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The role of shame and symptom severity on quality of life in Obsessive-Compulsive and Related Disorders

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ABSTRACT

Obsessive-Compulsive and Related Disorders (OCRDs) include Obsessive-Compulsive Disorder (OCD), Excoriation Disorder (skin-picking; SP), and Trichotillomania (TTM). Treatment for OCRDs mainly focuses on symptom reduction (i.e., exposure and response prevention, habit reversal training). However, the literature suggests that OCRDs may be associated with shame, which may also require clinical attention. Additionally, previous literature has indicated that Quality of Life (QOL) may be decreased in OCRDs, but this has not been examined in depth. This study examines the relationship between shame, QOL, and symptom severity in non-referred individuals meeting criteria for an OCRD diagnosis. We examined levels of symptom severity, shame, and QOL in adults who self-reported with OCD ($n=152$), TTM ($n=248$), and SP ($n=142$). We hypothesized that shame would be a significant predictor of QOL. Results indicated TTM, SP, OCD and severity of specific dimensions of OCD were significantly correlated with shame. Shame was negatively correlated with QOL for all OCRDs. Additionally, results indicated that gender differences existed within OCRDs in relation to shame and QOL. Regression analyses indicated shame was more strongly related to QOL than symptom severity for all three groups. Implications of these findings and future research directions are discussed.

1. Introduction

1.1. Obsessive-Compulsive and Related Disorders

Several conditions in the Diagnostic and Statistical Manual of Mental Disorders (DSM–5; American Psychiatric Association [APA], 2013) are classified as Obsessive-Compulsive and Related Disorder (OCRDs), including Obsessive-Compulsive Disorder (OCD), Hoarding Disorder, Excoriation Disorder (skin-picking; SP), Body Dysmorphic Disorder, and Trichotillomania (TTM). OCRDs are characterized by compulsive, oftentimes repetitive, behaviors, yet while symptoms may appear similar in presentation, disorders may differ in important ways. For example, OCD often includes obsessions associated with increases in anxiety, disgust, feelings of "not-just-right-ness", incompleteness, and/or perfectionism, followed by compulsions that are implemented to reduce the obsessions (Abramowitz & Jacoby, 2014). Although SP and TTM have topographical similarities to OCD, they may differ from OCD in function; individuals with SP and TTM often do not pull or pick due to an obsessional thought, urge to pick or pull, or an identifiable emotion, rather these behaviors usually occur outside of the person's awareness. Despite these differences, compulsions, hair-pulling, and skin-picking have some similar consequences; such as experiencing momentary relief of discomfort as a result of the behavior. However, some consequences differ as those with SP and TTM generally may report a sense of satisfaction or feeling of pleasure after picking or pulling whereas individuals with OCD typically find their compulsions to be unpleasant, but necessary to assuage their obsession (Abramowitz & Jacoby, 2014). For the purpose of our study we will be focusing on three specific OCRDs: OCD, SP, and TTM.

People with OCRDs may experience high levels of distress with symptoms that may consume many hours per day (Hajcak, Franklin, Simons, & Keuthen, 2006; Rachman, 1997). OCRDs may also lead to increased feelings of shame (Weingarden & Renshaw, 2015) and decreased quality of life (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2008; Wetterneck, Woods, Norberg, & Begotka, 2006). There is a dearth of research on the role of shame in OCRDs and how it might relate to symptom severity and QOL. The literature also suggests that TTM and SP lead to withdrawal from social environments due to negative feelings associated with shame (Flessner et al., 2008; Stemberger, Thomas, Mansueto, &

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Carter, 2000; Wetterneck et al., 2006). Previous research suggests that shame may be a construct of interest in OCRDs. However, there is a paucity of data specifically examining shame in the literature. Weingarden, Renshaw, Wilhelm, Tangney, and DiMauro (2016) assessed anxiety and shame as risk factors for depression, suicidality, and functional impairment in OCD and body dysmorphic disorder. Anxiety and shame were strongly associated with poor life outcomes, and shame was specifically associated with suicide risk and functional impairment (Weingarden et al., 2016). To date this is the only other article assessing the construct of shame in people with OCRDs.

1.2. Shame

Shame is an emotion that is reflective of self-evaluation, in which the entire self, not just the behavior, is negatively evaluated (Tangney, 1991). Because of this pattern of negative self-evaluation, shame affects mood and one's sense of personal identity (Woien, Ernst, Patock-Peckham, & Nagoshi, 2003). Shame has several dimensions, related to character, behaviors, and one's own body. Character shame includes feelings related to personal habits, manner with others, self-characterization, and personal ability (Andrews, Qian, & Valentine, 2002). Behavioral shame includes shame regarding doing something wrong, saying something stupid, and failing in competitive situations. Bodily shame relates to feelings about one's body characteristics, such as appearance or functioning (Andrews et al., 2002). Previous research has demonstrated behavioral, characterological, and bodily shame as three separate factors (e.g., Andrews et al., 2002; Doran & Lewis, 2012; Rockenberg & Brauchle, 2011), which may have unique impact on other phenomenology.

