust, and that disgust was higher in patients with obsessions about contamination and about responsibility for causing harm or making mistakes. However, TG and DP were highly correlated in the OCD sample, but not in the non-clinical group, suggesting that the association between guilt and disgust may be a characteristic of OCD patients only. Using a large non-clinical sample, Melli et al. (in press) reported significant correlations between contamination fears and both trait guilt and disgust propensity. In particular, they found support for a model in which disgust propensity partially mediates the relationship between trait guilt and fear of contamination, after controlling for confounding variables. The authors concluded that both guilt and disgust play a role in contamination fears, at least in non-patients.

Nonetheless, the aforementioned studies considered only specific sub-types of OCD symptoms. To our knowledge, no study has explored the relationship between both TG and DP and all the OCD symptom dimensions. In particular, the role of these constructs in OCD patients with unacceptable thoughts and obsessions about order and symmetry is unexplored. Besides, all the cited studies, with the exception of D'Olimpio et al. (2013), involved only non-clinical participants. In view of the limitations of the previous findings, the aim of the present study was to investigate the specific role of TG and DP in all the OCD symptom dimensions, using a heterogeneous and relatively large clinical sample. More specifically, on the basis of previous studies, we predicted that: (1) DP would be specifically associated with OCD symptoms related to contamination and (2) TG would be specifically associated with OCD symptoms related to responsibility for harm and mistakes and to contamination.

2. Method

2.1. Participants

112 OCD patients had been referred to an Italian private center for adult psychotherapy for evaluation and treatment. During the routine assessment phase patients were interviewed by one of the members of the research team (all doctoral psychologists experienced in diagnosing psychiatric disorders) using the Anxiety Disorder Interview Schedule IV (Brown, Di Nardo, & Barlow, 1994) to establish diagnoses. Each case was audio-recorded and carefully reviewed in supervisory meetings, and all diagnoses were reached by raters' consensus. Some participants had one or more secondary diagnoses, including anxiety disorders (social phobia [$n=2$], panic disorder [$n=3$] and generalized anxiety disorder [$n=8$]) and mood

disorders (major depressive disorder [$n=14$]). Potential participants with a secondary or tertiary diagnosis of OCD were excluded. Five participants were excluded as they were under 18 years old. The presence of psychosis, current mania, and/or substance dependence was other exclusionary criteria.

The final sample included 98 OCD patients (53.1% males), with a mean age of 32 years ($SD=10.4$). Two thirds of all participants were unmarried, and almost eighty-seven percent of the sample had at least 12 years of education.

2.2. Procedure

After signing the consent form, participants were given a brief explanation of the study and asked to complete a set of self-report questionnaires that included the Italian version of the Disgust Propensity Questionnaire (DPQ; Melli, Chiorri, Bulli, Stopani, & Carraresi, 2012), the Trait Guilt Short Scale (TGSS; Melli, Primi, Bulli, Carraresi, & Stopani, in preparation), the Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010), the Beck Anxiety Inventory (BAI; Beck & Steer, 1990), and the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). Questionnaires were presented to participants in random order. A research assistant waited until the participant had completed all the questionnaires and provided assistance if the participant did not understand the meaning of any question.

2.3. Measures

2.3.1. Disgust Propensity Questionnaire (DPQ)

This thirty-three-item scale was recently developed to improve the assessment of individual DP in Italian samples, as the Italian version (Melli, Chiorri, & Smurra, 2013) of the Disgust Scale-Revised (DS-R; Olatunji et al., 2007) – the best-known scale for the assessment of DP – has shown satisfactory, but not excellent psychometric properties, and some of the items of this scale are not appropriate to the Italian cultural context. Participants are asked to rate each item on a five-point Likert scale from 0 ("not at all") to 4 ("very much"). This questionnaire was found to have a one-factor structure, excellent internal consistency ($\alpha=.95$), adequate test-retest reliability ($r=.87$) and construct validity. In the present study, this scale showed excellent internal consistency ($\alpha=.95$).

2.3.2. Trait Guilt Short Scale (TGSS)

This eleven-item self-report measure is a shortened version of the Trait Guilt subscale of the Guilt Inventory (Kugler & Jones, 1992), developed to address the psychometric limitations of the Italian version of the original Trait Guilt subscale, which has shown unsatisfactory factor validity and reliability (Melli et al., in preparation). Response choices are scored from 1 ('strongly agree') to 5 ('strongly disagree') and total scores range from 11 to 55. The scale was found to have a one-factor structure, good internal consistency ($\alpha=.84$), test-retest reliability ($r=.84$) and construct validity (Melli et al., in preparation). In the present study internal consistency was also good ($\alpha=.83$).

2.3.3. Dimensional Obsessive-Compulsive Scale (DOCS)

The DOCS is a twenty-item scale that assesses the main obsessive-compulsive symptom dimensions of OCD: contamination obsessions and washing and cleaning compulsions; obsessions about responsibility for causing harm and checking compulsions; obsessions about order and symmetry and ordering or arranging compulsions; repugnant obsessive thoughts and mental compulsive rituals or other covert neutralizing strategies. Within each symptom dimension, items – rated on a scale ranging from 0 ('no symptoms') to 4 ('extreme symptoms') – assess 5 severity parameters in relation to the past month. The subscales were found to be highly valid and reliable (Abramowitz et al., 2010). The Italian version of the DOCS (Melli et al., 2014) replicates the four-factor structure of the original version and has shown good internal consistency ($\alpha > .80$ for all subscales), adequate temporal stability ($ICC > .75$ for all scales), and good construct validity. In the present study all the subscales showed excellent internal consistency (α between .92 and .95).

2.3.4. Beck Anxiety Inventory (BAI)

This is a twenty-one-item self-report inventory that assesses the severity of state anxiety. Statement choices are scored from 0 ('not at all') to 3 ('severely') and total scores range from 0 to 63. The original version has shown good psychometric properties, and in a series of studies the Italian version of the BAI has shown a one-factor structure, good internal consistency ($\alpha > .80$), adequate test-retest reliability ($r > .62$), and good construct validity (Sica, Coradeschi, Ghisi, & Sanavio, 2006; Sica & Ghisi, 2007). In the present study internal consistency was also good ($\alpha=.84$).

2.3.5. Beck Depression Inventory-II (BDI-II)

This twenty-one-item self-report inventory is used to assess depressive symptoms over the previous two weeks. Response choices are scored from 0 ('absent') to 3 ('severe') and total scores range from 0 to 63. The BDI-II has shown good psychometric properties, and the Italian version of the BDI-II (Ghisi, Flebus, Montano, Sanavio, & Sica, 2006; Sica & Ghisi, 2007) has been shown to have a

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