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Attachment Orientation, Obsessive Beliefs, and Symptom Severity in Patients with Obsessive Compulsive Disorder

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The present study was aimed to determine the predictors of twelve symptom dimensions of Obsessive Compulsive Disorder (OCD). Following cross-sectional research design, 90 patients with OCD (Men = 43; Women = 47) were taken with the age range of 18-50 years through nonprobability purposive sampling technique. The assessment measures included Demographic Questionnaire, two subscales of Obsessive Compulsive Disorder Symptom Checklist (Jabeen, 2008), Screening Questionnaire for Psychiatric Disorders (Kausar, 2013), Urdu version of Revised Adult Attachment Scale (Kausar, 2014) and Obsessive Belief Questionnaire-44 (Obsessive Compulsive Cognitions Working Group, 2001). Results revealed that attachment anxiety and avoidance had nonsignificant relationship with OCD symptom dimensions. Moreover, obsessive beliefs of overimportance/ need to control thoughts and overresponsibility/overestimation of threat had significant positive relationship with sexual and blasphemous obsessions as well as control compulsions. Attachment avoidance and over importance/need to control thoughts belief emerged as significant predictors of sexual obsessions; whereas, blasphemous obsessions were only predicted by overimportance/need to control thoughts belief after controlling for gender, age of onset of OCD, duration of illness, and depression. Overresponsibility/overestimation of threat belief was significant predictor of control compulsion. Research findings may help cognitive therapists in identification of obsessive beliefs underlying specific symptom dimensions of OCD subsequently leading to improved treatment outcomes.

Keywords. Obsessive compulsive disorder, attachment anxiety, attachment avoidance, obsessive beliefs, symptom dimensions

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The Obsessive Compulsive Disorder (OCD) is considered a great burden to the individual, family, health services, and society as a whole. OCD is identified by either obsessions or compulsions, having one or both are enough for the diagnosis (Mikulincer & Florian, 1998). Both obsessional thoughts as well as compulsive rituals are time consuming and cause marked impairment in educational, social, occupational, and personal domains of one's life. According to recent estimates, the lifetime OCD prevalence rate in United States is 1.2% which is fairly consistent across the international sites (American Psychiatric Association [APA], 2013). Moreover, Gadit (2003) found 3% prevalence rate for OCD in fisherman community of Karachi, Pakistan. OCD is the fifth most common psychiatric disorder in Punjab, Pakistan (Jabeen, 2008).

As the prevalence of OCD is increasing; efforts have been made to explain its etiology to devise better treatment protocols. In this context, the relationship between maladaptive attachment patterns and the development of OCD has been a matter of interest for a long time. Attachment is an uninterrupted emotional bond between two individuals in which each party tries to seek proximity with the object of attachment. The aim of attachment system is to achieve a sense of security (Carpenter & Chung, 2011). Mikulincer and Shaver (2007) categorized attachment orientations in terms of two dimensions: Attachment anxiety and avoidance. *Attachment anxiety* shows the extent to which a person fears that support from significant others will not be available in difficult life conditions; whereas, *attachment avoidance* shows the degree to which a person does not trust good will of significant others and tries to be independent and emotionally distant from them. Mikulincer and Shaver (2007) also carried out extensive researches in the field of attachment patterns and proposed a model named activation and dynamics of the attachment systems.

The model comprised of three major components. First, in order to activate proximity seeking with attachment figures, events are monitored and appraised as threatening. Second, external or internal attachment figures are closely monitored and appraisals are developed in terms of their availability and individualized security based strategies are executed. Third, attachment figures are used to cope with stress and attachment insecurity. If attachment figures are perceived as caring, security based strategies are implemented. If attachment figures are perceived as distant, hyper-activating (attachment anxiety) and deactivating strategies (attachment avoidance) are used and subsequently, the likelihood of emotional and psychological problems as well as self-related doubts enhance (Mikulincer, Shaver, & Pereg, 2003).

