



## Review

# The relationship between responsibility beliefs and symptoms and processes in obsessive compulsive disorder: A systematic review



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## ABSTRACT

**Background:** Cognitive models of Obsessive Compulsive Disorder (OCD) suggest that responsibility appraisals contribute to the aetiology and maintenance of OCD symptoms. An accumulating body of evidence supports this notion, and preliminary data indicates that modifying responsibility appraisals in treatment can be beneficial in reducing obsessive-compulsive symptomatology in individuals with OCD. This systematic review aims to evaluate the existing experimental research on the effect of responsibility on symptoms and processes in OCD across both adult and paediatric samples.

**Method:** The following databases were searched: PsycInfo, Medline, and Web of Science. Articles were limited to peer-reviewed, English language papers that examined the effect of responsibility on at least one behavioural measure related to OCD, during an experimental manipulation. Risk of bias and study results were reviewed for each study.

**Results:** In the 16 studies that met inclusion criteria, the responsibility manipulation had a consistently adverse effect on responsibility and threat appraisals, and an inconsistent effect on self and observer-rated variables. Effects of responsibility were generally not significantly greater for OCD participants.

**Conclusions:** Further research is warranted to determine the precise role of responsibility and other cognitive appraisals (e.g., threat appraisals) for both clinical and non-clinical individuals.

## 1. Introduction

Individuals presenting with Obsessive Compulsive Disorder (OCD) report recurrent and persistent obsessional thoughts, images, or impulses that are experienced as intrusive and inappropriate (DSM-5, American Psychiatric Association [APA], 2013). These obsessions are typically accompanied by repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting) aimed at preventing or reducing distress and feared negative outcomes (APA, 2013). These obsessions and compulsive behaviours cause marked anxiety or distress, are time consuming, and interfere significantly with everyday functioning (e.g., occupational, academic, social, relationship domains). Lifetime and 12-month prevalence estimates for OCD have been reported at 2.3% and 1.2% respectively (Ruscio, Stein, Chiu, & Kessler, 2010), and OCD has been placed amongst the top 20 disorders causing significant disability among 18–44 year-olds (World Health Organization, 2001). Moreover, research suggests that OCD in children and adolescents is similar in presentation to OCD in adults (March & Leonard, 1996) and is associated with severe impairment in children's academic, social and family functioning (Piacentini,

Bergman, Keller, & McCracken, 2003). Prevalence rates for OCD in young people range from 0.1% to 4% (Heyman et al., 2001), with varying rates across age groups, indicating that prevalence may increase with age (Douglass, Moffitt, Dar, McGee, & Silva, 1995).

Research has shown that the occurrence of intrusive thoughts alone is not sufficient to understand OCD, as up to 90% of non-clinical adults experience unwanted, intrusive thoughts, images or impulses that they find difficult to control (Julien, O'Connor, & Aardema, 2007). Rather, cognitive models of OCD propose that it is the interpretation of the content and presence of intrusive thoughts that determines whether such thoughts become obsessions resulting in marked anxiety and distress and related neutralising behaviours (Julien et al., 2007). This idea is common to various cognitive models of OCD (e.g., Obsessive Compulsive Cognitions Working Group [OCCWG], 1997; Rachman, 1993; Wells & Papageorgiou, 1998), which argue that an individual's appraisal of their obsessional thoughts and their response to such thoughts contribute to the aetiology and maintenance of OCD symptoms. Moreover, these models agree that the distress associated with intrusive thoughts and accompanying appraisals triggers anxiety and subsequent compulsive behaviours. However, each model implicates

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differing sets of beliefs and cognitive processes in the development and maintenance of OCD, such as inflated responsibility (Salkovskis, 1999), meta-cognitive beliefs (Wells & Papageorgiou, 1998), and thought-action fusion (TAF; Rachman, 1993).

The appraisal model of OCD (OCCWG, 1997) identifies six key belief domains that contribute to OCD symptomatology. These include inflated responsibility, threat estimation, perfectionism, intolerance of uncertainty, overimportance of thoughts, and a need to control thoughts (OCCWG, 1997). In this model, each cognitive domain is described as being of fundamental importance in the escalation of intrusive thoughts into obsessions and is associated with heightened anxiety and neutralising behaviours (Julien et al., 2007). Of these six cognitive domains, it is evident that a substantial body of research has focused on exploring the role of responsibility appraisals in OCD, which has been specifically defined as: “The belief that one has the power, which is pivotal to bring about or prevent subjectively crucial negative outcomes” (OCCWG, 1997, p. 669). Originally proposed by Salkovskis, (1985, 1989), the model asserts that inflated responsibility is central to OCD, whereby intrusive thoughts are interpreted to indicate personal responsibility for harm occurring to oneself or others. Appraising thoughts as indicative of harm increases discomfort and distress, resulting in attempts to reduce or neutralise the intrusion and associated anxiety. As such, compulsive behaviours are triggered in an attempt to minimise the likelihood of harm occurring and to reduce the associated anxiety (Salkovskis, Richards, & Forrester, 1995). Importantly, this model assigns a causal role to responsibility in the development and maintenance of OCD, such that when people with OCD are placed in a situation where they feel personal responsibility for preventing potential threat, they will engage in various repetitive behaviours to reduce the risk of the perceived negative outcome, more so than people without OCD (Rachman, 2002). Further, Salkovskis, (1985, 1989) has suggested that treatment of OCD should proceed from an understanding of the meaning that OCD patients attach to their intrusive thoughts, and as such, should include a component addressing inflated responsibility appraisals. The importance of targeting inflated responsibility biases during treatment for both adults and young people has been emphasised in a number of studies (e.g., Rees, 2009; Williams, Salkovskis, Forrester, & Allsopp, 2002).

