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Modeling Obsessive Beliefs Based on Parenting Styles and Inferential Confusion with the Mediating Role of Fear of Self

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ABSTRACT

Obsessive beliefs are among the most important cognitive components in explaining and maintaining obsessive–compulsive disorder (OCD) and are influenced by various cognitive, emotional, and environmental factors. The present study aimed to model obsessive beliefs based on parenting styles and inferential confusion with the mediating role of fear of self. This study employed a descriptive–correlational design using structural equation modeling. The statistical population included all patients diagnosed with OCD who referred to psychology and psychiatry clinics in Shiraz, whose diagnosis had been confirmed by psychiatrists and psychologists in 2024. A total of 130 participants were selected through convenience sampling and responded to the Obsessive Beliefs Questionnaire (OBQ-44), Inferential Confusion Questionnaire–Expanded (ICQ-E), Fear of Self scale, and Parenting Styles questionnaire. Data were analyzed using SPSS version 24 and AMOS version 26. Path analysis indicated that authoritarian and permissive parenting styles as well as inferential confusion directly predicted obsessive beliefs, and fear of self significantly mediated these relationships. These findings highlight that fear of self can either facilitate or intensify the impact of cognitive and environmental factors on the formation of obsessive beliefs. The results may be applied in designing cognitive–emotional interventions and in reconsidering parenting styles for the prevention and treatment of OCD.

Keywords: obsessive beliefs, parenting styles, inferential confusion, fear of self.

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Introduction

Obsessive–compulsive disorder (OCD) is a chronic and disabling psychological disorder characterized by the presence of intrusive thoughts, images, or impulses (obsessions) and repetitive behaviors or mental acts (compulsions) performed to reduce distress (1). Epidemiological research has consistently indicated that OCD affects a substantial proportion of the population, with lifetime prevalence rates ranging between 1% and 3% across cultures (2). The disorder is frequently associated with high comorbidity, functional impairment, and reduced quality of life, making it one of the most challenging psychiatric conditions to treat

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(3). Longitudinal studies suggest that, without adequate intervention, OCD often follows a chronic course, and residual symptoms persist even after treatment (4).

The development and persistence of OCD are best understood through cognitive–behavioral models, which highlight maladaptive beliefs and reasoning processes as central mechanisms (5). Among these cognitive constructs, obsessive beliefs such as inflated responsibility, perfectionism, overestimation of threat, and thought–action fusion play a pivotal role in shaping the clinical picture of OCD (6). These dysfunctional cognitions not only fuel compulsive rituals but also create a self-perpetuating cycle of fear, doubt, and intrusive thoughts (7). Recent studies emphasize that obsessive beliefs are not isolated but interact dynamically with reasoning errors, emotional vulnerability, and environmental influences (8, 9).

One of the most influential cognitive vulnerabilities underlying OCD is inferential confusion, which refers to reasoning errors where individuals give precedence to imagined possibilities rather than relying on sensory evidence (10). This process leads to mistrust in direct experience and reliance on hypothetical scenarios, thereby reinforcing obsessive doubts (11). The Inferential Confusion Questionnaire and subsequent empirical validations demonstrate that individuals with OCD exhibit higher levels of inferential confusion compared to healthy controls (12). Research indicates that inferential confusion is associated not only with obsessive beliefs but also with specific symptom dimensions such as checking and contamination fears (13). The interplay between inferential confusion and obsessive beliefs suggests a multidimensional vulnerability model in which reasoning errors amplify maladaptive cognitive schemas (14).

Experimental studies confirm that inferential confusion predicts the severity of obsessive beliefs and contributes to resistance against cognitive restructuring (15). Moreover, inferential confusion has been shown to operate through mediating mechanisms such as psychological distress, self-doubt, and maladaptive emotion regulation strategies (16, 17). In clinical contexts, inference-based therapy, specifically targeting inferential confusion, has yielded promising results in reducing obsessive symptoms and restructuring maladaptive reasoning patterns (18). These findings emphasize the centrality of inferential confusion in theoretical models of OCD and underscore the need to examine its interaction with other cognitive and environmental variables.

A more recent development in OCD research has been the concept of fear of self, defined as the perception that one possesses a dangerous or morally unacceptable potential self that may manifest in thoughts or actions (19). This concept extends beyond traditional models of obsessions, highlighting the existential dimension of intrusive thoughts. Fear of self is thought to exacerbate inferential confusion by increasing the salience of imagined threats and reinforcing distrust in one's own perceptions (15). Cross-cultural validation of the Fear of Self Questionnaire confirms its robust psychometric properties and its relevance across both clinical and non-clinical populations (14).