Empirical evidence has indicated the role of attachment insecurities in predicting vulnerability to OCD. First, attachment insecurities have been linked with beliefs specific to OCD such as attachment anxiety is related with inflated threat appraisals (Mikulincer & Florian, 1998) and perceived difficulty in suppression of unwanted thoughts (Mikulincer, Dolev, & Shaver, 2004), whereas, avoidant attachment is linked with intolerance of uncertainty belief (Rice & Lopez, 2004). Second, attachment insecurities are found to be related with symptoms of OCD. Besides attachment insecurities, specific types of obsessive beliefs have been identified over a period of time predisposing the person to develop OCD (Doron, Moulding, Kyrios, Nedeljkovic, & Mikulincer, 2009).

Several cognitive behavioral theories (Rachman, 1998; Salkovskis, 1999) have posited that obsessive beliefs underlie the development and maintenance of OCD. Obsessive Compulsive Cognitions Working Group (OCCWG; 2001) has identified belief domains that are relevant to OCD including overimportance of thoughts; overestimation of threat; inflated sense of responsibility; excessive concern about the importance of controlling one's thoughts; intolerance of uncertainty; and perfectionism. Empirical evidence suggests that different dysfunctional cognitions are associated with different OCD symptom dimensions (Smith, Wetterneck, Hart, Short, & Bjorgvinsson, 2012; Wheaton, Abramowitz, Berman, Riemann, & Hale, 2010).

OCD has varied level of heterogeneity. In order to reduce heterogeneity of OCD, several researchers have tried to categorize OCD into different subtypes such as checkers, washers, hoarders, etc. and then their respective severity is assessed (O'Conner, 2005). Other categorization of OCD subtypes include (1) presence vs. absence of tics; (2) early vs. later onset of OCD; and (3) presence vs. absence of neurological or psychotic features (Albert, Maina, Ravizza, & Bogetto, 2002; Calamari, Cohen, Riemann, & Norberg, 2004). The purpose of categorization is to make homogenous groups as much as possible.

However, due to rare availability of mono-symptomatic patients; subdividing patients into such subtypes and generating sufficient sample size is problematic and impractical (O'Conner, 2005). Therefore, severity of different OCD symptom dimensions is best assessed through dimensional approach in current clinical and empirical settings. Several factor analytic studies (Mikulincer & Shaver, 2007; O'Conner, 2005) supporting multidimensional model of OCD suggested that four or five dimensions of OCD commonly appeared such as symmetry/ordering, hoarding, contamination/

cleaning, aggressive obsessions/checking, and sexual/religious obsessions. Dimensional approach of OCD implies that each patient can score on one or more symptom dimension and symptom severity for each dimension is independently assessed. The emphasis is paid on behaviors or symptoms, not on number of patients (Mataix-Cols, Rosario, Campos, & Leckman, 2005).

Thus, empirical findings have provided guidelines under the light of which one can speculate how attachment insecurities and obsessive beliefs are linked with different OCD symptom dimensions and their relative severity. Some evidence suggests that dysfunctional obsessive beliefs predispose the person to develop OCD symptomatology (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006; Tolin, Woods, & Abramowitz, 2003); whereas, other postulates that attachment insecurities make the person vulnerable to psychopathologies including OCD (Doron et al., 2009; Mikulincer & Shaver, 2007). However, there is inconsistent evidence regarding relationship of specific types of attachment styles and obsessive beliefs with different symptom dimensions of OCD; therefore, research is needed to establish that. In short, attachment styles and obsessive beliefs are important for understanding of the development and maintenance of OCD symptoms.

If the role of attachment insecurities and obsessive beliefs is established in the etiology of OCD through present study; it may persuade mental health practitioners to devise management strategies so that patients with OCD can interpret relationship experiences and intrusive thoughts/impulses/images in more rational terms rather than frightening ways. The present study can help identify specific attachment style and obsessive beliefs underlying different OCD symptom dimensions, which may call for the need of devising different management plans for patients with different OCD symptom dimensions.

Objectives of the present study are to examine the nature of relationship among attachment insecurities, obsessive beliefs, and twelve OCD symptom dimensions. It is also intended to examine the likelihood of each attachment insecurities and obsessive beliefs to predict symptom severity in terms of obsessions and compulsions symptom dimensions.

Hypotheses

1. Anxiety and avoidance are likely to have positive relationship with twelve OCD symptom dimensions (attachment insecurities).

