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

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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). 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.
speculated the relationship between shame-proneness and other anxiety disorder constructs (i.e., worry). The researchers both accidental harm and symmetry even when controlling for were found between shame-proneness and symptom severity for sample and examined the relationship between shame-proneness Singh, and Hart (2014) replicated Fergus et al. (2010) with a larger sample and 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, Valentinier, 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 OCD 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
behavioral shame, as individuals with OCD typically feel a strong urge to engage in compulsions despite insight that their obsessions are not factual. This type of shame may result from feeling incapable of controlling one’s behaviors. For other OCRDs we predict that bodily shame, behavior shame, and character shame will be significantly related to TTM and SP symptom severity.

2. Method

2.1. Participants and procedure

Participants were non-referred adults reporting clinical levels of OCD, TTM, and SP. They completed an online study assessing demographics, symptom severity, shame, and QOL. Participants were recruited through websites related to OCRDs including the International OCD Foundation, Peace of Mind Foundation, Houston OCD Program, Trichotillomania Learning Center, and other related self-help sites. Participation was voluntary, and no compensation was provided. Data collection occurred from January 2013 to February 2014. The total number of individuals that provided online consent and started the survey was 3105. Data-checking measures were implemented to assess if data were valid (e.g., to ensure individuals did not select the same response for each question or complete the survey in an unreasonable amount of time). A total of 1592 individuals were excluded for incomplete responses or failing the data check. Screening questionnaires aided in assessing likely diagnoses of OCD, TTM, or SP. Of the 1517 participants remaining, 975 were excluded due to comorbidity. Participants were included if they completed all questionnaires and if they likely met criteria for exactly one of the three disorders based on the screening measures.

The total number of included participants was 542; 152 participants endorsed OCD, 248 endorsed TTM, and 142 endorsed SP. The sample was 76.4% female (n=414), and the ethno-racial backgrounds included 82.1% White, 1.8% Black, 3.7% Latino/Hispanic, 4.6% Asian/Eastern Indian, 4.1% Other, and 3.7% Biracial. The mean age was 30.3 years (SD = 10.7). Many were married or in a relationship (47.2%) and a majority accessed the survey through the Trichotillomania Learning Center (50.7%).

2.2. Measures

2.2.1. Wetterneck Hart OCD Screener (WHOS Hong et al., 2013)

The WHOS is a 4-item measure assessing DSM-5 criteria for OCD. This screener asks if one experiences obsessions and/or compulsions, distress from these obsessions and/or compulsions, and whether s/he has ever recognized if the obsessions/compulsions were excessive or unreasonable. Participants answering “Yes” to all four questions were included in the OCD category.

2.2.2. Trichotillomania Checklist

This 9-item self-report measure assesses diagnostic criteria of TTM. Participants indicate if they pull their hair for reasons other than cosmetic purposes, the site of hair pulling, and the feelings and sensations associated with hair pulling. This checklist was developed using questions from the Structured Clinical Interview for DSM disorders (SCID; First, Spitzer, Gibbon, & Williams, 2002) used to diagnose TTM in the DSM-IV-TR and has been used in previous studies to establish a diagnosis (Woods, Wetterneck, & Plessner, 2006). The questions were converted into a self-report format for the current study. Participants that answered all questions “yes”, indicating meeting all criteria on the measure, were included in the TTM category.

2.2.3. Skin Picking Checklist

This is a 9-item self-report measure converted from the TTM checklist questions used to assess diagnostic criteria of SP. Participants indicated whether they pick their skin for reasons other than cosmetic, the location of skin picking, and experiences, feelings, and sensations related to skin picking. Participants that answered all questions “yes”, which indicates meeting all criteria on the measure, were included in the SP category.

2.2.4. Dimensional Obsessive Compulsive Scale (DOCS; Abramowitz et al., 2010)

The DOCS is a 20-item measure examining severity in four dimensions of OCD: contamination, accidental harm, unacceptable thoughts, and symmetry. Each category includes five items assessing time occupied by obsessions and compulsions, avoidance, distress from obsessions/compulsions, interference with daily functioning, and difficulty with rationalizing obsessions and resisting compulsions. Items range from 0 (no symptom) to 4 (extreme symptoms). The DOCS has strong psychometric properties (cf. Abramowitz et al., 2010). Internal consistency in the current study was excellent for the total score ($\alpha=0.93$) and the dimensions: contamination ($\alpha=0.92$); accidental harm ($\alpha=0.94$); unacceptable thoughts ($\alpha=0.95$); and symmetry ($\alpha=0.94$).

