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Interpersonal hostility and suspicious thinking in obsessive-compulsive disorder

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ABSTRACT

Individuals with obsessive-compulsive disorder (OCD) may struggle with hostility and suspicious thinking, but this has not been the subject of much research. The purpose of this study is to examine the relationship between hostility, suspicious thinking, and OCD severity. Participants included 66 outpatients in treatment for OCD, 27 in treatment for other disorders, and 68 students (n=161). All completed the Inventory of Hostility and Suspicious Thinking (IHS), a measure of psychotic thinking/paranoia, the Obsessive Compulsive Inventory-Revised (OCI-R), the Beck Depression Inventory (BDI-II), and the Beck Anxiety Inventory (BAI). As expected, the IHS was significantly positively correlated with the BAI and BDI-II. Additionally, regression analyses revealed that individuals with OCD have higher levels of hostility than students. Hostility was also significantly positively associated with increased OCD severity. Hostility and suspicious thoughts are prominent in anxiety disorders in general, and thus necessitate continued research.

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1. Introduction

1.1. Background

Obsessive-compulsive disorder (OCD) is a burdensome condition with lifetime and 12-month prevalence rates of about 2.3% and 1.2%, respectively (Ruscio et al., 2010). OCD is typified by the presence of obsessions and compulsions that cause marked distress in those experiencing the disorder. Obsessions are persistent, intrusive, upsetting thoughts, and compulsions are repetitive behaviors and mental rituals performed to provide temporary relief from the psychological discomfort caused by obsessions (APA, 2013). Compulsions may disrupt an individual's daily living, causing additional distress. OCD symptoms are time-consuming and very often so disruptive that they threaten the occupational, social, and emotional well-being of people living with OCD. The mean age of onset for OCD is 19.5 years with very few new onsets after the age of 30 (Ruscio et al., 2010). OCD is known to occur comorbidly with other psychological disorders. Ruscio et al. (2010) found that 90% of respondents with OCD also met criteria for another DSM-IV (2000) disorder, the most common conditions being anxiety disorders (75.8%) and mood disorders (63.3%).

The presentation of OCD may vary greatly between individuals, as obsessions and compulsions may fall into a number of symptom dimensions, with common examples including contamination, doubt/checking, symmetry/arranging, and unacceptable/taboo thoughts (Williams et al., 2013). While some individuals may only present with symptoms in one dimension, one study found that 81% of respondents report symptoms across multiple areas (Ruscio et al., 2010).

1.2. Hostility, paranoia, and disordered thinking in OCD

Roughly 10–15% of the general population regularly experience paranoid delusions (Freeman, 2007). For example, an individual who had a fight with a neighbor may then think that the entire neighborhood is out to get him (Freeman, 2007). Individuals diagnosed with OCD may also struggle with hostility, suspicion, and disordered thinking about others. For example, many people with OCD experience an inflated sense of responsibility (Wilson and Chambless, 1999) that leads to them to take excessive precautions to ensure the safety of others (e.g., repeated checking of locks). As a result, such individuals may feel angry and resentful about the need to be constantly vigilant for the safety of others (Rachman, 1993). Furthermore, individuals with OCD may feel as though other individuals are not as responsible in protecting against harm (Ashbaugh et al., 2006), contributing to increased anger

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(Radomsky et al., 2007) and may in turn result in interpersonal hostility, as the individual may resent others for not being as responsible. Moritz et al. (2011) found a positive relationship between OCD severity and both latent aggression and distrust of others.

1.2.1. Paranoia

Obsessive thoughts are typically distinguishable from paranoid thoughts based on the content of the individual's obsessions, which in OCD follow the previously mentioned symptom dimensions, and the OCD thoughts are recognized by the individual as unwarranted and excessive (Poyurovsky, 2013). However, this may not always be the case, as up to one third of individuals with OCD are thought to have poor insight (Matsunaga et al., 2002).

Fear is also a major emotional component of both OCD and paranoia (Rawlings and Freeman, 1996). In both cases, individuals experience an irrational fear. These fears can range from a general sense of terror to very specific scenarios, for instance, the conviction that one's spouse will be hurt (obsession) if rituals (compulsions) are not performed consistently and without error. Additionally, individuals with OCD and those with paranoia believe that their safety behaviors, or compulsions, will prevent imminent threat from occurring (Morrison, 2001). One difference is that paranoid individuals may believe there is a persecutor that intends to harm them, while perceived threat in OCD is typically attributed to more broad, generalized stimuli (Freeman et al., 2001).