2. There is likely a positive relationship between three types of obsessive beliefs: Overresponsibility/overestimation of threat, overimportance/need to control thoughts, and perfectionism/ intolerance of certainty and twelve OCD symptom dimensions.
3. Attachment insecurities and obsessive beliefs are likely to predict the twelve OCD symptom dimensions

Method

Research Design and Sample

Cross-sectional research design was used to select the sample of 90 patients diagnosed with OCD. Nonprobability purposive sampling strategy was used to select the patients with OCD. Sample size was determined by G-power analysis with medium size effect.

Table 1

Demographic Characteristics of Sample (N = 90)

Variables	*f (%)*	*M(SD)*
Age		28.56(8.48)
Gender		
Men	43(47.8)	
Women	47(52.0)	
Education (years)		10(4.93)
Employment		
Unemployed	30(33.3)	
Employed	26(28.9)	
*Housewife	27(30.0)	
Student	7(7.8)	
Religion		
Islam	87(96.7)	
Christianity	3(3.3)	
Marital Status		
Single	52(57.8)	
Married	38(42.2)	
Age of onset of OCD in years		22.66(7.44)
Duration of OCD in months		71.13(69.15)

Note. *House wife category applied to women only.

Patients with OCD, on an average, were in their late adulthood and had studied till matriculation. The sample had almost equal

representation of both genders. Most were Muslims, single, and unemployed or had low income on average employed. Their mean age at onset and total duration of OCD was 22 years and 71 months, respectively.

Inclusion criteria. The practicing clinical psychologists and psychiatrists working at different government hospitals of Lahore were requested to refer those cases whose principal diagnosis was OCD. Moreover, researchers also confirmed the diagnosis of OCD and comorbid psychopathology was ruled out through administration of Screening Questionnaire for Psychiatric Disorders (Kausar, 2013). However, patients were recruited regardless of their duration of illness and treatment. The sample included only those patients who were falling within the age range of 18-50 years and who could easily understand Urdu language.

Exclusion criteria. Patients with a current or past history of drug dependence or psychosis were excluded from the study (n = 2). Patients having co-morbid organic, neurological, and psychiatric illness other than OCD as the principal diagnosis were also excluded from the study.

Measures

Demographic Questionnaire. It was devised by the researchers to obtain demographic information of the patients with OCD such as age, gender, level of education, employment status, duration of illness, and age of onset of OCD, etc.

Revised Adult Attachment Scale (Collins & Reed, 1990). This scale assesses two types of attachment styles. In the present study, Urdu translation of this scale was used (Kausar, 2014). It has 18 statements and 2 subscales, that is, Attachment Anxiety (6 items) and Attachment Avoidance (12 items). All items are scored in the same direction except five items in the Attachment Avoidance Subscale are reverse scored. Each statement is scored on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores on subscale indicate attachment insecurity, whereas, low scores indicate attachment security. Cronbach alpha acquired for the subscales of Attachment Anxiety (.73) and Attachment Avoidance (.68) showed that scale was dependable measure of the related construct in current sample.

Obsessive Belief Questionnaire-44 (OBQ-44; OCCWG, 2001). It consists of 44 statements depicting domains of belief related to obsessive thinking. The questionnaire was translated in Urdu using

back translation. It has three subscales: Overresponsibility and Overestimation of Threat (RT; 16 items), Overimportance or Need to Control Thoughts (ICT; 12 items), and Perfectionism or Intolerance of Uncertainty (PC; 16 items). The level of agreement with each statement is scored on a 7-point Likert scale (1 = *disagree very much*; 4 = *Neutral*; 7 = *agree very much*). All items are scored in same direction and elevated scores show strength of beliefs. Alpha coefficients for RT (.88), PC (.86), and ICT (.80) were found in the moderate range for the present sample.

