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Differences and similarities between obsessive and ruminative thoughts in obsessive-compulsive and depressed patients: A comparative study

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ABSTRACT

Repetitive, intrusive cognitive phenomena are central both to obsessive-compulsive patients - typically as obsessive thoughts - and to depressed patients - typically as ruminative thoughts. The objective of the present study is to compare obsessive and ruminative thoughts in non-depressed obsessive-compulsive and depressed patients. Thirty-four patients diagnosed with obsessive-compulsive disorder and 34 patients diagnosed with major depression disorder were asked to identify both a personally relevant obsessive and a personally relevant ruminative thought and to subsequently evaluate these thoughts on a modified version of the Cognitive Intrusions Questionnaire (CIQ) developed by Freeston, Ladouceur, Thibodeau, and Gagnon (1991). The CIQ assesses general descriptors, emotional reactions, appraisal and coping strategies on a nine-point Likert scale. A mixed-model ANOVA demonstrated that obsessive and ruminative thoughts are distinct cognitive processes, clearly distinguishable in form, appraisal and temporal orientation across disorders. In obsessive-compulsive patients, ruminative thoughts were more common and more emotionally distressing than predicted. In depressed patients, obsessive thoughts occurred infrequently and were not associated with high negative emotions. Clarifying similarities and differences between ruminative and obsessive thoughts and understanding their interaction might ultimately help to expand on the role of cognitive vulnerability factors in obsessive-compulsive and major depression disorder.

1. Introduction

Obsessions or obsessive thoughts (OTs) are a central feature of obsessive-compulsive disorder (American Psychiatric Association, 1994). They are defined as "intrusive, repetitive thoughts, images or impulses that are unacceptable and/or unwanted and give rise to subjective resistance…the necessary and sufficient conditions … are intrusiveness, internal attribution, unwantedness and difficulty to control."(Rachman & Hodgson, 1980, p.251). The content of obsessions is perceived as unacceptable, lies usually outside the person's normal experience and is inconsistent with their own values and attitudes, i.e. obsessions are ego-dystonic (Clark & Purdon, 1993; Turner, Beidel, & Stanley, 1992). The most frequent themes of obsessions are contamination, aggression, and harm coming to oneself or others; less frequent are obsessions about ordering, symmetry and exactness, somatic obsessions, religious obsessions and obsessions featuring sexual themes (Rasmussen & Tsuang, 1986; Turner et al., 1992).

Unacceptable, intrusive thoughts are typical of but not unique to obsessive-compulsive disorder (OCD). Eighty to ninety percent of the non-clinical population experience intrusive thoughts with similar form and content albeit associated with less distress and lower frequency (Belloch, Morillo, Lucero, Cabedo, & Carrio, 2004; Rachman & de Silva, 1978; Salkovskis & Harrison, 1984).[1] The occurrence of OTs in depressed patients has not been studied extensively to date. Theoretical accounts of obsessions propose that depressed mood increases the vulnerability for obsessions (Rachman, 1971, 1981). Clinical observations also suggest that, in depressed patients, the occurrence of OTs is heightened, which is, for example, accounted for by two separate items on the Hamilton

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[1] Note, however, that recent data suggest differences in the content of clinical and non-clinical obsessions (Rassin, Cougle, & Muris, 2007).

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Rating Scale of depression (Knesevich, Biggs, Clayton, & Ziegler, 1977) that assess solely obsessive-compulsive symptoms. Ricciardi and McNally (1995) found a strong relationship between depressive mood and the severity of obsessions but not compulsions. However, occurrence, form, appraisals and strategies in response to OTs in major depression disorder have not been researched systematically yet.

Ruminative thoughts (RTs) or, more specifically, a ruminative response style, has usually been studied in relation to depression. A ruminative response style is a "mode of responding to distress that involves repetitively and passively focusing on symptoms of distress and the possible causes and consequences of these symptoms" (Nolen-Hoeksema, Wisco, & Lyumbomirsky, 2008, p.400). It is described as a largely verbal activity, which consists of persistent and recurring thoughts that unintentionally enter consciousness and repetitively focus on depressive feelings, causes and consequences of these symptoms (Nolen-Hoeksema et al., 2008). Typical ruminative thoughts are: 'Why did this happen to me?' and 'Why can't I handle things better?'.

Nolen-Hoeksema (1991) postulated that rumination worsens and prolongs depression. A number of empirical studies with clinically depressed and dysphoric populations support this hypothesis (e.g., Just & Alloy, 1997; Kuehner & Weber, 1999; Nolen-Hoeksema, Morrow, & Frederickson, 1993; however, see Lara, Klein, & Kasch, 2000, for different results). Recently, RTs have also been studied in relation to anxiety, providing empirical evidence that the two are associated in healthy individuals and psychiatric populations (Calmes & Roberts, 2007; Fresco, Frankel, Mennin, Turk, & Heimberg, 2002; Nolen-Hoeksema, 2000; Segerstrom, Tsao, Alden, & Craske, 2000). Further, RTs have been found to be related to other psychopathologies, such as bulimia nervosa (Nolen-Hoeksema, Stice, Wade, & Bohon, 2007) and alcohol use disorder (Nolen-Hoeksema & Harrell, 2002). In fact, since ruminative thinking has been found to be involved in the maintenance of many psychiatric disorders, it has been suggested that it is a definite transdiagnostic process which is characterized by identical processual characteristics across disorders (i.e. repetitive, at least partly involuntary and difficult to disengage from) and disorder-specific content (Ehring & Watkins, 2008; Harvey, Watkins, Mansell, & Shafran, 2004).

