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RESEARCH ARTICLE

CORRELATIONAL STUDY OF GUILT, SHAME, BLAMING OTHERS AND SYMPTOM SEVERITY AMONG PERSONS WITH OBSESSIVE COMPULSIVE DISORDER.

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Abstract

The present study investigated the relationship of shame, guilt and blaming others with obsessive-compulsive disorder and also assessed guilt, shame, blaming others and symptom severity among OCD patients. A purposive sample of 71 (43 males and 28 females) OCD patients within the age range of 19-78 years were taken from IMHANS (Institute of Mental Health and Neuroscience) Srinagar and SMHS (Shri Maharaja Hari Singh Hospital) Srinagar. Test of Self-Conscious Affect TOSCA-3S Version 3 (Tangney, Dearing, Wagner & Gramzow, 2000) was used to assess the pathological guilt, shame and blaming others among OCD patients; Yale-Brown Obsessive Compulsive Scale Y-BOCS Symptom Checklist (Goodman, Price & Rasmussen, 1989) designed to measure the severity of OCD symptoms was used. Results revealed that out of 71 participants, 1 (1.40%) fall in the subclinical category, 12 (16.90%) fall in mild, 13 (18.30%) fall in moderate, 26 (36.62%) fall in severe and 19 (26.76%) fall in extreme categories of symptom severity of obsessive compulsive disorder. Correlational analysis revealed that symptom severity is positively and significantly related to shame and guilt and is negatively and insignificantly related to blaming others.

Introduction:-

Thoughts can refer to the ideas or arrangement of idea that result from thinking. Almost all of us have unwanted or unwelcomed thoughts more or less often, and have urges from time to time to behave in certain unacceptable ways that can prove hazardous or embarrassing. However, not all of us have what is known Obsessive Compulsive Disorder (OCD), a disorder in which the mind is perpetually pre-occupied with persistent uncontrollable thoughts and the individual is forced to perform certain acts repeatedly that leads to a significant interference and impairment with normal day-to-day functioning. Although there is evidence that even healthy people are often busy thinking about issues common in OCD, however, compared with the normal population, OCD symptoms are more severe, more constant, and more debilitating. These symptoms interfere with individuals' daily functioning (Moritz, *et. al,* 2005). Previously, included among the anxiety disorders, obsessive-compulsive disorder has now been eliminated from the group of anxiety disorders in the recent version of DSM.

Whereas the specific diagnostic criteria for obsessive-compulsive disorder (OCD) have changed in only minor ways in the transition from DSM-IV to DSM-5, a more substantial change is that OCD is no longer classified as an anxiety disorder. Rather, it is now the flagship diagnosis of new diagnostic category: the obsessive-compulsive and related disorders (OCRDs) (Jonathan, Abrahamowitz, & Ryan, 2014).

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Symptom severity:-

Symptoms refer to being away from normal functioning, or presence of unusual state. The presence of a cluster of such unusual states simultaneously, makes a person to be labelled with a particular disease/ disorder. And severity is synonymous with words like harshness, sternness, rigor, intensity or sharpness. Thus, symptom severity can be defined as the degree or the range of the harshness, intensity or rigor of any disorder that a person is suffering from. Assessing the symptom severity among patients help the professionals to understand the depth of the disorder and design the course of treatment accordingly.

In clinical practice, obsessive-compulsive disorder has also been demarcated under different levels of symptom severity. Both obsessions and compulsions are time consuming and their severity varies across individuals. The symptom severity includes:

1. **Substantial frequency:-** of obsessions and compulsions (from 4 hours a day to every minute of the patient's hours).
2. **Substantial impairment:-** usually all domains of life are affected (social, work and family)
3. **Substantial comorbidity:-** This complicates the symptoms of this disorder (e.g., PTSD and schizophrenia)

Guilt:-

It is closely related to the concept of remorse. It is an emotional or cognitive experience that occurs when a person realizes the he/ she bears a significant responsibility of violating his/ her own standard of conduct or a moral standard. But a person is subjectively aware about this responsibility and its distressing effects as the feeling of guilt is more internalized. Almost all of us feel guilty about one or the other thing in our lives which is normal but when this feeling of guilt goes out of its limits and starts interfering with our normal functioning in everyday life then it is termed as scrupulosity. Scrupulosity is characterized by pathological guilt about moral or religious issues. It is personally distressing, objectively dysfunctional and often accompanied by significant impairment in social functioning. It is typically conceptualized as a moral or religious form of obsessive compulsive disorder (Mancini & Gangimi, 2015). Studies have found that a region of brain called precuneus is associated with the feelings of anxiety and guilt and this part of brain is also highly active among people with OCD (Bastin, Harrison, Davey, Moll & Whittle, 2016). The key characteristic of OCD is believing that negative thoughts will become a reality, leading to a spiralling build-up of anxiety and guilt. The people with OCD have "thought-action-fusion" i.e., the belief that a negative event will become a reality (Henning, Michl & Meindi, 2015).