Obsessive Compulsive Disorder Symptom Checklist (Jabeen, 2008). This checklist is used to assess severity of obsessive compulsive symptom dimensions. Responses are rated on a 5-point Likert scale where 0 means *not at all* and 4 means *very much*. In present study, two subscales of this checklist were used: Obsessive and Compulsive Symptom Scale. Obsessive Symptom Scale has six dimensions: Contamination (11 items), Checking (3 items), Sexual Impulses and Images (3 items), Blasphemous/Religious Thoughts (3 items), Thought/Impulses of Harm (2 items), and Additional Obsessions (2 items). Compulsive Symptom Scale has five dimensions: Contamination Related Rituals (5 items), Checking General (4 items), Checking Safety (3 items), Controlling Compulsion (6 items), Orderliness (4 items), and Additional Compulsion (1 item). Higher scores indicate greater severity on particular symptom dimension. Alpha of .85 was achieved for Obsessive Symptoms Dimension and .83 for Compulsive Symptoms Dimension in the present study.

Screening Questionnaire for Psychiatric Disorders (Kausar, 2013). It was used to confirm the diagnosis of OCD and to rule out comorbid psychopathology. This questionnaire screens the patients for anxiety disorders: Panic Disorder; Phobia (specific and social); Post Traumatic Stress Disorder; Generalized Anxiety Disorder; OCD; and Major Depressive Disorder (MDD). It has two sections: First section is comprised of screening items for each above mentioned psychopathologies where responses are rated dichotomously (Yes/No). If the patient positively answers the questions then the second section of the questionnaire is administered for diagnostic clarity. Responses in second section are rated on 4-point Likert type scale ranging from 0-3 (0 = *Not at all* to 3 = *Very much*) and few questions are on dichotomous scale (Yes/No). First section had .69 Cronbach alpha value; whereas, only OCD and MDD Scales were administered from the second section as patients with OCD positively answered on their screening items. Alpha of .83 and .97 were acquired for OCD and MDD scales, respectively.

Procedure

The data for 90 patients with OCD were collected in 70 days from both outdoor and indoor Psychiatry departments of different government hospitals of Lahore, Pakistan such as, Services Hospital (n = 51), Mayo Hospital (n = 11), Ganga Ram Hospital (n = 8), Punjab Institute of Mental Health (n = 5), Jinnah Hospital (n = 6), and Consultancy Service Centre (n = 9) at Centre for Clinical Psychology, Punjab University, Lahore. Before data collection, written consent was obtained from the respective authorities and the information related to topic and sample characteristics were also provided to them. Patients diagnosed with OCD signed the written consent form and they were well informed about the purpose of the study and their right to withdraw from the research at any point.

Results

Statistical Package for Social Sciences (Version 21.0) was used to analyze the results. Pearson Product Moment Correlation Coefficient was run and results are explained in Table 2 which are related to the nature of relationship among attachment insecurities, obsessive beliefs, and OCD symptom dimensions. Table 3 and 4 presents results from Multiple Hierarchal Regression analyses to determine the predictors of twelve OCD symptom dimensions.

Results of screening showed that comorbidity with depression existed among 46 (51.1%) patients, while there was no comorbidity with depression among 44 (48.9%) patients.

Results presented in Table 2 indicated correlation matrix computed through Pearson Product Moment across attachment in securities, obsessive beliefs, and obsession and compulsion symptoms dimensions. The results in Table 2 show that none of the insecure attachment styles depicted significant relationship with any obsession and compulsion symptom dimension. However, patients diagnosed with OCD scoring high on ICT belief are more likely to have sexual and blasphemous obsessions. On the other hand, patients scoring high on RT and ICT beliefs are more governed by controlling compulsions. Rest of the obsession and compulsion symptoms dimensions do not have significant relationship with any of the obsessive beliefs (see Table 2).