Studies suggest that fear of self acts as a mediator between inferential confusion and obsessive symptoms, strengthening the pathway through which reasoning errors translate into maladaptive behaviors (20). It also overlaps with self-doubt, which has been found to exacerbate reassurance-seeking behaviors and amplify compulsive rituals (21). Thus, integrating the construct of fear of self into OCD models provides a more nuanced understanding of how cognitive, emotional, and identity-based factors converge to maintain obsessive beliefs.

Beyond individual cognitive vulnerabilities, environmental and familial influences are crucial in the development of obsessive beliefs. Parenting styles, defined as consistent patterns of child-rearing practices, significantly contribute to shaping children's cognitive and emotional schemas (22). Authoritarian, overcontrolling, and inconsistent parenting styles have been linked to heightened perfectionism, fear of mistakes, and conditional self-worth, all of which are associated with obsessive tendencies (23). Comparative studies indicate that mothers of children with OCD tend to exhibit more authoritarian and anxious parenting styles compared to mothers of children with phobias or no clinical conditions (24).

The relationship between parenting styles and OCD symptoms has also been supported by structural modeling approaches, which show that perfectionism mediates this association (25). Such findings suggest that dysfunctional parenting not only contributes to the emergence of obsessive beliefs but also reinforces cognitive vulnerabilities such as inferential confusion and self-doubt. In fact, research on childhood trauma further indicates that adverse early experiences are significantly associated with obsessive beliefs, fear of self, and mental contamination (26). Together, these studies underscore the importance of environmental factors in OCD models, highlighting the need for interventions that address both cognitive and familial dynamics.

The global COVID-19 pandemic has provided a natural context for observing the interaction between environmental stressors and OCD symptomatology. Studies report that rates of contamination fears and compulsive washing increased significantly during the pandemic (27). Similarly, clinical reports highlighted that pre-existing OCD symptoms often worsened due to heightened uncertainty and health-related anxieties (28). These findings further support the cognitive–behavioral model by illustrating how external stressors can interact with maladaptive cognitions to exacerbate obsessive beliefs. They also emphasize th e relevance of examining resilience factors, such as adaptive parenting and healthy self-concepts, as potential buffers against symptom escalation.

Taken together, evidence suggests that OCD arises from a complex interplay of maladaptive cognitions, reasoning errors, self-related vulnerabilities, and environmental influences. Obsessive beliefs are consistently associated with both inferential confusion and fear of self (9, 13). Moreover, self-doubt has been identified as a crucial mediating mechanism linking early experiences, such as insecure attachment or childhood trauma, with obsessive symptoms (26, 29). Structural equation models have provided strong empirical support for these pathways, confirming that psychological distress and maladaptive metacognitions further strengthen these associations (16, 21).

Furthermore, inference-based therapy studies demonstrate that directly addressing inferential confusion can reduce both obsessive beliefs and compulsive behaviors (30, 31). Similarly, interventions targeting parenting practices and attachment styles have shown promise in modifying cognitive vulnerabilities and reducing symptom severity (15). The integration of these lines of evidence underscores the necessity of multifactorial models that consider both individual vul nerabilities and environmental contexts.

Despite the progress in understanding OCD, important gaps remain. Few studies have simultaneously examined the joint contribution of parenting styles, inferential confusion, and fear of self in predicting obsessive beliefs.

Methods and Materials

Study Design and Participants

The present study was descriptive, correlational, and based on structural equation modeling. The statistical population consisted of all individuals diagnosed with obsessive–compulsive disorder (OCD) who referred to psychology clinics and psychiatrists' offices in Shiraz, and whose OCD diagnosis had been confirmed by a physician. Determining the minimum sample size for collecting data related to structural equation modeling is highly important. According to Meers, Gamst, and Garino (2006), for each measured or predictor variable, at least 10 participants should be considered. Klein (2010) also argued that a minimum sample size of 200 participants can be defensible. Considering that the number of measured variables in this study, based on the questionnaires, amounted to 13, a sample of 130 participants was deemed sufficient. Inclusion criteria were an age range of 18 to 50 years, a minimum education level of junior high school, diagnosis of OCD by a psychiatrist, willingness to participate in the study, and complete response to all study questions. Failure to meet any of these criteria led to exclusion from the study.