Shame:-

Shame is a state that occurs in response to a transgression or shortcoming, and is a self- conscious emotion, meaning that self-reflection is critical to its occurrence. In addition, although shame and guilt emotions can be deeply personal, both are crucially linked to interpersonal relationships and experiences state guilt is the result of a personal, private evaluation of one's own failure to live up to self-imposed standards or norms whereas state shame is caused by presumed negative judgments of the self by others, or by society at large. Research studies suggest that obsessive-compulsive patients are more sensitive to feelings of guilt and responsibility than other people, regardless of the domain and their obsessive activity is aimed at preventing, reducing or neutralising the possibility of being guilty (Shapiro & Stewart, 2011). Feelings of guilt seem to play a role in generating and maintaining checking symptoms as well as washing, order and symmetry symptoms. In fact, research has demonstrated that guilt feelings make non-clinical people more sensitive to contamination (Zhong & Lilijenquist, 2007) and Not Just Right Experience (Mancini et al., 2008), which are considered, respectively, to be at the base of washing (Rachman, 2004), order and symmetry symptoms (Coles et al., 2005).

Clinical research on etiology provide new insights into behavioural and neurobiological underpinnings of self-conscious emotions in OCD patients. On the behavioural self-report level OCD patients showed increased shame and guilt experiences which could signify an increased sensitivity to social norms. On the neurobiological level OCD patients showed an increased neural activation of emotion specific fronto-limbic-temporo-parietal networks when processing shame and guilt (Michl, *et. al*, 2012). One conclusion might be that on the one hand shame may play an important role in the development and maintenance of OCD pathology due to its highly situational, socio-contextual and psycho-vegetative components.

Rationale:-

Obsessive-compulsive disorder (OCD) in which one's mind is bombarded with persistent and uncontrollable thoughts and the individual is compelled to repeatedly perform certain acts, causing significant distress and interference with everyday functioning. The sufferers of this disorder go through a lot of troubles at different facets

of life as almost every aspect of their life gets badly hit by this disorder. Thus, in this study an attempt was made to understand the contribution of shame, guilt and blaming others, in maintenance and severity of obsessive-compulsive disorder as it might help the health professionals in treating this disorder efficiently and effectively and the treatment can have a long lasting effect on patients, so as to prevent the recurrence of this excruciating disorder. If abnormal processing or over sensitivity towards shame and guilt act as contributing causal factors of this disorder then working to eliminate such pathological causal factors can result in the alleviation of the disorder itself as keeping in check the practices that lead a person towards developing pathological guilt and shame such as the staunch disciplinarian environment at academic sphere, authoritarian parental behaviour towards children which later develops into self-doubt, self- shame talk and self-guilt talk. Shaping the academic and family milieu into a more cordial one can help reduce the crippling guilt and shame.

Objectives Of The Study:-

The objective of study was to assess shame, guilt, blaming others and symptom severity of OCD, and to investigate the relationship of symptom severity with shame, guilt and blaming others among OCD patients. Keeping in mind the rationale of study following objectives were formulated.

1. To assess guilt, shame, blaming others and symptom severity among OCD patients.
2. To find out relationship among guilt, shame, blaming others and symptom severity among OCD patients.

Sample Description:-

The sample comprised of 71 (43 males and 28 females) OCD patients within the age range of 19-78 years. The sample was taken from IMHANS (Institute of Mental Health and Neuroscience) Srinagar and SMHS (Shri Maharaja Hari Singh Hospital) Srinagar.The detailed description of the sample is given below.