Shame appears to be prominent in people with OCD with approximately half in certain samples reporting shame of the problem itself and even more reporting shame related to the need for outside help (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). Many with OCD endorse hiding rituals from others (Rachman, 2007). Given the role of thought-action fusion in OCD, it's easy to imagine that fears of accidental harm to others, contamination of others, or unacceptable thoughts (i.e., sinning, purposefully hurting others, sexual deviance) can lead to character shame. Weingarden and Renshaw (2015) conceptual review of the literature in OCRDs provided several examples where individuals believe obsessions to be true and then interpret a shameful meaning behind their obsessions (e.g., "I am a bad person for having these thoughts"). For TTM and SP, pulling or picking can change one's appearance (Grant, Stein, Woods, & Keuthen, 2012); subsequent concealment and embarrassment are likely associated with feelings of behavioral or bodily shame within OCRDs. This may be particularly prominent in females due to societal emphases on appearance (Girman, Hartmaier, Roberts, Bergfeld, & Waldstreicher, 1999).

Fergus, Valentiner, McGrath, and Jencius (2010) studied shame and guilt proneness in anxiety-related disorders. Although OCD severity was correlated with shame-proneness, a partial correlation controlling for other symptoms, such as worry and depression, indicated that shame-proneness did not share a specific relation with OCD symptoms. However, this finding may have been a result of low statistical power (Fergus et al., 2010). Wetterneck, Singh, and Hart (2014) replicated Fergus et al. (2010) with a larger sample and examined the relationship between shame-proneness and OCD symptom dimensions (contamination, accidental harm, symmetry, and unacceptable thoughts). Significant relationships were found between shame-proneness and symptom severity for both accidental harm and symmetry even when controlling for other anxiety disorder constructs (i.e., worry). The researchers speculated the relationship between shame-proneness and symmetry may be due perfectionism related to these dimensions and suggested that assessing individual symptom dimensions would be important for future research on OCD and shame.

1.3. Quality of life

OCD is associated with reduced functioning in personal relationships, at work, and in school, subsequently diminishing one's QOL (Goracci et al., 2007; Ruscio, Stein, Chiu, & Kessler, 2010; Sørensen, Kirkeby, & Thomsen, 2004). Bystritsky et al. (2001) suggest that reduced QOL may be related to difficulties in leisure activities, job/work related activities, social interactions, and domestic/every day functioning activities. Vorstenbosch et al. (2012) examined functional impairment across OCD dimensions with varied results for each dimension. Those with obsessions and checking compulsions reported greater overall impairment and impairment of lifestyle (Vorstenbosch et al., 2012).

Moreover, individuals with TTM report decreased functioning in social and economic environments (Wetterneck et al., 2006) due to avoidance of social situations where results of hair-pulling may be detected by others (i.e., bald spots, other patches of missing hair; Flessner et al., 2008). Social and interpersonal impairment were also observed in children and adolescents with TTM (Flessner et al., 2008; Lewin et al., 2009). Regarding individuals dealing with SP, there is extremely limited research, although researchers speculate that SP symptoms are associated with QOL impairment (Arbabi et al., 2008).

1.4. This study

Although Weingarden and Renshaw (2015) provide some conceptual evidence from previous literature on the presence of shame in OCRDs, the association between shame and QOL within the OCRDs has yet to be explored warranting more empirical investigations. This is important because OCRD symptoms may improve during treatment, but other behaviors associated with shame may not improve as rapidly or may persist (Koerner, Tsai, & Simpson, 2011; Norberg, Calamari, Cohen, & Riemann, 2008; Rogers et al., 2014). In other words, engaging in longstanding patterns of behavior in the service of reducing shame may not lead to the amelioration of shame even after reducing compulsions, hair pulling, or skin picking. Therefore, the current study aims to fill part of the void on the role of shame and QOL in OCRDs to better inform clinical practice.

QOL can include several dimensions, but for this study we include overall psychological health, environmental functioning (i.e., school or work), social relationships, and physical health (Thulin & Nortvedt, 1999). We expect that shame and OCRD symptom severity will be significantly inversely correlated with QOL. Additionally, we will explore the contributions of shame and symptom severity on QOL. If shame predicts QOL it may help explain previous findings with other psychological disorders in which reduced symptom severity failed to predict change in QOL (Davidoff, Christensen, Khalili, Nguyen, & IsHak, 2012; Shabani et al., 2013).

For OCD symptoms, this study examines four common symptom dimensions: contamination, accidental harm, symmetry, and unacceptable intrusive thoughts (Abramowitz et al., 2010; Williams, Mugno, Franklin, & Faber, 2013). We hypothesize that accidental harm, symmetry, and unacceptable thoughts will have a significant relationship with character shame. Accidental harm and unacceptable thoughts (e.g., responsibility for harming others or engaging in inappropriate acts) may contribute to beliefs that one is immoral or bad. We expect a replication of the finding of a significant relationship between character shame and symmetry (Wetterneck et al., 2014). In addition, we hypothesize that all symptom dimensions will be significantly correlated with