The statistical population consisted of all patients referred to psychology clinics and psychiatrists' offices in Shiraz who had been clinically diagnosed with OCD by a psychiatrist or clinical psychologist. A total of 130 participants took part in the study. The questionnaires were administered in person at the treatment centers, and participants completed them after receiving necessary explanations and providing informed consent.

Data Collection

Obsessive Beliefs Questionnaire (OBQ-44): This questionnaire was developed by the Obsessive–Compulsive Cognitions Working Group in 2005 and evaluates pathogenicity in the cognitive domain. The questionnaire consists of 44 items rated on a seven-point Likert scale, with each item scored from 1 to 7. The original version includes the following subscales: responsibility for harm and injury, risk and threat estimation, perfectionism and need for certainty, and importance and control of thoughts. Outside Iran, Diedrich and colleagues adapted the German version of the OBQ from the English version. In their study, the reliability of the tool across three administrations ranged from .92 to .93 (Diedrich, Scharppke, Schwartz, & Schlegel, 2016). In Iran, the reliability of the Persian version was calculated using Cronbach's alpha, which yielded .91 for the total score (Shams et al., 2004). In the present study, Cronbach's alpha was .92.

Inferential Confusion Questionnaire–Expanded (ICQ-E): This unidimensional questionnaire includes 30 items and was developed by Aardema and colleagues in 2005. Items are rated on a six-point Likert scale ranging from strongly disagree (1) to strongly agree (6). The total score ranges from 30 to 180, with higher scores indicating greater inferential confusion. The purpose of the scale is to assess the tendency to neutralize reality and rely on subjective probability-based perceptions (Aguilar, Sorino, Ranserra, Barada, Aardema, & O'Connor, 2020). In Italy, Pozza and colleagues examined the psychometric properties of the questionnaire, and factor analysis confirmed its unidimensional structure. Cronbach's alpha reliability was reported as .97 (Pozza, Torini, & Dettore, 2018). In Iran, convergent validity was examined through correlation with the Padua Inventory (University of Washington version), yielding r = .43, while Cronbach's alpha reliability was reported as .92 (Ghorbali et al., 2018). In the present study, Cronbach's alpha was .96.

Fear of Self Questionnaire: This 20-item scale was designed by Aardema and colleagues (2013) to measure perceptions related to fear of self. Items are rated on a six-point scale ranging from 1 (strongly disagree) to 6 (strongly agree). The authors also validated an 8-item unidimensional version of the questionnaire in non-clinical populations in relation to obsessive dimensions. Factor analyses in Canada, Australia, and Italy demonstrated internal consistency (Cronbach's alpha = .89–.97), test–retest reliability (.89–.97), as well as satisfactory convergent and divergent validity (Aardema et al., 2018). In the present study, Cronbach's alpha was .93.

Parent–Child Relationship Questionnaire: This is an indigenous tool that evaluates 8 dimensions of the exogenous parent–child relationship pattern: rigidity, instability, control and restriction, overindulgence, formality, enmeshment, conditional value, and indifference–rejection. The questionnaire was developed by Bagheri in 2011, consisting of 48 items rated on a five-point Likert scale from strongly disagree (1) to strongly agree (5). Examination of its psychometric properties indicated a Cronbach's alpha of .96, with content and face validity confirmed by experts. Exploratory and confirmatory factor analyses demonstrated acceptable model fit (Bagheri, 2013). In another study, A'rabian and colleagues (2015) reported Cronbach's alpha of .90. In the present study, Cronbach's alpha was .94.

Data analysis

Data were analyzed using both descriptive and inferential statistics. In the descriptive section, indices such as mean, standard deviation, skewness, kurtosis, maximum and minimum scores, and Pearson's correlation coefficient were calculated. In the inferential section, to test the conceptual model of the study, structural equation modeling was employed. All statistical analyses were conducted using SPSS version 24 and AMOS version 26.

Findings and Results

Demographic information showed that 32 participants, equal to 24.6%, were in the age range of 18–23 years, 26 participants, equal to 20%, were in the age range of 24–29 years, 23 participants, equal to 17.7%, were in the age range of 30–35 years, 25 participants, equal to 19.9%, were in the age range of 36–41 years, and finally 24 participants, equal to 18.5%, were in the age range of 42–47 years. In terms of education, 19 participants, equal to 14.6%, had less than a high school diploma, 38 participants, equal to 29.2%, had a high school diploma, 4 participants, equal to 3.1%, had an associate degree, 47 participants, equal to 36.2%, had a bachelor's degree, 19 participants, equal to 14.6%, had a master's degree, and finally 3 participants, equal to 2.3%, had a doctoral degree. In terms of gender, 34 participants, equal to 26.2%, were male, and 96 participants, equal to 73.8%, were female. Regarding marital status, 75 participants, equal to 57.7%, were single, and 55 participants, equal to 42.3%, were married.

