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Assessing Sexually Intrusive Thoughts: Parsing Unacceptable Thoughts on the Dimensional Obsessive-Compulsive Scale

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Sexual obsessions are a common symptom of obsessive-compulsive disorder (OCD), often classified in a broader symptom dimension that includes aggressive and religious obsessions, as well. Indeed, the Dimensional Obsessive-Compulsive Scale (DOCS) Unacceptable Thoughts Scale includes obsessional content relating to sexual, violent, and religious themes associated with rituals that are often covert. However, there is reason to suspect that sexual obsessions differ meaningfully from other types of unacceptable thoughts. We conducted two studies to evaluate the factor structure, initial psychometric characteristics, and associated clinical features of a new DOCS scale for sexually intrusive thoughts (SIT). In the first study, nonclinical participants (*N* = 475) completed the standard DOCS with additional SIT questions and we conducted an exploratory factor analysis on all items and examined clinical and cognitive correlates of the different scales, as well as test-retest reliability. The SIT Scale was distinct from the Unacceptable Thoughts Scale and was predicted by different obsessional cognitions. It had good internal consistency and there was evidence for convergent and divergent validity. In the second study, we examined the relationships among the standard DOCS and SIT scales, as well as types of obsessional cognitions and symptom severity, in a clinical sample of individuals with OCD (*N* = 54). There were indications of both convergence and divergence between the Unacceptable Thoughts and SIT scales, which were strongly correlated with each other. Together, the studies demonstrate the potential utility of assessing sexually intrusive thoughts separately from the broader category of unacceptable thoughts.

Keywords: OCD; sexual obsessions; unacceptable thoughts; assessment; symptom dimensions

Obsessive-compulsive disorder (OCD) is characterized by intrusive thoughts (obsessions), which give rise to performance of rituals (compulsions) as part of an effort to neutralize, suppress, or reduce distress or perceived harmful effects associated with obsessions (American Psychiatric Association [APA], 2013). OCD is heterogeneous in its manifestation of obsessional content and types of compulsions,

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which can lead to difficulty in assessing OCD adequately and comprehensively (Glazier, Calixte, Rothschild, & Pinto, 2013; Sussman, 2003).

OCD and associated symptoms may best be conceptualized from a dimensional perspective rather than a categorical perspective (e.g., Abramowitz et al., 2010; Mataix-Cols, Rosario-Campos, & Leckman, 2005). However, instruments such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) focus largely on identification and assignment of symptoms to individual categories. This may result in test construction that is theoretically inconsistent with a dimensional conceptualization. As a result, current assessment instruments may be lengthy due to exhaustive symptom lists, theoretically inconsistent with the current empirical literature, and lack a clear assessment of overall OCD severity independent of the number or type of obsessions and compulsions (Abramowitz et al.).

In response to the need for theoretically consistent measures, the Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010) was developed to address several of the shortcomings inherent in many categorical measures such as the Y-BOCS. The DOCS assesses OCD on the basis of four dimensions pertaining to contamination, responsibility for harm and mistakes, unacceptable thoughts, and symmetry and completeness. These four dimensions are the most frequently replicated factors identified in previous structural analyses (e.g., Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008), and were therefore included as primary OCD dimensions. For each symptom dimension, individuals completing the DOCS rate the amount of time spent on obsessions and compulsions, extent of avoidance and functional interference, degree of distress, and difficulty disregarding obsessions and refraining from compulsions. The structure of the DOCS allows for the assessment of obsessive-compulsive symptoms while addressing several difficulties inherent in the categorical assessment of OCD.

Of specific interest in the current investigation is the structure of the DOCS as it pertains to the inclusion of sexual obsessions in the unacceptable thoughts symptom group. Sexual obsessions often include thoughts about inappropriate or taboo sexual behavior, such as with children or animals, incest, or using violence. They may also include concerns about sexual orientation (Williams & Farris, 2011). Sexual obsessions are fairly common, affecting 13% to 21% of individuals with OCD at any given time (Grant, Pinto, Gunnip, Mancebo, Eisen, & Rasmussen, 2006; Pinto et al., 2008). The Unacceptable Thoughts DOCS Scale includes obsessional content relating to sexual, religious, or violent themes associated with rituals that are often characterized by covert attempts to neutralize or suppress the aforementioned obsessions. Although several factor analytic studies support this grouping, there is evidence to suggest that there may be utility in separating them from one another. For example, Siev, Steketee, Fama, and Wilhelm (2011) found that sexual and religious obsessions were associated with different obsessional cognitive styles and personality characteristics from each other. In fact, sexual obsessions loaded as a unique symptom component in one study of African-Americans with OCD (Williams, Elstein, Buckner, Abelson, & Himle, 2012).

Smith, Wetterneck, Short, Hart, and Little (2011) added a fifth dimension to the DOCS to assess sexually intrusive thoughts (DOCS-SIT) by adapting content from the existing Unacceptable Thoughts Scale and specifying a wider range of sexual obsessional content. In an initial investigation, the DOCS-SIT and Unacceptable Thoughts scales were moderately correlated with each other (r = .38), although the association was not significant (p = .09) in the small sample (N = 44) (Smith et al., 2011). The magnitude of this correlation implies that the DOCS-SIT is not redundant with the Unacceptable Thoughts Scale, even if they are related. The latter may not provide an adequate representation of the breadth of sexually intrusive thought content.

We conducted two studies to evaluate the factor structure, initial psychometric characteristics, and associated clinical features of the DOCS-SIT. In the first study, nonclinical participants completed the standard DOCS with additional SIT questions and we conducted an exploratory factor analysis on all items and examined clinical and cognitive correlates of the different scales, as well as test-retest reliability. In the second study, we examined the relationships among the standard DOCS and DOCS-SIT scales, as well as types of obsessional cognitions and symptom severity, in a clinical sample of individuals with OCD. Some of the data for some of the participants in the second study have been published previously in the context of a different investigation (Smith, Wetterneck, Hart, Short, & Björgvinsson, 2012). However, data on the SIT Scale—the focus of this study—have not been published for any of the participants. The focus of this investigation is specifically on the utility and features associated with the SIT Scale, with particular attention to similarities and differences between the DOCS Unacceptable Thoughts Scale and the SIT Scale.

Study 1

METHOD

Data were collected via the Internet at www.surveymonkey.com during the 2009–2010 academic year at a large southern university. All

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