Table 2

Correlation Matrix among Attachment Insecurities, Obsessive Beliefs, and Obsession and Compulsion Symptom Dimensions (N = 90)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. AA	-																
2. AV	.53***	-															
3. RT	.43***	.28**	-														
4. PC	.04	.02	.11	-													
5. ICT	.31***	.24**	.47***	.22*	-												
6. Obs.	.09	.08	.07	.05	-.08	-											
7. Com.	-.07	-.08	.20	.17	.09	.19	-										
8. Cont.	-.01	.17	.01	.02	.23*	-.27*	.20	-									
9. Che.	.04	.03	.02	-.08	.40***	-.29*	-.06	.33**	-								
10. SO	.04	-.03	.02	-.09	.13	.21	.25*	.21*	.18	-							
11. BO	.07	.08	.16	.03	.06	.08	.41***	.25*	.21*	.36**	-						
12. HO	-.06	-.09	.18	.06	.07	.12	.90***	.06	-.01	.12	.33**	-					
13. AO	.03	-.02	.14	.14	-.03	.19	.75***	.04	-.01	.22*	.37**	.75***	-				
14. CGC	.07	.12	.31***	.09	.27*	-.09	.08	.26*	.34*	.08	.06	.08	.09	-			
15. CSC	.01	.06	.06	.10	-.02	.88***	.20	-.10	-.19	.16	.11	.13	.16	-.15	-		
16. CC	.13	.01	.16	.08	.02	.26*	.69***	-.08	-.05	.19	.41***	.72***	.65***	-.07	.26**	-	
17. OC	-.02	-.01	.04	.05	.15	.11	.34**	.22	.21	.73***	.28*	.20	.31**	.25*	.13	.19	-

Note. AA = Attachment Anxiety; AV = Attachment Avoidance; RT = Over-Responsibility/Over-Estimation of Threat; PC = Perfectionism or Intolerance of Uncertainty; ICT = Over-Importance/Need to Control Thoughts; Obs. = Obsession; Com. = Compulsion; Cont. = Contamination; Che. = Checking; SO = Sexual Obsession; BO = Blasphemous Obsession; HO = Harm Obsession; AO = Additional Obsession; CGC = Checking General Compulsion; CSC = Checking Specific Compulsion; CC = Control Compulsion; OC = Orderliness Compulsion.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Predictors of OCD Symptom Dimensions

Multiple hierarchal linear regression analyses were performed to identify the predictors of OCD symptom dimensions. Six obsessions and six compulsion dimensions were entered as dependent variable separately. In Block 1, gender, age of onset of OCD, depression scores, and duration of illness were entered as control variables because previous empirical literature (Fullana et al., 2010; Labad et al., 2008) has shown that these variables are likely to increase the symptom severity of OCD dimensions. Therefore, their effects were controlled so that prediction could solely be attributed to the effects of attachment insecurities and obsessive beliefs. In block 2, both insecure attachment styles and three types of obsessive beliefs were entered simultaneously as independent variables. The assumption of independent errors and the other assumption of no perfect multicollinearity were met in all total twelve regression outputs.

Table 3

Hierarchal Linear Regression Analyses Predicting Obsession Symptom Dimension (N = 90)

Predictor	Contam.		Checking		Sexual		Blasphemous		Harm		Add	
	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β
Block 1	.05		.07		.21***		.05		.07		.02	
CV[a]												
Block 2	.03		.08		.11*		.22**		.03		.04	
AA		.01		-.19		-.16		.02		-.02		.02
AV		.10		-.04		.24*		-.09		-.01		.05
RT		.10		.23		-.06		-.17		-.02		.19
PC		.09		.14		-.13		-.20		-.11		.01
ICT		-.16		.03		.27*		.52***		.19		-.04
Total R^2	.08		.15		.31***		.27**		.11		.05	

Note. Contam. = Contamination; Add = Additional; CV = Control Variables; AA = Attachment Anxiety; AV = Attachment Avoidance; RT = Over Responsibility/ Overestimation of Threat; PC = Perfectionism/Intolerance of Uncertainty; ICT = Over Importance/Need to Control Thoughts.

[a]control variables included gender (men = 0; women = 1); age of onset of OCD; duration of illness; and depression scores.

*p < .05. **p < .01. ***p < .001.

Results from Table 3 depict that only sexual and blasphemous obsessions symptom dimensions are predicted by attachment (anxiety and avoidance) orientations and obsessive beliefs.

Table 3 show that in Block 1, control variables predict significantly for **sexual obsession**, R^2 = .21, $F(4, 85) = 5.58$, $p < .001$. In Block 2, by adding insecure attachment styles and obsessive beliefs, variance significantly increased up to 31% and model predicted the outcome of sexual obsessions $F(9, 80) = 4.05$, $p < .001$. Moreover, in Block 2, exclusion of the effects of control variables and retaining predictors such as insecure attachment styles and obsessive beliefs strongly predict the outcome of sexual obsession in patients $F(5, 80) = 2.45$, $p = .04$. The model shows that 11% of the variability in sexual obsessions is predicted by insecure attachment styles and obsessive beliefs together. Specifically, attachment avoidance and over importance/need to control thought (ICT) belief emerge as significant predictors of sexual obsession dimension.