2.2.5. Massachusetts General Hospital Hairpulling Scale (MGHHPS; Keuthen et al., 1995)

The MGHHPS is a 7-item measure assessing TTM severity via urges to pull, intensity of urges, ability to control urges, actual amount of pulling, attempts at resisting, control over pulling, and distress from pulling. Items are presented on 5-point scales ranging from 0 to 4, and the measure has shown strong psychometric properties (Keuthen et al., 1995). In this study, good internal consistency was observed ($\alpha=0.87$).

2.2.6. Skin Picking Scale (SPS; Keuthen et al., 2001)

The SPS is a 6-item measure assessing SP severity. The scale assesses frequency, intensity, time spent, distress, interference from and avoidance of normal activities due to skin picking and has a total scale range from 0 to 24. The validation study showed good psychometric properties (Keuthen et al., 2001). Internal consistency in the current study was good ($\alpha=0.88$).

2.2.7. World Health Organization Quality of Life (WHOQOL-BREF; Thulin & Norvedt, 1999)

The WHOQOL-BREF is a 26-item questionnaire assessing life satisfaction in four domains: psychological, physical, social, and environmental. For the current study, we consider the total score to quantify overall QOL. In validation studies, internal consistency for the total score of the WHOQOL-BREF was 0.81. Internal consistency for the current study was good ($\alpha=0.89$).

2.2.8. Experience of Shame Scale (ESS; Andrews et al., 2002)

The ESS is a 25-item measure assessing characterological, behavioral, and bodily shame. Past or current behaviors related to shame are ranked on a scale of 1 (Not at all) to 4 (Very Much) yielding total scores ranging from 25 to 100. The validation study showed high internal consistency; in the present study internal consistency was excellent for the total score ($\alpha=0.94$) and within the excellent to good range for the subscales of characterological ($\alpha=0.91$), behavioral ($\alpha=0.91$), and bodily shame ($\alpha=0.87$).

2.3. Statistical methods

Participants were classified by disorder and filtered into OCD, TTM, or SP categories based upon responses to screening questionnaires: WHOS, TTM checklist, and SP checklist. In addition to
meeting WHOS criteria, participants needed clinical levels of OCD severity (i.e., a score of > 20 on the DOCS) to be included in the OCD category.

Correlations were conducted between DOCS dimensions and total score, MGHHPS, SPS and all ESS subscales, and WHOQOL total score. Correlations were also conducted between all ESS shame subscales with the WHOQOL total score. Finally, multiple linear regression analyses were used to examine the association between gender, DOCS total score, MGHHPS, SPS, ESS total score, and WHOQOL total score.

3. Results

Table 1 represents mean scores for each measure based on diagnostic group and gender. On average, DOCS total scores were above the score used to differentiate OCD from other anxiety disorders (Abramowitz et al., 2010). MGHHPS and SPS means also indicated clinical levels of severity. Mean scores of the ESS total score indicated high levels of shame. Finally, the mean score for the WHOQOL-BREF indicated that participants had low QOL.

Results from Pearson’s correlations are presented in Table 2. Cohen (1988) interpretation of effect sizes are also described throughout with effects of 0.1 indicative of small effects, 0.3 indicative of medium effects, and 0.5 as large effects. In terms of significant relationships between character shame and OCD severity, overall OCD severity and contamination were significantly positively correlated with character shame. The effects of these correlations were small. The findings indicated significant relationships between symmetry and behavioral shame, as well as with total DOCS score and behavioral shame. The effects of these relationships were small. Contamination, accidental harm, and unacceptable thoughts were not associated with behavioral shame. Finally, the DOCS total and symmetry dimensions had a significant correlation with total shame, also with small effects. None of the DOCS scales exhibited a significant relationship with bodily shame.

