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Specific and general cognitive predictors of Sexual Orientation-Obsessive Compulsive Disorder

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ABSTRACT

Sexual Orientation-Obsessive Compulsive Disorder (SO-OCD) is yet understudied in the literature. The current study was prompted to test the role of specific and general beliefs potentially involved in the genesis and maintenance of SO-OCD. As such, 263 patients with SO-OCD, 42 patients with OCD (NSO-OCD) and 116 non-clinical participants (NCP) were administered the Sexual Orientation-Obsessive Beliefs Scale (SO-OBS), which was designed to evaluate specific beliefs hypothesized to relate to SO-OCD, together with other measures assessing SO-OCD symptoms, general obsessive beliefs, depression and anxiety. The final SO-OBS consisted of 12 items and showed a four-factor structure and a very good internal consistency. Regression analysis and multivariate analysis of covariance (MANCOVA) highlighted the significant role of beliefs regarding the negative impact of homosexuality on one's identity and beliefs about the meaning of sexual problems in heterosexual intercourse as well as a more marginal role of black/white beliefs regarding what it is "right" to feel in heterosexual sexuality. There were no significant differences between SO-OCD and NSO-OCD patients on homophobic beliefs. Despite some limitations of the study, including the limitation to heterosexual individuals with SO-OCD, the identification of these specific cognitive factors has important implications for the prevention and treatment of SO-OCD.

1. Introduction

Obsessive Compulsive Disorder (OCD) is a common and debilitating mental illness, with its lifetime prevalence estimated to be between 1.9% and 2.5% in most countries across the world (Nedeljkovic, Moulding, Foroughi, Kyrios, & Doron, 2012). It is highly disabling, both to the individual (Eisen et al., 2006; Murray & Lopez, 1996), and also to their families (Ramos-Cerqueira, Torres, Torresan, Negreiros, & Vitorino, 2008). OCD is characterized by intrusive, unwanted thoughts, images or urges (obsessions), and by the resultant compulsive overt or covert actions that are designed to eliminate the danger or distress related to the obsession, or the affected person's responsibility for it (American Psychiatric Association, 2013). OCD is a heterogeneous disorder, with specific symptom dimensions including dirt/contamination, order/symmetry, doubt/checking, and repugnant or unacceptable thoughts (Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008).

Sexual Orientation-OCD (SO-OCD) is a debilitating form of OCD, that is generally considered part of the wider symptom dimension of repugnant thoughts (Moulding, Aardema et al., 2014). Williams and Farris (2011) found that 8% of those with diagnosed with OCD reported current SO-OCD symptoms, while 12% had lifetime symptoms, although it has suggested that these numbers are an underestimate (Williams, Wetterneck, Tellawi, & Duque, 2014). SO-OCD can be characterized by the individual's obsessive fear of having or developing a sexual orientation that contrasts with their actual sexual orientation, by their experiencing unwanted mental images related to that undesired sexual orientation, and/or by the obsessive fear that others may believe they are of the undesired sexual orientation (based on Williams, 2008). SO-OCD is most commonly associated with fears related to homosexuality in individuals who identify as heterosexual; although the reverse manifestation also occurs (Goldberg, 1984). Individuals with SO-OCD are preoccupied with their sexual orientation and the meaning of intrusive thoughts that contradict their sexual preferences. As a consequence, they may engage in overt and covert compulsive and neutralizing behaviors in order to reassure themselves of their sexual orientation, or to remove negative thoughts that imply they are of the opposite sexual orientation (Melli, Moulding, Gelli, Chiorri, & Pinto,

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2016; Williams, 2008). Overall, SO-OCD obsessions are associated with increased distress, interference, and avoidance in individuals with OCD (Williams & Farris, 2011), and SO-OCD may also be associated with lower self-worth (Williams, 2008). Indeed, Williams et al. (2014) found that among those with SO-OCD, 91% had distress that was rated as between "much" to "suicidal". However, while there have been recent developments in measuring SO-OCD symptoms (Melli et al., 2016; Wetterneck, Siev, Adams, Slimowicz, & Smith, 2015; Williams et al., 2014), our knowledge of what predicts SO-OCD is still in its infancy.

More generally, cognitive models of OCD are based on the suggestion that intrusive thoughts are a universal phenomena (Radomsky et al., 2013). As such, it is the maladaptive interpretations given to intrusive thoughts that is thought to be the key factor in leading to increased OCD-related distress (Moulding & Coles, 2014). Such misappraisals are driven by specific underlying beliefs, such as responsibility and threat (Salkovskis, 1985), perfectionism and the need to control thoughts (Obsessive Compulsive Cognitions Working Group, 1997, 2005). The misappraisals lead to distress and compulsions, which paradoxically lead to the perpetuation of the intrusions (Clark, 2004). Studies have also examined the specificity of these beliefs to particular symptom manifestations. Theoretically, the domain of the importance of and need to control thoughts seems most relevant to the unacceptable thoughts domain, with studies seeming to generally find this relationship (Julien, O'Connor, Aardema, & Todorov, 2006; Tolin, Brady, & Hannan, 2008; Tolin, Woods, & Abramowitz, 2003; Viar, Bilsky, Armstrong, & Olatunji, 2011; Wheaton, Abramowitz, Berman, Riemann, & Hale, 2010); although not all studies have found this association (most notably, Obsessive Compulsive Cognitions Working Group, 2005). Recently, studies have been examining more specific beliefs that may be relevant to more particular manifestations of OCD. For example, Doron, Derby, Szepsenwol, Nahaloni, and Moulding (2016) found that a clinical group with Relationship-oriented OCD (ROCD) showed greater endorsement of OCD-relevant beliefs regarding the importance of thoughts and responsibility, but also endorsed more specific relationship-related beliefs such as overestimating the negative consequences of being in the wrong relationship when compared to a non-ROCD group and community controls, while perfectionism and threat, and relationship-related beliefs on the consequences of being alone, were higher in the ROCD group compared only to community controls. Their findings were taken to show the importance of both more general OCD-related beliefs as well as specific relationship-oriented beliefs to ROCD symptoms, giving the potential for more specific models of ROCD symptoms to be developed that may give additional avenues for treatment.