A ruminative thinking style as defined by Nolen-Hoeksema is not identical to obsessional rumination, which is – lacking a consistent definition in the relevant literature – usually seen as the presence of obsessional thoughts (in particular aggressive, sexual or blasphemous ones) and the absence of overt forms of neutralizing. It typically includes mental forms of compulsions or neutralizing, such as mental rituals, counting, self-arguing, but also thought suppression or silent forms of distraction (Freeston & Ladouceur, 1997). Whether RTs occur in OCD, their potential form, accompanying emotions, appraisals and strategies and whether RTs are possibly inherently linked to obsessional rumination has not been studied to date.

OTs and RTs share several similarities. Both are repetitive cognitive intrusions accompanied by negative emotions, difficulty to dismiss and subjectively experienced as loss of mental control (e.g. Turner et al., 1992; Papageorgiou & Wells, 1999). On the other hand, OTs and RTs are characterized by distinct features. OTs are not only verbal but can take the form of impulses or images (APA, 1994), are negatively appraised (e.g. Rachman & Hodgson, 1980), are perceived as ego-dystonic (Clark & Purdon, 1993) and are followed by attempts to ignore, suppress or neutralize the thought (APA, 1994). RTs are described as typically verbal activity (Nolen-Hoeksema, 1991), associated with both positive and negative evaluations (Papageorgiou & Wells, 2001; Watkins & Moulds, 2005) and are largely past oriented (Papageorgiou & Wells, 1999; Watkins, Moulds & Mackintosh, 2005).

Clarifying similarities and differences between RTs and OTs in depressed patients and non-depressed OCD patients has important clinical relevance. It might help to understand their interaction and their potential roles as cognitive vulnerability or maintenance factors in obsessive-compulsive and major depression disorder. Ultimately, it might foster the development of more accurate models of the disorders and of novel interventions in cognitive therapy if appropriate. Further, this information might help our understanding of the high rates of comorbidity between OCD and major depression and to improve treatment of OCD with comorbid depression. Estimates vary between one-quarter and one-half of OCD sufferers experiencing at least one episode of major depression (Crino & Andrews, 1996; Hong et al., 2004; Nestadt et al., 2001). OCD patients with comorbid depression show higher rates of other comorbid conditions and of functional disability (Ricciardi & McNally, 1995; Tukel, Meteris, Koyuncu, Tecer, & Yazici, 2006) and respond less well to exposure and response prevention (e.g. Abramowitz & Foa, 2000).

The present study aims to specify the differences between OTs and RTs across a series of variables, including form and content, appraisals, strategies and emotional reactions within two clinical samples. Whereas other forms of repetitive negative thinking such as rumination and worry (Watkins, Moulds, & Macksintosh, 2005) and obsessions and worry (Langlois, Freeston, & Ladouceur, 2000) have been compared previously in non-clinical populations, RTs and OTs have not been compared directly before. By adapting a methodology by Langlois et al. (2000), the current study directly compares OTs and RTs using a modified version of the Cognitive Intrusions Questionnaire (CIQ) developed by Freeston et al. (1991) in patients diagnosed with major depression and non-depressed obsessive-compulsive patients.

It was hypothesized that frequency of thought type and typical accompanying emotions are disorder specific, i.e. (1) OTs occur more frequently than RTs in OCD, and RTs occur more frequently than OTs in major depression disorder; (2) in OCD, OTs are associated with higher anxiety/distress than RTs; (3) in major depression disorder, RTs are associated with higher sadness than OTs. Additionally, it was predicted that RTs and OTs can be clearly distinguished across disorders in terms of form, temporal orientation, appraisals and urge to act upon them. In particular, it was expected that OTs (4) occur with greater visual quality/vividness, (5) are rated as more irrational and (6) are associated with a higher urge to act than RTs. Finally, it was predicted that RTs (7) are more past oriented and (8) are rated as more realistic than OTs.

2. Methods

2.1. Participants

Thirty-four adults with OCD and 34 adults diagnosed with major depression disorder participated in the present study. DSM-IV (APA, 1994) diagnosis was assessed with the Structured Clinical Interview for DSM-IV (SCID) (First & Gibbon, 2004) administered by experienced clinical psychologists or psychiatrists. Patients were recruited from an inpatient clinic specializing in the cognitive behavioural treatment of anxiety and mood disorders. It was assured that participants were in the early stages of treatment before any repetitive thinking processes had been discussed. Exclusion criteria were substance dependency or any psychotic symptoms. In the OCD group, the primary diagnosis was OCD. Three patients (8.8%) were acutely diagnosed with another disorder (i.e. specific phobia, generalized anxiety disorder and hypochondriasis). None of the obsessive-compulsive patients was currently depressed. In the major depression group, the primary diagnosis was major depression. Thirteen patients (38.3%) met DSM-IV