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Associations between rumination and obsessive-compulsive symptom dimensions

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ABSTRACT

In recent years there has been increased interest in understanding cognitive processes that play a role in the pathogenesis of obsessive-compulsive disorder (OCD). One cognitive factor that has received little attention is rumination. Rumination, defined as the tendency to repetitively analyze ones problems and feelings of distress, has been implicated in the development and maintenance of several mood and anxiety-related disorders. Thus, the primary aim of the current study was to examine the role of rumination in OCD symptoms using an unselected treatment-seeking sample ($N = 105$). Multiple regression analyses revealed a significant association between rumination and the unacceptable thoughts/neutralizing domain of OCD. These findings remained significant even after accounting for a relevant and related construct, in particular negative affect. These findings support a growing body of literature establishing rumination as a transdiagnostic risk factor. Further clinical and experimental research is needed to confirm these findings and expand our knowledge of metacognitive models of OCD.

1. Introduction

Obsessive-compulsive disorder (OCD) is a psychiatric condition characterized by recurrent and persistent unwanted thoughts or images (i.e., obsessions) that bring about distress and/or impairment, as well as repetitive behaviors (i.e., compulsions) aimed at reducing or neutralizing the associated anxiety (American Psychiatric Association, 2013). OCD is estimated to affect around 2–3% of the population (Kessler et al., 2005) and has been associated with diminished quality of life as well as substantial impairment in social, occupational, and familial domains (Torres et al., 2006). Although the specific content of obsessions and compulsions may vary by individual, recent research on the multidimensional structure of OCD has identified four common symptom dimensions. These include: 1) contamination obsessions/washing compulsions, 2) responsibility for harm obsessions/checking compulsions, 3) unacceptable thoughts (sexual, religious, or violent in nature)/neutralizing or re-assurance seeking compulsions, and 4) symmetry, completeness, or ordering obsessions/arranging compulsions (Abramowitz et al., 2010).

According to cognitive models of OCD, obsessions arise from unwanted intrusive thoughts or images followed by an appraisal of these thoughts as important, unacceptable, or as posing a threat for which the person is responsible (Abramowitz, Taylor, & McKay, 2009). While 80 to 90% of the general population experience intrusions, similar in form and content to those with OCD (Belloch, Morillo, Lucero, Cabedo, & Carrió, 2004), the misinterpretation of these otherwise normal intrusions are thought to play a key role in the pathogenesis of obsessions. Thus, research has attempted to understand cognitive processes that may underlie dysfunctional beliefs and appraisals (Raines, Oglesby, Capron, & Schmidt, 2014; Sarawgi, Oglesby, & Cougle, 2013). Whereas the metacognitive model of OCD proposes perseverative thinking such as rumination as one such factor (Wells, 2013), little research has examined the role of this cognitive construct in relation to obsessive-compulsive (OC) symptoms.

Rumination is defined as the tendency to repetitively and passively analyze ones problems, concerns, and feelings of distress without taking action to make positive changes (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Watkins, 2008). A ruminative thinking style (RTS) has been found to predict the severity and length of major depressive episodes (Just & Alloy, 1997), and most recently has been studied as a transdiagnostic maintenance factor within various anxiety disorders including generalized anxiety disorder, posttraumatic stress disorder, and social anxiety disorder (Abbott & Rapee, 2004; Ehlers & Clark, 2000; Fresco, Frankel, Mennin, Turk, & Heimberg, 2002). Across these disorders, rumination is thought to increase negative maladaptive thoughts, lead to the use of other maladaptive emotion regulation strategies, and lower problem solving abilities (Lyubomirsky, Kasri, Chang, & Chung, 2006; Lyubomirsky & Nolen-Hoeksema, 1993).

At first glance, rumination and obsessions may appear indistinct. Indeed, they both involve similar cognitive processes characterized by repetitiveness, intrusiveness, and uncontrollability. However, obsessions are largely intrusive and unwanted (American Psychiatric Association, 2013) whereas rumination is a mode of responding to distress that

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involves repetitively focusing the causes and consequences of symptoms (Nolen-Hoeksema et al., 2008). We believe rumination may exacerbate OC symptoms, in particular obsessional symptoms. Existing models of obsessional symptoms posit that obsessions arise via misappraisals of naturally occurring intrusive thoughts as especially important or meaningful (Abramowitz et al., 2009; Purdon, 2008). The obsessions are hypothesized to persist in the context of continued misinterpretations and subsequent attempts to control or suppress the thoughts (Rachman, 1997). It is possible that ruminating about intrusive thoughts may lead to more internal negative appraisals of naturally occurring intrusive thoughts. That is, OCD patients may be more likely to attempt to understand the causes and consequences of their recurrent intrusions subsequently leading to more intrusive thoughts and distress. Consistent with this conceptualization, Freeston and Ladouceur (1997) found that OCD patients were more likely to use ruminative strategies such as over analyzing the nature and implications of their obsessive thoughts as a way to cope with the distress brought on by these unwanted cognitions. Thus, just as rumination exacerbates distress and interferes with effective problem solving abilities in individuals with depression (Nolen-Hoeksema, 2000), rumination may also amplify the distress brought on by the unwanted cognitive intrusions experienced in the context of OCD.