When examining TTM and SP symptom severity in relation to shame, TTM and SP were significantly correlated with character shame, bodily shame, and total shame. For behavioral shame, only skin picking symptom severity was significantly correlated, with a small effect size.

Relationships between QOL and contamination, unacceptable thoughts, symmetry, and total DOCS were significantly negatively correlated and effect sizes from small to medium. Accidental harm, and hair pulling and skin picking severity were not correlated with QOL. Finally, all subscales of shame and total shame were negatively correlated with the QOL for all three groups with effect sizes from small to medium. These results aligned with our hypotheses and previous literature suggesting that individuals with OCD often report lowered QOL (Bystritsky et al., 2001; Goracci et al., 2007).

Table 3 represents partial correlations between QOL and each OCD dimension with the other OCD dimensions being held constant. When controlling for other OCD dimensions, significant relationships between QOL and contamination and unacceptable thoughts were observed. However, the relationship between QOL and symmetry were not correlated when other dimensions were held constant.

Initial linear regression analysis found that gender was a significant predictor for QOL, \( b = 0.54, t(542) = 2.31, p < 0.05 \). Given this significant relationship, gender was controlled for in all following regression analyses. Likewise, due to the significant associations between gender, shame, and quality of life, moderation analyses were conducted to understand whether gender moderates the relationship between shame and quality of life across the three disorders. However, none of the interaction terms indicated moderation (OCD: \( b = -0.0689, 95\% CI [-0.252, 0.114], t = -0.743; TTM: b = -0.0691, 95\% CI [-0.288, 0.150], t = -0.620; SP: b = 0.0222, 95\% CI [-0.226, 0.270], t = 0.177).

Table 4 presents the summary of linear regression analyses of variables of gender, shame, and symptom severity in the prediction of QOL for each diagnostic group. In each regression, shame was a stronger significant predictor of QOL than symptom severity. Although gender was significantly related to variables in the study, it was not a significant predictor of QOL in the OCD or SP sample. However, it was a significant predictor in the TTM sample but not as strong of a predictor as shame. OCD was the only OCRD in which symptom severity was found to be a significant predictor of QOL.

4. Discussion

Our analyses supported several of the main hypotheses. Most importantly, shame was a stronger predictor of quality of life than symptom severity for all OCRDs, which may suggest that shame about symptoms plays a greater role in diminished quality of life than symptom severity. Overall, the findings suggest that many individuals with OCRDs may struggle with shame and a diminished quality of life and supports the conceptual review by Weingarden and Renshaw (2015) suggesting that shame is a critical concern within OCRDs.

Several other hypotheses were supported as well. Symmetry in OCD was significantly positively correlated with behavioral shame, even after controlling for gender and other OCD dimensions, which is consistent with previous literature (Ashby, Rice, & Martin, 2006; Calamari et al., 2006; Wetterneck et al., 2014). Building upon previous suggestions between the relationship between symmetry, perfectionism, and shame, individuals with symmetry issues may experience greater amounts of shame because they may hold themselves to higher, unachievable standards due to their perfectionistic tendencies. When unable to meet the
their obsessions and rituals to accommodators, and this openness may avert shame because they are not spending a great deal of time attempting to conceal symptoms. An interesting finding from this study was that, after controlling for gender, a significant relationship between contamination and character shame remained. It may be helpful for future research to examine this relationship further.

We also predicted that bodily, behavioral, and character shame would be related to TTM and SP severity. All hypothesized relationships were found with the exception of behavioral shame and TTM. Gender was found to be a significant predictor of greater quality of life in the regression analysis of the TTM sample with men reporting greater quality of life compared to women in the sample.

Contrary to our hypotheses, only OCD symptom severity, and not TTM or SP severity, was significantly correlated with quality of life. This may be due to the fact that the OCRDs have different phenomenological characteristics; in OCD obsessions are unwanted, cause distress, and compulsions reduced distress. In TTM and SP not all behaviors are related to distress (e.g., there is no awareness with habitual, compared to focused, pulling), and “compulsive” pulling or picking can lead to relief, pleasure, or gratification (Abramowitz & Jacoby, 2014). It is also possible that this distinction was observed due to the debilitating nature of OCD. The World Health Organization (WHO) has previously ranked it as one of the most disabling illnesses by lost income and decreased quality of life (World Health Organization. (WHO), 2008). Another possibility is the difference in how the severity measures assess symptoms. Most of the questions on the DOCS inquire about impairment, distress, avoidance, and difficulties with rationalizing or resisting, while the MGHHPS and SPS have

unachievable standards set for themselves, they may experience increased shame related to these perceived failures.

