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Unwanted intrusive thoughts: Cultural, contextual, covariational, and characterological determinants of diversity

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ABSTRACT

Cognitive behavioral theories trace the origins of clinical obsessions to common unwanted intrusive thoughts, images or impulses that are universally experienced in the general population. It is the erroneous interpretation of the intrusion as a personally significant threat that must be diminished or neutralized that result in the vicious escalation into a clinical obsession. This paper reviews four critical determinants of individuals' diverse experience of unwanted intrusive thoughts (UITs). First we consider the role that culture may play in the types of thoughts that become intrusive, repetitive and persistent. Next the role of context is considered and the differences found between UITs and obsessions that are externally precipitated versus those that are more autonomous. A third section considers the role of current clinical state and whether there is a specific relation between certain types of intrusions and obsessional states in particular. The final section examines the role of personality, enduring dysfunctional beliefs and self-view discrepancies as potential vulnerability factors for UITs and obsessions. The paper concludes with a summary of current status and future directions for research on UITs.

1. Introduction

Contemporary cognitive behavioral theories (CBT) and treatment protocols for obsessions assume continuity between the unwanted intrusive thoughts, images and impulses found in healthy populations and the clinical obsessions that characterize diagnosable obsessive compulsive disorder (OCD). This dimensional assumption is critical to CBT because the models propose that obsessions arise from faulty appraisals and maladaptive control efforts that seek to neutralize naturally occurring intrusive thoughts (e.g., Clark, 2004; Rachman, 1997, 1998; Salkovskis, 1985, 1989). Beginning with the seminal research by Rachman and de Silva (1978), numerous studies have since demonstrated that nonclinical individuals experience unwanted intrusive thoughts (UITs) of dirt/contamination, doubt, harm/injury, sex, religion, order/symmetry, superstition, etc. that are similar in form and content to the clinical obsessions of individuals with OCD, although their frequency and distress are much less than in clinical samples (e.g., Freeston, Ladouceur, Thibodeau, & Gagnon, 1991; García-Soriano, Belloch, Morillo, & Clark, 2011; Lee & Kwon, 2003; Parkinson & Rachman, 1981; Purdon & Clark, 1993). More recently, a large international study of UITs across 13 countries found that over 90% of individuals experienced unwanted intrusions within the last 3 months (Radomsky et al., in press). Thus we can now say with considerable confidence that the majority of healthy, nonclinical individuals experience unwanted intrusions that are similar in content to the obsessions of OCD patients.

After 25 years of research on obsessions and normal UITs, two observations remain constant across studies. Regardless of sample characteristics, whether OCD patients, nonobsessional patients or nonclinical individuals, there is a remarkable diversity across individuals in the content and form of their intrusions/obsessions. By form we mean a diverse range of parameters that define the experience of UITs such as frequency, intensity (or distress), intrusiveness, unexpectedness, persistence (duration), controllability, vividness, valence (positive versus negative), adhesiveness (durability), and modality (verbal- versus imagery-based). Unfortunately only three parameters, frequency, distress and controllability, have been researched with any degree of consistency by the most popular OCD measures (e.g., Yale–Brown Obsessive Compulsive Scale (Y-BOCS); Obsessive Compulsive Inventory (OCI), Vancouver Obsessive Compulsive Inventory (VOCI), etc). The second finding is of considerable inter-individual differences in the frequency and negative consequence of UITs. It ranges from the tiny minority who deny any UITs (less than 10%) to those who report daily occurrences of unwanted cognitions. However much

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of this research is hampered by methodological weaknesses such as an overreliance on retrospective questionnaires that assume individuals can accurately report on their intrusion experiences.

The purpose of the current review paper is to examine several broad factors that might account for the diverse form and content of UITs and obsessions as well as individual differences in the propensity to experience unwanted intrusions. Four determinants of UIT/obsession diversity are considered; cultural factors, context, psychopathology, and enduring individual differences in personality and cognition. Variables related to both form and content are reviewed in each category, and both nonclinical and clinical obsessive intrusive phenomena are evaluated, based on the continuity of UITs and obsessions. We conclude with a summary of the findings to date and offer suggestions for further investigation.

2. Cross-cultural determinants of UITs/obsessions

OCD has a heterogeneous symptom presentation and so there have been various attempts to subcategorize the disorder according to obsessive and compulsive symptom dimensions (e.g., washing, checking compulsions, repugnant obsessions, order/symmetry, pathological doubt, primary obsessions, etc). The intent was to determine whether there might be different treatment implications associated with OCD symptom subtypes (i.e., Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002), or, more specifically, whether a distinct treatment protocol might lead to a more efficacious outcome for each disorder subtype (e.g., Rachman, 2003, 2006). Despite considerable effort in developing a symptom-based classification for OCD, the subtyping approach has met with only limited success because of symptom co-occurrence, unreliability and unclear associations with treatment (Starcevic & Brakoulias, 2008). Nevertheless, the notion of OCD subtypes has led to an interest in whether culture might influence the types of obsessions and compulsions people develop when they succumb to OCD.