1.2.2. Delusional thinking

When poor insight and paranoia merge, this may present in a more extreme form, such as delusional thinking and/or hallucinations, which are characteristic of individuals with psychosis. Psychotic symptoms may be maintained by the sufferer attending to his unwanted thoughts and misinterpreting them (or himself) as being threatening (Morrison, 2001).

Safety behaviors are acts that individual engages in order to halt a fear outcome from occurring (Deacon and Maack, 2008). Both individuals with OCD (in the form of compulsions) and those with delusions and/or hallucinations use safety behaviors to cope with mental intrusions. However, these behaviors may present differently. Individuals with these hallucinations and delusions use safety behaviors that are directly in response to hallucinations (Morrison, 1998), use more punishment and less distraction strategies than individuals without these experiences (Morrison and Wells, 2000), and use behaviors that may result in increases in their hallucinations, such as watching television to suppress voices (Nayani and David, 1996).

Individuals with OCD may also have characteristics of delusionality, which has been referred to as OCD with poor insight (APA, 2013) or OCD with psychotic features (Eisen and Rasmussen, 1993). This presentation of OCD may be characterized by increased rumination and compulsions (Solyom, 1985), lack of control of compulsions (Catapano et al., 2009), and increased OCD symptom severity (Turksoy et al., 2002).

1.2.3. Hostility

Hostility includes a combination of attitudes, such as bitterness, distrust, and suspicious thinking. Hostility is a product of anger, which tends to occur when individuals feel threatened (Freeman, 2007). However, people diagnosed with OCD tend to also experience anxiety, which may keep them from expressing their anger due to concern about how others will react to a display of aggression (Freeman, 2007; Angelopoulos, 2006).

While hostility has been related to anxiety disorders, the relationship between increased hostility, paranoia, and OCD remains unclear. Some early studies have shown that an increase in hostility is positively correlated with an increase in anxiety (Foulds, 1965), while others have shown that expressing hostility can reduce anxiety (Lorenz, 1966). A study by Radomsky and colleagues found that those reporting significant checking symptoms reported more trait anger, yet less occurrences of anger expression, than a control group composed of undergraduate students (Radomsky et al., 2007). This coincides with research on anger in anxiety disorders at large—those experiencing an anxiety disorder are far more likely than their non-anxious counterparts to control or suppress their expression of anger (Erwin et al., 2003). A study by Walker and Beech (1969) found a positive relationship between hostility, depression, and anxiety, and noted that hostility was related to more ritualizing in the individual.

Another study found that women with OCD scored higher than controls on an anger scale (Rubenstein et al., 1995). Whiteside and Abramowitz (2004) found similar results in a college student sample, in which individuals with clinical levels of OCD symptomology scored higher in anger than those without OCD. However, when controlling for depressive symptoms, there were no longer differences in anger between students with clinical OC symptoms and those without. Whiteside and Abramowitz (2005) later replicated these findings by determining that differences in anger between OCD patients and controls were attributable to general distress. Furthermore, Watson et al. (2011) found that an individual's reported hostility level in the past week was positively correlated to OCD. However, despite a limited number of studies indicating that OCD may be positively correlated with anger, high rates of comorbidity in OCD make it difficult to determine whether this relationship is due to OCD symptoms or other associated psychopathology. More research is needed to determine the relationship between OCD and hostility.

Research suggests that it is more difficult for OCD patients to relieve their anxiety if they have high levels of hostility, which predicts a poor treatment outcome (Angelopoulos, 2006). Thus, the importance of finding an accurate measure with which to gauge levels of hostility in OCD is of great clinical importance, yet there is a relative dearth of research on the subject. The current study aims to clarify the relationship between hostility, paranoia, and the manifestation of OCD symptoms. We hypothesized that individuals with OCD would score higher than a clinical comparison group and a student group on the IHS, and that higher scores on the IHS would be associated with higher levels of symptom severity across all measures of psychopathology in individuals with OCD.

2. Methods

2.1. Sample

Participants included 161 adults, and of these 93 were in outpatient treatment, either for OCD ($n=66$) or other disorders ($n=27$). The remaining participants ($n=68$) were students at a large public university who completed the survey online. Demographic information for each of the three groups is presented in Table 1.

Primary diagnoses for outpatients without OCD included major depressive disorder (31.8%), adjustment disorder (13.6%), posttraumatic stress disorder (13.6%), generalized anxiety disorder (9.1%), social phobia (9.1%), hoarding disorder (9.1%), illness anxiety disorder (4.5%), bipolar disorder (4.5%), and excoriation disorder (4.5%). Hoarding was determined through the use of hoarding specific self-report questionnaires, clinical interview, and a home visit. Students with probable OCD based on the Wetterneck Hart OCD Screener (WHOS; Hong et al., 2013), a four-item measure used to screen for the presence of OCD, were excluded.

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