Before data analysis, skewness and kurtosis values were examined for the study variables, and all variables were within the acceptable range of -1 to +1, indicating the normal distribution of scores for the study variables. Accordingly, parametric tests were applied for data analysis.

Table 1. Correlation matrix among study variables

Variables	1	2	3	4
Fear of self	1			
Parenting styles	.33	1		
Inferential confusion	.60	.44	1	
Obsessive beliefs	.62	.48	.62	1

*p < .05; **p < .01*

The results of Pearson's correlation test indicated that there was a positive and significant relationship between parenting styles, inferential confusion, and fear of self with obsessive beliefs. In addition, the relationships among parenting styles, inferential confusion, and fear of self were positive. Before further analysis, the Kolmogorov–Smirnov test was used to examine the normality assumption. The results showed that when the significance level of the variables was greater than .05, the data could be considered normally distributed. As can be observed, all variables had significance levels greater than .05; thus, the null hypothesis of normal distribution was retained for all variables. Furthermore, to examine the multicollinearity assumption among predictor variables, tolerance and variance inflation factor (VIF) statistics were calculated. The results showed that the assumption of non-collinearity was met, as tolerance values were close to 1 and VIF values were below the critical threshold of 2, indicating no multicollinearity among the predictors. To investigate the presence of outliers, the Explore command in SPSS was used; the results revealed no outliers in any of the study variables.

Another estimated parameter was the total effects, obtained by combining direct and indirect effects. The comparison of direct, indirect, and total effects of variables is presented below.

Table 2. Direct, indirect, and total effects on obsessive beliefs

Variables	Direct Effect	Indirect Effect	Total Effect
Parenting styles	.23	.31	.30
Inferential confusion	.31	.39	.64
Fear of self	.37	–	.37

p < .01

The results of Table 2 show that the total effect of parenting styles on obsessive beliefs (.30) was higher than the direct effect of parenting styles on obsessive beliefs (.23). Similarly, the total effect of inferential confusion on obsessive beliefs (.64) was greater than the direct effect (.31).

Table 3. Fit indices of the final model

Index	χ^2/df	GFI	NFI	AGFI	TLI	CFI	RMSEA
Obtained	1.82	.93	.94	.98	.91	.98	.07
Acceptable	< 3	> .90	> .90	> .90	> .90	> .90	< .08