Despite suggested associations, only two studies to date have examined the relationship between a ruminative response style and OCD. Using a sample of 116 patients with unipolar mood disorders, Watkins (2009) found that the brooding aspect of rumination was significantly associated with OCD status. Wahl, Ertle, Bohne, Zurowski, and Kordon (2011) extended this research by examining the associations between rumination and OCD symptom dimensions utilizing two independent, non-clinical student samples. In both samples, the authors found a significant association between students' tendency to ruminate and the severity of OC symptoms, particularly obsessive rumination. These findings held even after controlling for overall levels of depression, suggesting this relationship is not merely due to co-occurring depressive symptoms. The authors concluded that a ruminative response style and obsessive rumination may share common processual properties.

While informative, several limitations of this literature warrant further investigation. First, Wahl et al. (2011) utilized a non-clinical undergraduate sample. Although previous literature suggests OC symptoms occur on a continuum and have their origin in largely normal human processes (Gibbs, 1996), results may be exclusive to individuals on the non-clinical end of this continuum. Second, whereas Watkins (2009) sample was clinical in nature, all participants met criteria for a unipolar mood disorder. Considering the robust relationship between rumination and depression (Nolen-Hoeksema et al., 2008), it is important to examine these associations in samples not primarily comprised of depressed patients.

A third limitation of the previous literature includes the use of the Padua Inventory, Revised (PI-R; German version by Emmelkamp & Van Oppen, 2000; Van Oppen, Hoekstra, & Emmelkamp, 1995) to assess OC symptoms. It has been argued that measurement of OC symptoms using the PI-R is not ideal due to an underrepresentation of certain OC dimensions and an overrepresentation of others (Abramowitz et al., 2010). More specifically, the PI-R is comprised of an abundance of items related to obsessions about harm, but no items related to symmetry concerns and few assessing items related to unacceptable thoughts. This inconsistency of item content limits the ability to identify potential relationships between rumination and certain OC symptom dimensions.

Thus, the current study sought to extend the findings of Watkins (2009) and Wahl et al. (2011) by examining the associations between rumination and OC symptoms within a non-selected clinical sample using the Dimensional Obsessive Compulsive Scale (DOCS; Abramowitz et al., 2010), which was designed to capture the most commonly replicated OC symptom dimensions while also 1) taking into account various parameters of impairment/distress, 2) assessing for avoidance related behaviors, and 3) assessing for obsessions and compulsions equally across dimensions. To control for the possibility that the associations among RTS and OC dimensions may better be accounted for by an underlying depressive or anxiety temperament, we also controlled for overall levels of negative affect (NA). Based on extant literature identifying rumination as a potentially important transdiagnostic process that contributes to a number of anxiety and mood-related disorders (Abbott & Rapee, 2004; Ehlers & Clark, 2000; Fresco et al., 2002), we hypothesized that frequent RTS would be associated with increased OC symptoms above and beyond the effects of NA. In particular, consistent with the findings of Wahl et al. (2011), we predicted an association between RTS and the unacceptable thoughts and neutralizing compulsions domain of OCD.

2. Methods

2.1. Participants and procedures

The sample consisted of 105 individuals receiving outpatient psychological services and/or participating in research at the Florida State University (FSU) Anxiety and Behavioral Health Clinic (ABHC). The ABHC primarily serves individuals from the local community, though individuals suffering from psychotic and/or bipolar-spectrum disorders or those who are an immediate danger to themselves or others are referred for services elsewhere. Participants were primarily female (61%), ranging in age from 18 to 67 ($M = 31.54$, $SD = 14.38$). The self-identified racial breakdown was as follows: 59% Caucasian, 22.9% African American or Black, 1.9% Asian or Asian American, and 16.2% as other (e.g., bi-racial). Of the total sample, 15.2% identified as Hispanic. In terms of primary diagnoses 45% of the sample met for a primary anxiety disorder, 21% a primary depressive disorder, 20% a primary trauma- and stressor-related disorder, 4% a primary obsessive-compulsive and related disorder, 2% a primary substance use disorder, and 8% no primary diagnosis. Finally, 6% of the sample met for an OCD diagnosis regardless of whether it was the primary diagnosis.

All individuals in the current sample provided informed consent to participate in the Institutional Review Board approved research being conducted at the FSU ABHC. Diagnoses were determined by a structured diagnostic interview and were later confirmed at weekly supervision meetings with the director of the ABHC and a licensed clinical psychologist. After the diagnostic interview participants completed a battery of questionnaires, including the DOCS, RRS, and NA subscale of the PANAS.

2.2. Materials

2.2.1. Structured Clinical Interview for the DSM-5 (SCID)

The SCID is a widely administered and well-validated semi-structured interview designed to assess for the presence of current and lifetime psychiatric conditions (First, Williams, Karg, & Spitzer, 2015). The SCID was administered by highly trained, advanced clinical psychology doctoral students. Training included review of SCID training tapes, live observation of SCID administration, and conducting SCID interviews with a trained interviewer. Feedback was provided to the trainee until high reliability was demonstrated. Additionally, all SCIDs were presented to and reviewed by the director of the ABHC and a licensed clinical psychologist. In the present study the rate of agreement was over 80% with a kappa value of 0.77 (Timpano & Schmidt, 2012). The SCID was administered upon intake to assess for potential psychiatric diagnoses including OCD.

2.2.2. Dimensional Obsessive-Compulsive Scale (DOCS)

The DOCS is a 20-item self-report measure designed to assess the severity of the most reliably found OCD symptom dimensions: contamination, responsibility for harm and mistakes, symmetry/ordering, and unacceptable thoughts (Abramowitz et al., 2010). Respondents rated each item on a 5-point Likert-type scale with higher scores indicating greater severity. The DOCS demonstrates excellent psychometric properties and has been validated in both clinical and non-clinical samples