In first Block, control variables do not significantly predict the outcome of **blasphemous obsession**, R^2= .05, $F(4, 85) = 1.15$, $p = .34$. In step 2, adding the effects of predictors such as insecure attachment styles and obsessive beliefs make the model significant $F(9, 80) = 3.23$, $p = .00$ and increase the variance up to 27%. Afterwards, when the effect of control variables were excluded from the model; remaining predictors still significantly predict blasphemous obsessions $F(5, 80) = 4.69$, $p = .00$. All predictors together contribute 22% of the variability in blasphemous obsessions. From all predictors, only ICT belief emerged as significant predictor of blasphemous obsession dimension.

Table 4

Hierarchal Linear Regression Analyses Predicting Compulsion Symptom Dimension (N = 90)

Predictor	Check (G)		Check (S)		Control		Contam.		Orderliness		Additional	
	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β
Block 1	.07		.06		.03		.04		.06		.04	
CV[a]												
Block 2	.04		.04		.14*		.02		.02		.04	
AA		-.16		-.04		-.25		-.01		.09		-.13
AV		-.03		-.04		.11		.09		-.05		.04
RT		.18		.14		.28*		.11		.11		.02
PC		.05		.16		.03		.09		.08		.01
ICT		.03		-.11		.18		-.11		-.06		.18
Total R^2	.12		.10		.17		.07		.08		.08	

Note. Check (G) = Checking (General); Check (S) = Checking (Safety); Contam = Contamination; CV = Control Variables; AA = Attachment Anxiety; AV = Attachment Avoidance; RT = Over Responsibility/Overestimation of Threat; PC = Perfectionism/Intolerance of Uncertainty; ICT = Over Importance/Need to Control Thoughts.

[a] = control variables included gender (men = 0; women = 1); age of onset of OCD; duration of illness; and depression scores

*$p < .05$. **$p < .01$. ***$p < .001$.

Results from Table 4 demonstrate that only control compulsion symptom dimension is predicted by attachment insecurities and obsessive beliefs.

In first block, control variables predict nonsignificantly for **control compulsion**, R^2= .03, $F(4, 85) = .72$, $p = .58$. Including attachment insecurities and obsessive beliefs in block 2 along with control variables explained 17% variability in control compulsion, but the model remain nonsignificant $F(9, 80) = 1.81$, $p = .08$. Moreover, when the effect of control variables is subtracted from block 2; remaining predictors explain 14% variance and the model significantly predict the outcome of control compulsion in patients, $F(5, 80) = 2.64$, $p = .03$. Overresponsibility/overestimation of threat (RT) belief emerged as significant predictor of control compulsions.

Discussion

The aim of the present study was to examine the etiological causes of OCD symptom dimensions from insecure attachment styles and obsessive beliefs.

Contrary to prediction, attachment anxiety or avoidance was not linked with OCD symptom dimensions. Different reasons can be accounted for this result. First, patients with OCD were recruited regardless of their duration of treatment. Though patients' early attachment experiences could be less nurturing, but development of illness and subsequent therapeutic interventions might have made parents restore a sense of attachment security to patients due to which relationship between attachment insecurities and OCD symptom dimensions might have become nonsignificant. Second, this finding support theories of Rachman (1998), and Wells and Matthews (1996) which do not consider attachment insecurities as vulnerability to OCD. This suggests that there must be other underlying factors, other than attachment insecurities, which pave the way for the development of this incapacitating illness.

Second hypothesis was partially supported as obsessive belief of ICT had significant positive relationship with only sexual and blasphemous obsessions as well as control compulsion, whereas, RT belief related significantly with only control compulsions. Empirical evidence suggests that there is an association between belief domains and OCD (Julien, O'Connor, & Aardema, 2007), while intrusive sexual and religious thoughts are linked with ICT beliefs (Smith et al., 2012). Control compulsion is majorly performed in response to sexual and blasphemous obsessions; therefore, it is quite likely that it is

linked with obsessive belief of ICT and RT in present study. Since the concept of God and sex is heavily laden with emotional, moral, and religious significance (Gordon, 2002); it could be well understood why only patients scoring high on dimensions of religious and sexual obsessions as well as control compulsions endorsed obsessive beliefs in this study.

