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What are the roles of perfectionism and responsibility in checking and cleaning compulsions?

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Abstract

Empirical findings revealed that an inflated sense of responsibility has a major impact on obsessive–compulsive symptomatology (OCS). Another cognitive variable, perfectionism, is also theoretically linked to OCS. The assumption about the insufficient but necessary role of perfectionism for OCS and the view of perfectionism as a manifestation of avoidance of serious consequences led us to explore the role of an important cognitive mediator (responsibility) in this relationship. The present study aimed to explore the mediational role of responsibility for the effects of perfectionism on checking and cleaning symptom profiles of OCS in a nonclinical population in Turkey. Findings of the present study suggested that responsibility appraisals mediate effects of self-oriented and socially prescribed perfectionism on checking and the effect of socially prescribed perfectionism on cleaning. There was a partial mediation for self-oriented perfectionism on cleaning. The findings are discussed within the scope of current literature and implications for clinical applications are suggested.

Keywords: Responsibility; Perfectionism; Checking; Cleaning; Obsessive–compulsive symptomatology

Obsessive–compulsive disorder (OCD) is characterized by obsessions in the form of recurrent and persistent thoughts, images, and impulses, and

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accompanying compulsions that are aimed to reduce or prevent distress caused by obsessions (DSM IV; APA, 1994). The most common phenomenological presentations of OCD are contamination obsessions coupled with cleaning compulsions and doubting accompanied by checking compulsions (Rasmussen & Eisen, 1989). Among the cognitive mediators assumed to underlie OCD, responsibility, or in a more concrete term perceived sense of responsibility has attracted the most attention in the literature for the last 15 years (Rachman, 1998, 2002; Salkovskis, 1985, 1989, 1993; Salkovskis et al., 2000). The cognitive model of OCD (Salkovskis, Shafran, Rachman, & Freeston, 1999) defined responsibility as the belief of possessing a pivotal role for leading or preventing negative and crucial outcomes, and highlighted the central role of dysfunctional responsibility schema or inflated sense of responsibility for both the development and the maintenance of OCD (Salkovskis, 1985, 1989, 1993). The model assumes that dysfunctional responsibility schema are formed through previous experience (see Salkovskis et al., 1999 for detailed information). The interaction of such schema with a critical incident/s results in the catastrophic misinterpretation of intrusive thoughts, images, impulses, environmental stimuli and related automatic thoughts which is focused on the fear of causing harm to others and self. The relationship between excessive sense of responsibility and OCS was supported in both clinical and nonclinical samples by clinical observations (Rachman, 1993; Tallis, 1994), by questionnaires (e.g., Foa, Sacks, Tolin, Preworski, & Amir, 2002; Salkovskis et al., 2000), by experimental manipulations (e.g., Ladouceur et al., 1995; Lopatka & Rachman, 1995) and by treatment efficacy studies which showed that therapies focusing on inflated sense of personal responsibility (Freeston, Rheaume, & Ladouceur, 1996; Ladouceur, Leger, Rheaume, & Dube, 1996) induced significant changes in the OCS.

Although OCD is viewed as a unitary diagnosis (DSM-IV; APA, 1994), its homogeneity has been questioned (e.g., Calamari, Wietgartz, & Janeck, 1999; Summerfeldt, Richter, Antony, & Swinson, 1999). Efforts for categorization of symptom representations (especially for cleaning and checking subtypes of OCD) have been quite elaborate. Apart from the factor structure of OCD measures such as Maudsley Obsessive–Compulsive Inventory (Rachman & Hodgson, 1980), different demographic (Gibbs & Oltmanns, 1995; Rasmussen & Tsuang, 1986) and clinical characteristics (Frost, Steketee, Cohn, & Griess, 1994) and cognitive processes (Sher, Frost, & Otto, 1983) were assigned for the subtypes of cleaning and checking. Furthermore, this symptom differentiation also seems to represent itself for varying roles of responsibility. Rachman (2002) suggested that in checking the focus of the inflated sense of responsibility is on mainly protecting others rather than self from coming to harm. However, in cleaning self-focused responsibility operates. Moreover, empirical studies suggest that inflated responsibility has a more identifiable and salient role in checking symptoms as compared to cleaning symptoms (e.g., Foa et al., 2002; Lopatka & Rachman, 1995; Rachman, 1998; Rheaume, Freeston, Dugas, Letarte, & Ladouceur, 1995; Smari, Gylfadottir, & Halldorsdottir, 2003).