Table 1:- Sample Description (N=71)

Demographics	***Groups***	***f***	***%***
Gender	Male	43	60.56
	Female	28	39.44
Domicile	Urban	28	39.44
	Rural	43	60.56
Marital status	Married	28	39.44
	Unmarried	43	60.56
Age	19-33	48	67.60
	34-48	19	26.76
	49-63	3	4.23
	64-78	1	1.41

Inclusion criteria:-

1. Patients having definite diagnosis of OCD.
2. At least six months time duration since the diagnosis of the disease.
3. Patients providing informed consent.

Exclusion criteria:-

1. Patients with other physical or psychological problems were excluded from the study.
2. Patients below the age of 18 years were also excluded from the study.

Tools Used:-

Biographic Information Sheet:-

Biographic information sheet was designed to tap the personal and socio-demographic information about respondent's age, gender, domicile, marital status, educational qualification etc.

Test of Self-Conscious Affect TOSCA-3S Version 3 (Tangney, Dearing, Wagner & Gramzow, 2000):-

This inventory consists of 11 statements, each designed to assess the pathological guilt, shame and blaming others among OCD patients.

Yale-Brown Obsessive Compulsive Scale Y-BOCS Symptom Checklist (Goodman, Price & Rasmussen, 1989):-

For measurement of symptom severity among OCD patients Y-BOCS Symptom Checklist was used. The inventory is designed to measure the severity and type of symptoms in patients with obsessive compulsive disorder (OCD). It consists of 67 statements, each designed to assess the dimensions of symptomatology and 10 statements each designed to measure symptom severity among OCD patients above the age of 18 years.

Result and Interpretation:-

Table 2:- Frequency distribution of males (n=43) on Shame, Guilt and Blaming others subscales of TOSCA

Shame	***Range***	***f***	***%***
Seldom	0-24	9	20.9
Average	25-32	12	27.90
Often	33-55	22	51.16
Guilt			
Seldom	0-38	14	32.55
Average	39-45	22	51.16
Often	46-55	7	16.27
Blaming others			
Seldom	0-21	9	20.9
Average	22-28	16	37.2
Often	29-55	18	41.8

Table 3:- Frequency distribution of females (n=28) on Shame, Guilt and Blaming others subscales of TOSCA

Shame	***Range***	***f***	***%***
Seldom	0-26	10	35.71
Average	27-35	7	25
Often	36-55	11	39.28
Guilt			
Seldom	0-42	12	42.85
Average	43-48	10	35.71
Often	49-55	6	21.42
Blaming others			
Seldom	0-20	8	28.57
Average	21-28	7	25
Often	29-55	13	46.42

Table 4 : - Frequency distribution of sample (N=71) on Symptom Severity

	Range	***f***	***%***
Sub clinical	0-7	1	1.40
Mild	8-15	12	16.90
Moderate	16-23	13	18.30
Severe	24-31	26	36.62
Extreme	32-40	19	26.76

The above table shows that out of 71 participants, 1 (1.40%) fall in the subclinical category, 12 (16.90%) fall in mild, 13 (18.30%) fall in moderate, 26 (36.62%) fall in severe and 19 (26.76%) fall in extreme categories of symptom severity of obsessive compulsive disorder

Table 5 : - Correlation between Symptom Severity, Shame, Guilt and Blaming others.

Variables	***Symptom Severity***
Shame	.52 (p = 0.001)
Guilt	.31 (p=.008)
Blaming others	-.14(p=.23)

$p \leq 0.05$

The above table shows that symptom severity is positively and significantly related to shame (r = .52; p = 0.001) and guilt (r = .31; p=.008) and is negatively but insignificantly related to blaming others (r = -.14; p = .23).

Conclusion:-

The correlation analysis revealed that there is a positive correlation between shame and symptom severity of OCD as is supported by the study of Averill, Diefenbach, Stanley, Breckenridge and Lusby, (2001). Results of the study conducted by Basile, Mancini, Macaluso, Caltagirone and Bozzali (2013) are consistent with our results that there is a positive correlation between guilt and symptom severity of OCD. They checked the processing of guilt among OCD and normal sample and found through FMRI, that there was abnormal processing of guilt among OCD individuals. Guilt plays a significant role in the occurrence and maintenance of obsessive– compulsive disorder (OCD) and is also in line with the results of the study of Shapiro and Stewart (2011). However, no correlation was found between blaming others and OCD symptom severity.

Thus as per the findings, the self-conscious affect of guilt and shame contribute towards the worsening of obsessive-compulsive disorder.

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