Sexual obsessions were significantly predicted by attachment avoidance and obsessive belief of ICT suggesting that attachment avoidance as a pattern of interaction was more likely to be evident in patients with sexual obsessions. It may be argued that avoidance of seeking proximity in times of crisis is more prominent in patients whose content of obsessions are sexual in nature because of the fear of perceived rejection and embarrassment from attachment figures (Mikulincer & Shaver, 2007). On the other hand, patients who held ICT beliefs were more likely to have severe sexual obsessions. Myers, Fishers, and Wells (2008) have found positive association between sexual obsession dimension and ICT belief.

In present study, blasphemous obsessions were predicted by ICT belief reflecting that patients who held ICT belief were more likely to have severe blasphemous obsessions. Blasphemous thoughts/images are misinterpreted as likely to be true and important, therefore, efforts are made to control them (Myers et al., 2008; Wheaton et al., 2010). Though in Islam there exists a concept of *waswas* [insinuating whispers] suggesting that doubts/intrusive thoughts about religious beliefs/rituals are considered as invitation by Satan aimed to test faith and that they are merely whispers and imaginations which have no basis (Al-Issa & Qudji, 1998); but they are mostly considered as dangerous and a signal of apostasy. Therefore, owing to ICT belief; patients with OCD resist such intrusive thoughts and perform compulsive rituals which may maintain obsessive compulsive symptoms.

RT belief predicted the outcome of control compulsion in patients with OCD. Patients with OCD holding RT belief may think that they are personally responsible for having intrusive thoughts, images, and impulses and if they do not control them; they will be held responsible for subsequent damage; therefore, they are more likely to use control compulsion to uplift anxiety (OCCWG, 2001).

Alternative reasons can be accounted for the purpose of explaining current findings that only sexual and blasphemous obsessions as well as control compulsions were significantly predicted by proposed etiological factors. First, this may suggest that different etiological mechanisms underlie different OCD symptom dimensions

such as attachment insecurities and obsessive beliefs might play a causal role in only some types of OCD symptom dimensions (McKay et al., 2004). Second, dimensional approach was selected to minimize the difficulty of selecting a sufficient sample size for each OCD subtype. It can be assumed that most symptom dimensions, that is, contamination, checking, washing, and ordering etc. were not predicted by study variables because they were present in small proportion of patients with OCD in present study.

Limitations and Suggestions

In present study, patients with OCD were recruited without controlling duration of treatment. Attachment insecurities and obsessive beliefs are subjected to modification as a result of treatment, therefore, future studies need to be conducted while controlling this confounding. Moreover, future studies need to assess OCD symptom dimensions with some other measure to confirm reliability of present findings.

Conclusion and Implications

The present findings confirm heterogeneity of OCD as a disorder and attempt to highlight the etiological factors behind the development of OCD symptom dimensions. Attachment insecurities did not relate significantly with any of the OCD symptom dimension. However, after controlling for gender, age of onset of OCD, duration of illness, and depression, attachment avoidance predicted for sexual obsessions. On the other hand, obsessive belief of RT and ICT predicted for control compulsions as well as sexual and blasphemous obsessions.

Findings may help psychotherapists to examine whether targeting specific obsessive beliefs such as RT and ICT can lead to improved treatment outcome for patients with OCD. However, present findings may also indicate that not all OCD symptom dimensions require management plans for modification of dysfunctional obsessive beliefs. For example, keeping in view of current results, psychotherapists may need to employ cognitive restructuring techniques to modify ICT belief while treating patients holding blasphemous obsessions; whereas, patients with contamination obsessions may not benefit from cognitive restructuring. Since attachment insecurities were not related with OCD symptom dimensions; it poses a doubt on findings of those researches (Doron et al., 2012; Yarbro, Mahaffey, Abramowitz, &

Kashdan, 2013) which demand the incorporation of attachment related processes into theoretical and therapeutic models of OCD.

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