The large majority of studies showing support for an inflated responsibility bias in adults with OCD are correlational, and report significant positive associations between responsibility and obsessive-compulsive (OC) behaviours. For example, several studies have found that individuals with OCD score significantly higher on measures of responsibility beliefs than individuals without OCD symptoms (see Pozza & Dèttore, 2014b for a review). Moreover, higher scores on attitudes about responsibility are associated with higher levels of OC symptoms (e.g., neutralising behaviours), and these associations have been shown in studies comparing OCD patients to control participants (e.g., Niemeyer, Moritz, & Pietrowsky, 2013; Steketee, Frost, & Cohen, 1998), as well as studies using non-clinical participants (e.g., Parrish & Radomsky, 2011; Rhéaume & Freeston MH, 1995; Wilson & Chambless, 1999). For example, Parrish and Radomsky (2011) and Wilson and Chambless (1999) found that higher levels of OC symptoms were significantly associated with inflated responsibility beliefs in non-clinical adults. Further, some studies have found that this responsibility bias is specific to OCD, especially with respect to checking compulsions, and thus may not be characteristic of anxiety disorders in general (e.g., Foa, Amir, Bogert, Molnar, & Przeworski, 2001; Steketee et al., 1998), although this is a less reliable finding with inconclusive support (see Pozza & Dèttore, 2014a for a review). While demonstrating an association between responsibility beliefs and OCD symptoms, correlational research proves problematic for relevant cognitive models in asserting that responsibility is a specific and pivotal causal factor in the development and expansion of compulsive behaviour in OCD patients.

Similarly, research exploring the role of responsibility in OCD

among children and adolescents is based mostly on correlational studies, preventing causal inferences on the role of responsibility in paediatric OCD from being made. Within these studies, support has been shown for an inflated responsibility bias in OCD using both clinical and non-clinical samples. For example, Magnúsdóttir and Smári (2004) and Matthews, Reynolds, and Derisley (2007) found that responsibility beliefs significantly predicted OC symptoms in non-clinical children and adolescents. When comparing groups, Barrett and Healy (2003) found significantly higher responsibility ratings for OCD compared to non-clinical, but not anxious, children; while Libby, Reynolds, Derisley, and Clark (2004) found significantly higher responsibility scores for young people with OCD compared to both non-clinical and anxious control groups. Additionally, some researchers have hypothesised that responsibility appraisals may be impacted by developmental differences, given findings showing that children with OCD report significantly less responsibility biases than adolescents and adults with OCD, who do not differ from each other (Farrell & Barrett, 2006; Pişgin & Özen, 2010). This was further supported in a recent meta-analysis which found that responsibility was more strongly related to OCD symptoms in adult than in child or adolescent samples (Pozza & Dèttore, 2014a). Given such findings, and the fact that 50–80% of adults with OCD identify the onset of their symptoms before the age of 18 years (Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995), experimental research investigating responsibility beliefs with a developmental focus is clearly warranted. However, research focusing on assessing the impact of responsibility beliefs on anxiety and behavioural symptoms associated with OCD utilising an experimental design is lacking, for both adult and child samples.

While most studies have been correlational, a number of studies have assessed the role of responsibility beliefs on OCD symptoms with an experimental design. For example, Arntz, Voncken, and Goosen (2007) tested the causal status of responsibility in OCD by conducting an experiment in which responsibility was experimentally manipulated. They found that participants with OCD in the high responsibility condition (responsible for reducing incorrect use of medication) gave higher ratings on both subjective OCD-like experiences and checking behaviours compared to participants without OCD, supporting the causal role of responsibility beliefs in OCD. In other experiments (i.e., Lopatka & Rachman, 1995; Shafraan, 1997), OCD patients reported a reduced urge to execute their rituals when the experimenter took total responsibility for a potential negative outcome. The authors thus implied that responsibility plays an essential role in checking and other OCD-like behaviours.

### 1.1. Aims and objectives

A sizable body of literature suggests that responsibility appraisals play a significant role in OCD symptomatology. Thus, this review aims to critically evaluate the effect of inflated responsibility on OCD symptoms and processes by analysing the available peer-reviewed studies using an experimental design. Of particular importance are studies that assess not only anxiety but the impact of responsibility appraisals on behavioural processes such as urges to neutralise or time spent engaging in neutralising behaviours. This systematic review includes the extant literature for adult and child samples and as such will assist in determining whether the inflated responsibility model of OCD applies to both adults and children, with implications for understanding the potential benefits of addressing responsibility in treatment. Our hypotheses are exploratory in formally assessing the experimental literature with a focus on in vivo manipulations of responsibility, behavioural outcomes, size of effects and overall quality of research.

In this review we specifically sought to analyse identified studies with a focus on seven key areas: participants, assessment, experimental design, behavioural task, appraisal ratings, and both symptom and behavioural process outcomes. Risk of bias within and across these

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