Contamination, accidental harm, and unacceptable thoughts were not correlated with behavioral or character shame. This may be because many individuals with OCD often seek out accommodators to assist with rituals (Lebowitz, Panza, Su, & Bloch, 2012). If participants were willing to ask others for help with rituals, it implies that their behavior is not a major source of shame. If participants asked for accommodations they are likely to explain

### Table 2
(a) Correlations between Symptom Severity, Shame, and Quality of Life.

<table>
<thead>
<tr>
<th></th>
<th>ESS Character Shame</th>
<th>ESS Behavioral Shame</th>
<th>ESS Bodily Shame</th>
<th>ESS Total Shame</th>
<th>Total WHOQOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCS Total (n = 152)</td>
<td>0.19</td>
<td>0.16</td>
<td>0.15</td>
<td>0.20</td>
<td>−0.32**</td>
</tr>
<tr>
<td>DOCS Contamination</td>
<td>0.16</td>
<td>0.11</td>
<td>0.04</td>
<td>0.12</td>
<td>−0.22*</td>
</tr>
<tr>
<td>DOCS Accidental Harm</td>
<td>0.11</td>
<td>0.10</td>
<td>0.12</td>
<td>0.13</td>
<td>−0.13</td>
</tr>
<tr>
<td>DOCS Unacceptable Thoughts</td>
<td>0.04</td>
<td>0.01</td>
<td>0.07</td>
<td>0.03</td>
<td>−0.27**</td>
</tr>
<tr>
<td>DOCS Symmetry</td>
<td>0.13</td>
<td>0.16</td>
<td>0.13</td>
<td>0.16</td>
<td>−0.19</td>
</tr>
<tr>
<td>MGHHPS (n = 248)</td>
<td>0.15</td>
<td>0.08</td>
<td>0.27*</td>
<td>0.18</td>
<td>−0.05</td>
</tr>
<tr>
<td>SPS (n = 142)</td>
<td>0.40</td>
<td>0.28</td>
<td>0.45</td>
<td>0.43</td>
<td>−0.14</td>
</tr>
</tbody>
</table>

(b) Correlations between Shame and Quality of Life by OCRD.

<table>
<thead>
<tr>
<th></th>
<th>ESS Character Shame</th>
<th>ESS Behavioral Shame</th>
<th>ESS Bodily Shame</th>
<th>ESS Total Shame</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHOQOL Total by Condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOCS Total</td>
<td>−0.40</td>
<td>−0.29</td>
<td>−0.45</td>
<td>−0.42</td>
</tr>
<tr>
<td>MGHHPS</td>
<td>−0.44</td>
<td>−0.27</td>
<td>−0.29</td>
<td>−0.43</td>
</tr>
<tr>
<td>SPS</td>
<td>−0.40</td>
<td>−0.28</td>
<td>−0.45</td>
<td>−0.43</td>
</tr>
</tbody>
</table>

Note: n = 542; DOCS: Dimensional Obsessive-Compulsive Scale. ESS: Experience of Shame Scale. WHOQOL-BREF: World Health Organization Quality of Life. MGHHPS: Massachusetts General Hospital Hairpulling Scale. SPS: Skin Picking Scale.

### Table 3
Partial Correlations Between OCD Dimensions and Quality of Life.

<table>
<thead>
<tr>
<th>Control Variables:</th>
<th>WHOQOL Total</th>
<th>Harm, Unacceptable Thoughts, and Symmetry</th>
<th>Contamination, Unacceptable Thoughts, &amp; Symmetry</th>
<th>Contamination, Harm, &amp; Unacceptable Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCS Contamination</td>
<td>−0.22**</td>
<td>−0.16*</td>
<td>0.04</td>
<td>−0.29**</td>
</tr>
<tr>
<td>DOCS Harm</td>
<td>−0.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOCS Unacceptable Thoughts</td>
<td>−0.27**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOCS Symmetry</td>
<td>−0.32**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: n = 152.