In the same manner, in this study we wished to explore specific and general beliefs as they related to SO-OCD (specifically, homosexual SO-OCD in individuals who identified as heterosexual). SO-OCD symptoms may involve cognitive beliefs and biases similar to those underlying other OC phenomena. For instance, perfectionism and intolerance of uncertainty beliefs are likely to promote a preoccupation with removing any uncertainty regarding one's sexual orientation. Equally, the presence of unwanted intrusive thoughts regarding sexuality is likely to be more distressing if one believes that thoughts can be taken as an indication of one's sexuality, and that one should be able to rid their mind of such thoughts. In addition to general beliefs, clinical experience gives us reason to believe that specific beliefs may be relevant to SO-OCD (Gelli et al., 2016). First, we expected that patients with SO-OCD may exhibit a perfectionistic and dichotomous view of the feelings that a person who is heterosexual should experience, and of what it is "right" to feel, as part of one's heterosexual sexuality. Second, following ideas that intrusions are more threatening if one is less secure about their identity (e.g., Bhar & Kyrios, 2007), we expected that SO-OCD patients may hold catastrophic beliefs concerning the impact of homosexuality on their sense of self. Third, considering that sexual orientation obsessions may be strongly linked with relational doubts (Williams & Farris, 2011), we hypothesized that SO-OCD clients may overestimate the relevance of internal states related to heterosexual sexual intercourse (e.g., sexual satisfaction, sexual desire, performance anxiety) and catastrophically misinterpret the meaning of sexual difficulties in the heterosexual relationships. Finally, while it is generally acknowledged that SO-OCD can be differentiated from genuine conflict about one's sexuality (Gordon, 2002), from homophobia (Williams, 2008), and also from internalized homophobia (Szymanski, Kashubeck-West, & Meyer, 2008), it remains possible that individuals with more general homophobic beliefs may be threatened by thoughts regarding being gay.

Finally, recent studies have been investigating the relevance of specific self-representations to OCD symptoms; a cognitive style that has been termed the "fear of self" (Aardema et al., 2013; Jaeger, Moulding, Anglim, Aardema, & Nedeljkovic, 2015; Melli, Aardema et al., 2015; Nikodijevic, Moulding, Anglim, Aardema, & Nedeljkovic, 2015). While Higgins (1987) suggested that discrepancies between the "actual" and "ought" self were relevant to feelings of anxiety in the general population, in the clinical population it has been suggested that it might be more relevant to examine the "ought not" or "feared" self, as outlined by researchers such as Oyserman and Markus (1990). For example, Ferrier and Brewin (2005) found that individuals with OCD were more likely to draw negative inferences about themselves as bad, immoral and insane on the basis of the intrusions they experienced compared with non-clinical and anxiety disorder controls. Lipton, Brewin, Linke, and Halperin (2010) found that intrusive images were more frequent in those with OCD than anxious controls, and more often contained themes of unacceptable ideas of harm, implying a "dangerous self". Doron, Sar-El, and Mikulincer (2012) found that threats to moral self-perceptions triggered OCD contamination-related behavioral tendencies in non-clinical samples. Aardema et al. (2013) found evidence that their "feared self" measure correlated strongly with measures of OCD symptoms in two non-clinical samples, while Nikodijevic et al. (2015) and Jeager et al. (2015) found that greater feared-self endorsement was related to higher believability of OCD-related narratives. Most recently, in two separate clinical samples, Melli et al. (2016) and Aardema et al. (2017) found that the feared self specifically predicted the symptom dimension of unacceptable or repugnant thoughts, consistent with the items within the measure which imply a self that is dangerous or immoral. Given these relationships with the wider unacceptable thoughts symptom dimension, it seems reasonable to suggest that this measure may be an important cognitive predictor of SO-OCD symptoms in clinical samples.

The current study was therefore prompted by need to investigate the specific and general predictors of SO-OCD, and was conducted in a relatively large Italian clinical sample. As an initial step, we aimed to develop and evaluate a new scale for clinical and research settings – the Sexual Orientation-Obsessive Beliefs Scale (SO-OBS)—which assesses the hypothesized specific beliefs. We predicted that higher sexual orientation symptoms in a group of individuals with SO-OCD would be predicted by both general OCD-relevant beliefs, fear of self beliefs, as well as by the newly developed sexual orientation beliefs measure. We also predicted that the specific sexual orientation beliefs would predict SO-OCD symptoms over-and-above the more general beliefs. Finally, we predicted that the specific sexual orientation beliefs would significantly differ between OCD patients with and without sexual orientation-related symptoms, and between SO-OCD patients and community controls.

2. Methods

2.1. Participants

The total study sample consisted of 421 Italian heterosexual adults, including 263 participants who self-reported that they had received a diagnosis of SO-OCD by a qualified clinician (licensed psychiatrist or clinical psychologist; SO-OCD group), a small control group composed