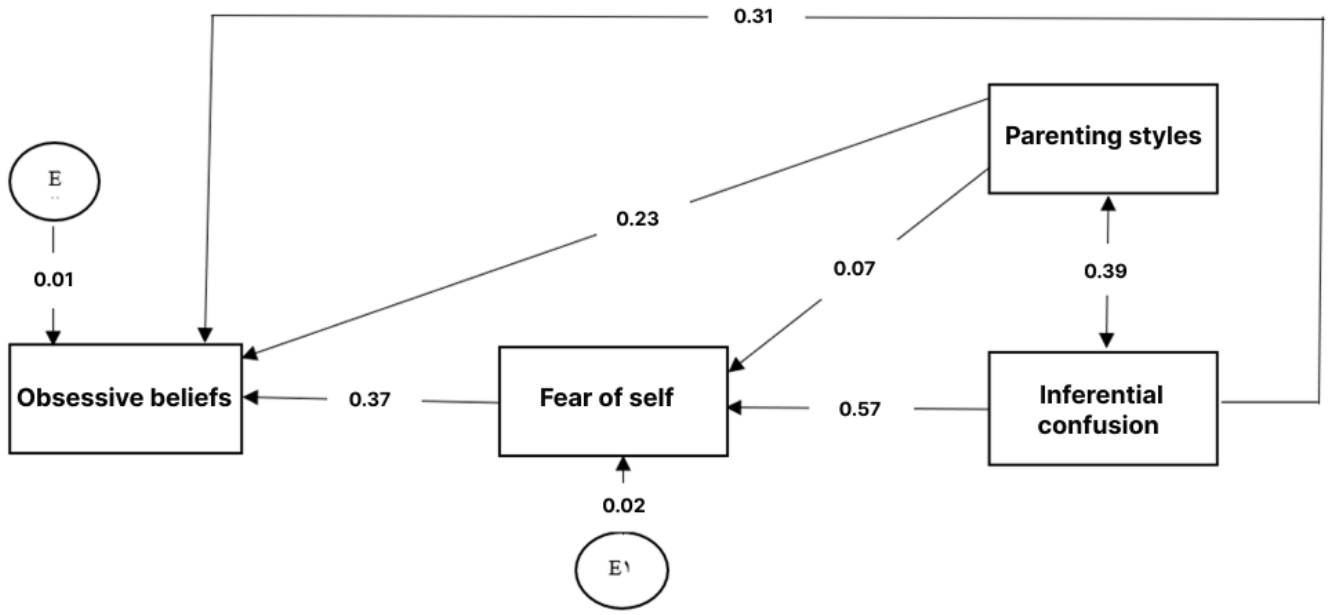

Figure 1. Model of obsessive beliefs based on parenting styles and inferential confusion with the mediating role of fear of self

To evaluate the model fit, several well-established indices were used, as presented in Table 3. The first index examined was the chi-square to degrees of freedom ratio (normed chi-square), which was 1.82, falling below the acceptable threshold of 3, indicating a good fit. The comparative fit index (CFI), which compares the specified model with the null model, was .93, above the recommended threshold of .90, showing a very good fit. The goodness-of-fit index (GFI), which represents the proportion of variance and covariance explained by the model, was .94, also above the .90 criterion, confirming model adequacy. The adjusted goodness-of-fit index (AGFI), which adjusts the GFI for sample size and degrees of freedom, was .98, very close to 1, further supporting model adequacy. The Tucker–Lewis index (TLI) was .91, above the .90 threshold, confirming a good fit. Finally, the root mean square error of approximation (RMSEA) was .07, below the cutoff value of .08, indicating that the model fit was acceptable.

Discussion and Conclusion

The present study aimed to model obsessive beliefs based on parenting styles and inferential confusion with the mediating role of fear of self. The findings revealed that authoritarian and permissive parenting styles, as well as inferential confusion, directly predicted obsessive beliefs. Furthermore, fear of self significantly mediated these relationships, thereby amplifying the role of both cognitive vulnerabilities and environmental influences in shaping obsessive beliefs. These results provide further empirical support for multidimensional models of obsessive–compulsive disorder (OCD) that integrate cognitive, emotional, and familial factors.

The significant association between parenting styles and obsessive beliefs underscores the influence of familial dynamics on the development of OCD-related cognitions. Prior studies have demonstrated that dysfunctional parenting, particularly authoritarian and inconsistent approaches, is linked to maladaptive

schemas such as perfectionism and conditional self-worth (22, 25). This aligns with evidence that authoritarian parenting fosters heightened standards and fear of mistakes, both of which are predictive of obsessive tendencies (24). The results of the current study echo these findings, showing that parenting practices exert both direct and indirect effects on obsessive beliefs through their influence on self-perceptions and inferential reasoning.

The role of inferential confusion as a predictor of obsessive beliefs also corroborates a large body of evidence pointing to its centrality in OCD models (10, 11). Inferential confusion involves reasoning errors whereby imagined possibilities override sensory evidence, generating persistent doubts about one's actions or safety (12). The results of this study confirmed that inferential confusion not only had a direct effect on obsessive beliefs but also exerted indirect effects via fear of self. This finding is consistent with research that highlights inferential confusion as a cognitive vulnerability that strengthens maladaptive belief systems and reinforces compulsive rituals (9, 13). Moreover, recent structural equation modeling studies demonstrate that inferential confusion operates through mediators such as psychological distress, self-doubt, and maladaptive metacognitions (16, 17), findings that align with the present results.

The mediating role of fear of self observed in this study provides further insight into the mechanisms linking parenting styles and inferential confusion with obsessive beliefs. Fear of self, conceptualized as the perception of possessing an unacceptable or dangerous potential identity, has been shown to exacerbate reasoning errors and amplify obsessive concerns (15, 19). In this study, fear of self significantly mediated the relationship between cognitive and environmental variables and obsessive beliefs, suggesting that self-perceptions may act as a gateway through which maladaptive cognitions and familial influences manifest as obsessive symptoms. This is consistent with findings that fear of self interacts with self-doubt and reassurance-seeking to maintain OCD-related symptoms (20, 29). Validation studies also confirm that fear of self is a robust construct across different cultures, highlighting its relevance as a transdiagnostic mechanism (14).

