



Fathers' "not just right experiences" predict obsessive-compulsive symptoms in their sons: Family study of a non-clinical Italian sample



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ABSTRACT

The heart of the obsessional process may be considered the subject's underlying impression that "something is wrong". Therefore, the phenomenon labeled "not just right experiences" (NJREs) has increasingly been receiving attention since it captures the subjective sense that "something isn't just as it should be". In the present study we sought to add to the evidence that NJREs may be a putative psychological marker of OCD. To this aim, measures of NJREs, obsessive-compulsive (OC) symptoms and OC-related cognitions were completed by 382 undergraduates (43.2% females), 318 mothers and 288 fathers. NJREs correlations between parents and children were typically in the small-medium range of magnitude and comparable to correlations both for OC beliefs and symptoms. A series of hierarchical multiple regression analyses showed that fathers' (but not mothers') NJREs predicted OC symptomatology in their sons even when parents' anxiety symptoms and their level of OC-related beliefs were controlled. This relationship generally also held for single symptom dimensions such as washing, checking, ordering, and mental neutralizing symptoms. On the contrary, none of parents' psychological variables considered in the present study predicted OC symptoms in daughters. The possible role of NJREs as a marker of OCD is discussed.

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1. Introduction

The key diagnostic feature of obsessive-compulsive disorder (OCD) in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV-TR; American Psychiatric Association, 2000)* is the presence of persistent, intrusive, and distressing obsessions or compulsions, with marked impairments in quality of life (Eisen et al., 2006; Parkin, 1997). Obsessions are defined as persistent thoughts, ideas, impulses, or images that are initially experienced as intrusive and senseless. Compulsions are a physical corollary to obsessions; they are intentional, repetitive behaviors or mental rituals that are performed in response to obsessive thoughts, or in some stereotyped manner.

Experts have recognized that the manifestations of the condition may be marked by a heterogeneous set of dimensions; for example, McKay et al. (2004) have identified as many as nine subtypes or replicable dimensions of OCD: contamination/washing, harming/

checking, hoarding, symmetry/ordering, obsessionals, sexual and religious, certainty, sexual-somatic, and contamination/harming. Patients with OCD may report one (Stein, Forde, Anderson, & Walker, 1997) or, more typically, multiple symptoms (Antony, Downie, & Swinson, 1998).

OCD has a chronic course, with symptom intensity that usually remains elevated once it has reached clinical levels (e.g., Mataix-Cols et al., 2002). OCD is associated with significant impairments in daily life, including impairments in both social and occupational functioning (Albert, Maina, Bogetto, Chiarle, & Mataix-Cols, 2010; Mancebo et al., 2008). For example, upwards of one in three patients with OCD is unable to work, and nearly one-half of these individuals receive disability payments primarily related to their condition (Mancebo et al., 2008).

Data from twin and family studies completed over the past 60 years suggest that OCD is familial. Twin studies of OCD show a strong genetic effect, with significantly higher concordance rates among monozygotic than dizygotic twins (see reviews by Arnold and Richter (2007), van Grootheest, Cath, Beekman, and Boomsma (2005), and Pauls (2008)). A meta-analysis based on five family studies with adult probands found an odds ratio of 4.0 for OCD in case and control first-degree relatives (Hettrema, Neale, & Kendler,

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2001). Black, Gaffney, Schlosser, and Gabel (2003) found that both having a mother with OCD and family dysfunction were predictive of OCD in offspring. Grabe et al. (2006) demonstrated that relatives of OCD probands (from clinical and community settings combined) had a significant 6.2-fold higher risk of definite OCD compared with relatives of comparison subjects.

Many studies found that subclinical OCD and obsessive-compulsive (OC) symptoms also aggregate in families in both clinical (e.g., Mathews et al., 2007; Pauls, 2005; see also Arnold & Richter, 2007) and non-clinical samples (e.g., Grabe et al., 2006; van Grootheest, Cath, Beekman, & Boomsma, 2007; van Grootheest et al., 2008; Iervolino, Rijdsdijk, Cherkas, Fullana, & Mataix-Cols, 2011; Taberner, Fullana, Caseras, Pertusa, & Bados 2009). Lastly, several studies documented a family history of OCD especially in males, perhaps due to the preponderance of men with early onset OCD (e.g., Taylor, 2011), or with a higher frequency of tics (e.g., Leckman et al., 2010). It is also true that recent research in early childhood samples suggests that the gender ratio of early onset OCD may be closer than these retrospective data suggest (Garcia et al., 2009). In any case, other studies have reported the presence of specific genetic influences for OCD in males (Pooley, Fineberg, & Harrison, 2007; Wang, Samuels, Chang, Grados, & Greenberg, 2009; see also Hu et al., 2013). Research conducted during the last few decades has dramatically expanded our understanding of the OCD (see Sica, Chiri, McKay, & Ghisi, 2010). In particular, scholars have increasingly considered the lack of a sense of satisfaction and presence of feelings of doubt as central features of obsessions and associated compulsions (Ferrão et al., 2012; Gentsch, Schütz-Bosbach, Endrass, & Kathmann, 2012; Harkin, Mielle, & Kessler, 2012; Prado et al., 2008). Such features have been referred to as “premonitory urges”, “sensory tics”, “just-right perceptions”, “sensory experiences”, “feelings of incompleteness,” and “not just-right phenomena/experiences” (NJREs). OCD patients talk about a tormenting sense of dissatisfaction with their current state, profound feelings of imperfection regarding their need for experiences to conform to exact, yet often inexpressible criteria (Ghisi, Chiri, Marchetti, Sanavio, & Sica, 2010). In agreement with clinical reports, some studies documented prevalence of NJREs ranged from 70% to 80% in OCD patients (Ferrão et al., 2012; Leckman, Walker, Goodman, Pauls, & Cohen, 1994; Miguel et al., 1997; Miguel et al., 2000).