2.1. Cultural differences in OC symptom content

Over the years researchers have reported differences between countries in the proportion of various symptom content found in OCD samples. For example, contamination and religious obsessions are more frequent in Arab and Middle Eastern countries including Israel and Turkey (Mahgoub & Abdel-Hafeiz, 1991; Tukel, Polat, Ozdemir, Aksut, & Turksoy, 2002; Zohar, Goldman, Calamary, & Mashiah, 2005) and there is a greater predominance of aggression obsessions in Brazilian OCD samples (Fontenelle, Mendlowicz, Marques, & Versiani, 2004). Factor analysis of the Y-BOCS in a large Indian OCD sample revealed two distinct dimensions of obsessions without overt compulsions involving sexual and religious themes (Girishchandra & Khanna, 2001). This differs from American factor analytic studies of the Y-BOCS where obsessions and compulsions tend to load together on the same dimensions (e.g., Leckman et al., 1997). Two Chinese studies based on the Y-BOCS produced inconsistent results, with one indicating that symmetry obsessions were most common (Li, Marques, Hinton, Wang, & Xiao, 2009) and the other reporting that aggression obsessions and checking compulsions were the most prevalent (Zhang, Liu, Cui, & Liu, 2013). In a Korean OCD study again using the Y-BOCS, the symmetry and ordering dimension was most common, but sexual/religious obsessions were also elevated relative to the percentages seen in other countries (Kim, Lee, & Lee, 2014). In a Y-BOCS study of African-Americans with OCD, contamination and fear of being misunderstood obsessions were much more prevalent than the rates reported for European American/non-Hispanic White OCD samples (Williams, Elstein, Buckner, Abelson, & Himle, 2012). In sum there appear to be more similarities than differences in OCD symptom presentation between countries, or even across cultural and ethnic groups within the same country. In most clinical samples contamination, doubt, and harm/aggression are the most common obsessional themes, whereas washing and checking are the predominant compulsions (Fontenelle et al., 2004). And yet, differences do emerge with sex/religious obsessions more common in highly religious societies, aggressive obsessions more prevalent in Brazil, order and symmetry more prominent in Asia, and contamination/cleaning greater in African-American and possibly Indian OCD samples. So cultural differences do play a role in OC symptom presentation, but much remains unknown about the extent of its influence and its significance in the etiology and treatment of obsessions.

It has been suggested that extrinsic factors like religion, geography, locality, etc. might affect the symptom content of OCD but that intrinsic factors like age, gender, etc. influence the form of obsessive and compulsive symptoms (Akhtar, Wig, Varma, Pershad, & Verma, 1978; Fontenelle et al., 2004). A recent Indian study found that men with OCD had a higher frequency of sexual, religious and doubt obsessions, whereas women with OCD had more fear of contamination (Cherian et al., in press). Leckman et al. (1997), however, found that the only gender effect was on the Y-BOCS symmetry and order factor, with American men scoring greater than women. The European Study of the Epidemiology of Mental Disorders found 13% lifetime prevalence for OC symptom dimensions in the general population, with harm/checking and somatic obsessions the most common and contamination/cleaning the least common (Fullana et al., 2010). Women had more contamination/cleaning, harm/checking and somatic obsessions than men, and there was increased risk of harm/checking symptoms in France and somatic obsessions in Italy.

Overall it would appear that cultural differences might influence the content of obsessions and compulsions, although the extent of cultural determinism remains unclear. There is considerable inconsistency in symptom percentages between studies conducted in the same country so it is difficult to arrive at a consensus on cultural differences in OCD symptom presentation. It is also possible that cultural influences could be moderated by intrinsic factors such as age or gender. As well, the specific cultural characteristics responsible for symptoms differences remain speculative at best, and whether cultural-related effects have any treatment implications is again undetermined. For example, would there be a better treatment response for religious obsessions in someone from a religion-dominant culture or someone from a secular, less religious society? In other words, what is the implication of having “culture-congruent” obsessions versus “culture-incongruent” obsessions?

2.2. Cultural differences in intrusion content

Only a handful of studies have examined cultural differences in the experience of obsession-relevant intrusive thoughts, symptoms or beliefs in nonclinical samples. Kyrios, Sanavio, Bhar, and Liguori (2001) compared Italian and Australian undergraduates on OC symptoms, inflated responsibility, perfectionism, guilt, depression and anxiety. Few differences emerged except that perfectionism was more highly correlated with OC symptoms and urges/worries (i.e., loss of control) were more strongly related to negative affect symptoms in the Australian sample. A comparison of Greek, Italian and American students on OC symptoms and beliefs revealed significant but modest differences in beliefs (Sica, Taylor, Arrindell, & Sanavio, 2006). Although hierarchical regression analysis indicated that cultural factors moderated the relationship between beliefs and symptoms, this was due primarily to low correlations between beliefs and contamination/checking symptoms in the Greek sample. A study of highly religious Christian