The overall model fit obtained in the present study supports the robustness of the hypothesized relationships. Fit indices indicated that the integrated model successfully explained the interaction between parenting styles, inferential confusion, fear of self, and obsessive beliefs. These results echo prior structural models, which also identified inferential confusion and maladaptive self-perceptions as mediators between environmental stressors and obsessive symptoms (21, 26). Collectively, the findings provide strong evidence for adopting a multifactorial model that accounts for the simultaneous influence of cognitive errors, emotional vulnerabilities, and environmental contexts.

From a theoretical perspective, these findings reinforce cognitive models of OCD, which argue that dysfunctional beliefs and reasoning processes are central to symptom persistence (5, 6). The integration of fear of self into this framework extends traditional models by emphasizing identity-based vulnerabilities as mediators of obsessive beliefs (19). The current study thus supports a multidimensional understanding of OCD that goes beyond isolated cognitive constructs.

Clinically, the results highlight the importance of addressing both reasoning errors and self-related perceptions in intervention strategies. Inference-based therapy, which specifically targets inferential confusion, has been shown to effectively reduce obsessive beliefs and compulsive behaviors (18, 30, 31). Likewise, therapeutic approaches that focus on modifying fear of self—such as self-compassion and identity-

based interventions—may reduce the intensity of obsessive concerns (15). Parenting-based interventions, particularly those aimed at reducing authoritarian and inconsistent parenting styles, may also serve as preventive strategies by reducing the environmental reinforcement of maladaptive beliefs (23, 25).

The findings also resonate with recent research on the exacerbation of OCD during external stressors such as the COVID-19 pandemic. Studies have shown that contamination fears and compulsive behaviors increased during the pandemic, highlighting the role of environmental stress in magnifying obsessive beliefs (27, 28). These results parallel the present study by showing how external contexts can interact with cognitive vulnerabilities such as inferential confusion and fear of self, leading to increased symptom severity. Additionally, research suggests that dysfunctional parenting and childhood trauma contribute to heightened vulnerability under stressful conditions (26).

Finally, the present results also align with epidemiological evidence showing that OCD is a widespread and chronic condition across diverse populations (1, 2). The chronicity and resistance to treatment observed in OCD are likely due to the interplay of multiple vulnerabilities, including obsessive beliefs, inferential confusion, fear of self, and environmental influences. The integration of these findings within a single model, as presented here, provides a more comprehensive framework for understanding the persistence of OCD and the challenges associated with its treatment.

Despite its contributions, this study is not without limitations. First, the cross-sectional design restricts causal inferences, and longitudinal studies are needed to establish the temporal sequence of relationships among parenting styles, inferential confusion, fear of self, and obsessive beliefs. Second, the sample size, while sufficient for structural equation modeling, was relatively modest, and larger samples would enhance the generalizability of the results. Third, the reliance on self-report measures may have introduced response biases, such as social desirability or underreporting of symptoms. Additionally, the sample was drawn from a single city, which may limit the applicability of the findings to broader cultural contexts. Future research should aim to address these limitations to strengthen the validity of the conclusions.

Future studies should employ longitudinal and experimental designs to clarify causal pathways between parenting styles, inferential confusion, fear of self, and obsessive beliefs. Cross-cultural research is also warranted to examine the universality of these relationships in different sociocultural settings, given that parenting practices and self-concepts vary across cultures. It would also be beneficial to integrate biological measures, such as neuroimaging and genetic markers, to explore how cognitive and environmental factors interact with neurobiological vulnerabilities in OCD. Finally, intervention-based studies should test the effectiveness of combining inference-based therapy with parenting-focused interventions and self-concept enhancement strategies to reduce obsessive beliefs more effectively.

The findings of this study suggest several practical implications. Clinicians should assess not only cognitive vulnerabilities such as inferential confusion but also self-related constructs like fear of self when designing treatment plans for OCD. Psychoeducational programs for parents could help reduce authoritarian and inconsistent parenting styles, thereby mitigating the environmental reinforcement of maladaptive beliefs. Preventive interventions in schools and communities could also target self-doubt and perfectionism as early risk factors. Ultimately, a multifaceted approach that combines cognitive, emotional, and familial interventions may yield the most effective outcomes for individuals struggling with OCD.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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