### Table 4
(a) Summary of Simple Linear Regressions Predicting Quality Of Life For Participants with OCD (n = 152).

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE (B)</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>4.05</td>
<td>3.24</td>
<td>0.13</td>
<td>1.80</td>
</tr>
<tr>
<td>DOCS Total</td>
<td>−0.33</td>
<td>0.09</td>
<td>−0.26</td>
<td>−3.57</td>
</tr>
<tr>
<td>ESS Total Shame</td>
<td>−0.33</td>
<td>0.06</td>
<td>−0.39</td>
<td>−5.24</td>
</tr>
</tbody>
</table>

(b) Summary of Simple Linear Regressions Predicting Quality of Life for Participants with TTM (n = 248).

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE (B)</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>5.61</td>
<td>2.47</td>
<td>0.14</td>
<td>2.27</td>
</tr>
<tr>
<td>MGHHPS</td>
<td>−0.05</td>
<td>0.13</td>
<td>−0.43</td>
<td>−0.38</td>
</tr>
<tr>
<td>ESS Total Shame</td>
<td>−0.36</td>
<td>0.05</td>
<td>−0.02</td>
<td>−7.26</td>
</tr>
</tbody>
</table>

(c) Summary of Simple Linear Regressions Predicting Quality of Life for Participants with SP (n = 142).

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE (B)</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2.92</td>
<td>3.12</td>
<td>0.08</td>
<td>0.94</td>
</tr>
<tr>
<td>SPS</td>
<td>−0.02</td>
<td>0.26</td>
<td>−0.01</td>
<td>−0.08</td>
</tr>
<tr>
<td>ESS Total Shame</td>
<td>−0.31</td>
<td>0.06</td>
<td>−0.41</td>
<td>−4.74</td>
</tr>
</tbody>
</table>

Note: DOCS: Dimensional Obsessive-Compulsive Scale. ESS: Experience of Shame Scale. MGHHPS: Massachusetts General Hospital Hairpulling Scale. SPS: Skin Picking Scale.

*p < 0.05,

**p < 0.01
only four and three questions (out of 7 or 6 respectively), that inquire about inability to control urges or pulling/picking and distress, while the other three questions ask about frequency and intensity of urges or pulling/picking. Finally, the role of shame in each condition may explain the difference.

4.1. Limitations

There are several limitations within the current study. The data were composed completely of self-report measures administered through an online survey. Despite the use of validated questionnaires, we did not obtain formal diagnoses. Also, the effects of the majority of findings were small. The self-report nature of the study is limited to the individual’s perception of the self and therefore may not be as accurate a representation as observational study might portray. Finally, although the data were checked for random or inattentive responding related to nature of online data collection, it is possible a participant could have responded inaccurately or without as much care if the study were administered in the presence of another human being, such as a research assistant or clinician.

4.2. Future Directions

While the magnitude of correlation between OCD severity and impairment was similar to a recent systematic review on this topic (McKnight, Monfort, Kashdan, Blalock, & Calton, 2016), a lot of variance in QOL remains unexplained for each condition. Therefore, if the goal of treatment is more than symptom reduction, additional techniques may be needed.

Clinicians should provide psychoeducation about shame and incorporate shame-reducing techniques into treatment to reduce such feelings and further improve quality of life (Weingarden & Renshaw, 2015). Although many clinicians may already address shame in treating OCRDs, research assessing an added focus on shame in CBT treatment is sparse (Spragg & Cahill, 2015). Future studies could examine whether shame decreases with successful symptom reduction during treatment and at follow ups, with or without specific techniques used to address shame-related behaviors and feelings.

It is also possible that the introduction of contextual behavior therapies (i.e., Acceptance Commitment Therapy, Dialectical Behavior Therapy, etc.) may be helpful in addressing shame within OCRDs (Weingarden & Renshaw, 2015). One suggestion for reducing shame in treating OCRDs, research assessing an added focus on shame in CBT treatment is sparse (Spragg & Cahill, 2015). Future studies could examine whether shame decreases with successful symptom reduction during treatment and at follow ups, with or without specific techniques used to address shame-related behaviors and feelings.

References