Moreover, a few broad theoretical models of OCD explicitly included NJREs as *etiologic factors* for OCD. Summerfeldt, Richter, Antony, and Swinson (1999) posit the existence of two continuous orthogonal core dimensions – harm avoidance and *incompleteness* – that cut across overt symptoms and, in combination, may underlie most manifestations of OCD. Szechtman and Woody (2004); see also Hinds, Woody, Van Ameringen, Schmidt, and Szechtman (2012) contend that OCD stems from an inability to generate the normal “feeling of knowing” that would otherwise signal task completion and terminate the expression of a security motivational system. Lastly, it has been proposed that the dysregulated activity in frontostriatal system often observed in patients with OCD (e.g., Chamberlain et al., 2008; Rotge et al., 2009; for a review, see Melloni et al., 2012) may manifest as persistent “error signals” erroneously prompting the individual to a (fruitless) corrective action (e.g., Aouizerate et al., 2004; Brown, Friston, & Bestmann, 2011; Maltby, Tolin, Worhunsky, O’Keefe, & Kiehl, 2005; O’Tool, Weinborn, & Fox, 2012).

Several studies have provided evidence for the association between NJREs and OCD or OC symptoms. In two studies with large undergraduate samples, Coles, Frost, Heimberg, and Rhéaume (2003) reported that a measure of NJREs was significantly related to OC features. Further, NJREs have been found to be more strongly correlated with OC symptoms than other domains of psychopathology (e.g., social anxiety, worry, depression). In another study on

undergraduate students, experimentally induced NJREs produced distress and urges to change something, but did not produce feared consequences (Coles, Heimberg, Frost, & Steketee, 2005). In the same study, significant relationships were found between NJREs and OC-related constructs (e.g., responsibility, incompleteness), but not between NJREs and non-OC-related constructs (worry, depressive symptoms, social anxiety; Coles et al., 2005).

Cogle, Goetz, Fitch, and Hawkins, (2011), asked non-clinical participants to complete a measure of NJREs along with other self-report measures. Participants were then asked to immerse their hands in a dirt mixture, and afterwards to wash their hands. Cogle et al. (2011) found that number and intensity of NJREs predicted hand-washing duration. Also, Cogle, Fitch, Jacobson, and Lee, *in press* found that two different measures of NJREs (the Obsessive-Compulsive Trait Core Dimensions Questionnaire and the Not Just Right Experiences Questionnaire-Revised) were predictive of urge to check following a stove checking task in nonclinical individuals.

Sica, Caudek, Chiri, Ghisi, and Marchetti, 2012, administered measures of NJREs, OC symptoms, general distress (i.e., anxiety, depression), and looming maladaptive style to 187 college students on three occasions six months apart (baseline, six-months, and one-year later). Linear mixed effects regression models indicated that NJREs explained OC symptoms variation over time even when general distress and looming style were accounted for. Ghisi et al. (2010) examined the relation between self-reported NJREs and OC symptoms in non-clinical and clinical samples. They found an association between severity of NJREs and OC symptoms in a non-clinical sample after controlling for anxiety, depression, and perfectionism. In addition, NJREs sharply discriminated OCD patients from patients with other anxiety disorders or depression.

Lastly, Coles, Hart, and Schofield (2012) investigated patients’ reports of various factors that may have played a role in the transition from the presence of obsessions and compulsions to full-blown OCD. Increases in the strength of urges for things to feel ‘just right’ and increases in attention to one’s thoughts were commonly viewed as contributing to the onset of OCD.

The putative role of NJREs in OCD appears therefore promising both from a theoretical and empirical perspective and encourages further study. In particular, in agreement with some scholars, we consider NJREs as the manifestation of a deficit in the ability to use emotional experience and sensory feedback to guide behavior (an emotional indicator that lets one know when a state has been satisfactorily achieved (e.g., Ecker & Gonner, 2008; Szechtman and Woody, 2004; Summerfeldt et al., 1999). As a such, NJREs may be investigated as a psychological marker of the disorder, a feature possibly reflecting vulnerability for OCD; in fact, in the last few years scholars have been trying to fill the gap in the causal chain between basic mechanisms responsible for OCD (i.e., genes and/or environment context in which an individual is raised) and their phenotypical expression (i.e., symptoms), by focusing on different types of putative markers of vulnerability (Sica et al., 2012; see also Hasler, Drevets, Manji, & Charney, 2004; Miguel et al., 2005; Taylor, 2012).

1.1. The current study

Given the empirical support for OCD as a familial-based disorder, we speculated that a putative marker of vulnerability to this disorder should be shared between parents and their offspring, and that the presence/severity level of such marker in parents should predict OC symptoms in offspring. In fact, many studies have shown that children having a parent with OCD or OC symptoms are more likely to have OC symptoms (Jacobi, Calamari, & Woodard, 2006; Leckman et al., 2003; Liakopoulou et al., 2010; Taberner et al., 2009).

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