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The role of cognitive factors in the pathogenesis of obsessive–compulsive symptoms: A prospective study

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Abstract

Cognitive models of obsessive–compulsive disorder (OCD) posit that specific kinds of dysfunctional beliefs (e.g., pertaining to responsibility and the significance of intrusive thoughts) underlie the development of this disorder. The present study was designed to prospectively evaluate whether dysfunctional beliefs thought to underlie OCD act as a specific vulnerability factor in the pathogenesis of obsessive–compulsive symptomatology. Eighty-five individuals were prospectively followed over a period of time thought to be associated with an increased onset of OCD symptoms—childbirth and the postpartum. The majority of these new mothers and fathers experienced intrusive infant-related thoughts and performed neutralizing behaviors similar to, but less severe than, those observed in OCD. Scores on a measure of dysfunctional beliefs thought to underlie OCD predicted the development of obsessive–compulsive symptoms after controlling for pre-existing OCD symptoms, anxiety, and depression. Dysfunctional beliefs also predicted the severity of checking, washing, and obsessional OCD symptom dimensions, but not neutralizing, ordering, or hoarding symptom dimensions. These data provide evidence for specific dysfunctional beliefs as risk factors in the development of some types of OCD symptoms.
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Introduction

Obsessive–compulsive disorder (OCD) is an anxiety disorder characterized by persistent, inappropriate intrusive thoughts, ideas, images, or impulses that evoke anxiety and subjective resistance (obsessions) and urges to perform overt or covert acts to neutralize obsessional fear or according to rigidly applied rules (compulsive rituals). The themes of OCD symptoms typically concern contamination, violence, sex, religion, responsibility for harm, hoarding, and symmetry (Foa et al., 2002; McKay et al., 2004). In most cases, untreated OCD runs a chronic and deteriorating course (Eisen & Steketee, 1998). Moreover, symptoms often

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produce significant personal distress and functional disability (Crino, Slade, & Andrews, 2005). When the chronicity and personal costs are considered along with the relatively high prevalence rate (2–3% in adults; Karno, Golding, Sorenson, & Burnam, 1998), one recognizes the importance of identifying the causes and treatments of OCD.

Although treatments with demonstrated efficacy exist for OCD (i.e., serotonergic medication and exposure-based cognitive-behavioral therapy), it remains largely unknown why some people develop this disorder whereas others do not. Among the most promising explanatory models of OCD are those based on Beck's (1976) cognitive specificity hypothesis, which proposes that different types of psychopathology arise from different types of dysfunctional beliefs. Social phobia, for example, is thought to develop from maladaptive beliefs about rejection or ridicule by others (Beck & Emery, 1985; e.g., "It's terrible to be rejected"). Similarly, several theorists (e.g., Rachman, 1997; Salkovskis, 1996) have proposed that obsessions and compulsions arise from specific sorts of dysfunctional beliefs. The foundation of cognitive models of OCD is the well-established finding that intrusions (i.e., thoughts, images, and impulses that intrude into consciousness) are experienced by most people (i.e., normal obsessions; Rachman & de Silva, 1978). An important task for any theory is to explain why almost everyone experiences cognitive intrusions (at least at some point in their lives), yet only some people experience intrusions in the form of clinical obsessions (i.e., intrusions that are unwanted, distressing, and difficult to remove from consciousness).

Rachman (1997) proposed that normal intrusions—whether wanted or unwanted— reflect important issues in the individual's life and are often triggered by internal or external cues. He argued that such intrusions develop into obsessions only when the person attaches exaggerated significance to these thoughts and regards them as horrific, repugnant, dangerous, immoral, and so on. To illustrate, consider a man who has just become a father for the first time, and while changing his baby's diaper, experiences a normal, yet unwelcome thought about the baby's genitals. Whereas many parents would likely disregard such an intrusion as nonsensical, the man described above believes that "since I have this awful thought, it means I am a bad father and a depraved man" and that "thinking improper thoughts will lead to improper behavior". Thus, he becomes extremely fearful when such thoughts come to mind ("What if I am really a child molester!?"). To avoid a recurrence of the anxiety-evoking thought, he takes precautions such as avoiding changing the baby's diaper, compulsively repeating prayers, seeking reassurance, and thinking "positive" thoughts instead. He also tells himself that he must not let anyone else know about these thoughts. Paradoxically, these responses become reminders of the intrusion and increase its frequency and intensity. Moreover, when the man does not "go crazy" or act in "depraved" ways, he attributes this to the precautionary responses, rather than to the innocence of the intrusive thought, thereby sustaining the dysfunctional beliefs about the thought's importance.

Extending the theoretical work of Rachman (1997), Salkovskis (1996), and others, the Obsessive Compulsive Cognitions Working Group (OCCWG, 1997, 2005) empirically derived the following three domains of dysfunctional beliefs considered to underlie OCD symptoms:

(1) *Overestimation of threat/Inflated Responsibility*. Individuals with OCD evidence exaggerated estimates of the probability and costs of negative events and believe themselves to be personally responsible for causing or preventing any disastrous consequences associated with obsessional thoughts.
(2) *Beliefs about the importance of, and need to control, intrusive thoughts*. Individuals with OCD believe that the mere presence of intrusive thoughts indicates that such thoughts are very meaningful. They also believe that complete control over such intrusions is both necessary and possible.
(3) *Perfectionism and intolerance of uncertainty*. Individuals with OCD show inability to tolerate mistakes or imperfection, as well as the strong need for a guarantee of safety.

Although underlying biological or genetic factors might predispose individuals toward developing OCD in a general way, cognitive formulations of OCD are specific, face valid, and can account for the disorder's highly idiosyncratic nature (Rachman, 1997; Salkovskis, 1996). However, empirical evaluations of cognitive theories have thus far included only cross-sectional (correlational) research and laboratory experiments. Laboratory studies in which dysfunctional beliefs have been experimentally induced suggest that the kinds of cognitive biases described above give rise to obsessive–compulsive phenomena (e.g., Rassin, Merckelbach, Muris, &

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