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Pathological and non-pathological features of obsessive-compulsive disorder: Revisiting basic assumptions of cognitive models

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ABSTRACT

Cognitive models of obsessive-compulsive disorder (OCD) (e.g., Rachman, 1997; Salkovskis, 1985) have been highly influential over the last few decades, garnering a wealth of research support. However, they have not generally led to improvements in the treatment of OCD. In the current paper, we argue that several features of OCD that cognitive models identify as dysfunctional may actually be non-pathological. Specifically, we discuss how dysfunctional beliefs central to cognitive theories may be epiphenomena and features of OCD assumed to be pathological (e.g., intrusion-related distress) may be normative. We also identify several gaps in the literature and present directions for future research.

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1. Introduction

Over the last 20–25 years, cognitive approaches to obsessive-compulsive disorder (OCD) have generated a wealth of research. Such approaches have their origins in Beck's (1976) cognitive theory of emotional disorders, which posits that anxiety is caused by negative interpretations of stimuli. Salkovskis (1985) subsequently argued that intrusive cognitions are normal occurrences that the individual with OCD misinterprets. The disorder then emerges from continued misinterpretations of thoughts, especially misinterpretations regarding responsibility for harm. Subsequent elaborations of the cognitive model of OCD have posited additional dysfunctional beliefs that lead to the emergence of the disorder,

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including beliefs regarding the overimportance of thoughts, need to control thoughts, overestimation of threat, perfectionism, and intolerance of uncertainty (Obsessive Compulsive Cognitions Working Group, 1997, 2005). There is a significant degree of overlap between cognitive perspectives that have appeared, with more similarities than differences (Taylor, Abramowitz, McKay, & Cuttler, 2012). The focus of this paper will be primarily on the work of Salkovskis (1985, 1989, 1999) and Rachman (1997, 1998, 2002, 2003), who have published the most influential theoretical articles in this area.

The notion that intrusive cognitions are a universal phenomenon has been largely supported (Julien, O'Connor, & Aardema, 2007). Additionally, since the publication of Salkovskis's (1985) original model, numerous studies have lent support for a significant role of faulty interpretations in OCD. For example, individuals with OCD have been found to display the cognitive bias known as 'thought–action fusion,' or the tendency to interpret thoughts as being morally equivalent to their associated actions (moral thought–action fusion) or as increasing the likelihood of dangerous outcomes (likelihood thought–action fusion; Shafran, Thordarson, & Rachman, 1996). Obsessive beliefs have also been found to prospectively predict the development of postpartum OCD symptoms (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006; Abramowitz, Nelson, Rygwall, & Khandker, 2007). Experimental manipulation of the interpretation of intrusions has demonstrated that negative interpretations lead to greater intrusion frequency and distress (Rassin, Merckelbach, Muris, & Spaan, 1999). Lastly, cognitive interventions that target negative appraisals have shown efficacy in the treatment of OCD (Freeston, Leger, & Ladouceur, 2001; Ladouceur, Leger, Rheaume, & Dube, 1996; Whittal, Woody, McLean, Rachman, & Robichaud, 2010) and may be more tolerable than exposure and response prevention (ERP) treatment (Abramowitz, Taylor, & McKay, 2005; Whittal, Robichaud, Thordarson, & McLean, 2008).

Despite the accumulating evidence in support of cognitive models of OCD, there have also been reports of contradictory findings. For example, while some studies have found individuals with OCD to report elevated levels of dysfunctional beliefs proposed by cognitive models (e.g., Cougle, Lee, & Salkovskis, 2007), several studies have demonstrated that relative to control groups, individuals with OCD do not score higher on measures of OC-related beliefs and appraisals (e.g., Tolin, Worhunsky, & Maltby, 2006). Crucially, cognitive interventions for OCD have not led to improvements in treatment efficacy (Cottraux, et al., 2001; Whittal, Thordarson, & McLean, 2005). While such findings alone do not implicate problems with the cognitive model, they suggest there may be value in the clarification, expansion, or modification of current cognitive approaches. Given the low rates of recovery associated with current treatments for OCD (Fisher & Wells, 2005), there is certainly room for growth.

In the current essay, we discuss basic assumptions of cognitive models of OCD. Some of this discussion is focused specifically on approaches to repugnant obsessions (i.e., aggressive, sexual, or blasphemous intrusions), though we discuss issues related to other symptom presentations, as well. Importantly, we argue that it is not yet clear whether each of the maintaining factors identified by the cognitive model of OCD is clearly dysfunctional. Some features of OCD addressed by the cognitive model, including the distress associated with repugnant intrusions and responsibility for harm appraisals, may be considered normative, non-pathological processes. Further, we discuss ways in which dysfunctional beliefs posited by the cognitive model could be considered epiphenomenal: either a consequence of OC symptoms or a more central dysfunction (e.g., neuropsychological deficits, 'not just right' experiences). We also draw attention to current gaps in the literature that may be worthy of future research and present specific research proposals of relevance to each issue raised. Our hope is that this essay would spur research that might ultimately improve the understanding and treatment of OCD.

2. Are obsessional intrusions benign or inherently distressing?

A basic assumption of cognitive approaches to obsessions is that repugnant thoughts are a common occurrence for most of the population and *pathological* interpretations of such *non-pathological* thoughts are pivotal to the disorder. Obsessions are defined as intrusive and inappropriate mental intrusions that cause *marked anxiety or distress* (American Psychiatric Association, 2000), and cognitive models suggest that the causes of such negative emotional reactions are the pathological cognitive appraisals of mental intrusions. Further, according to the model, negative interpretations of intrusions give rise to neutralization and suppression efforts, as well as heightened distress reactions. Rachman's (1997, 1998) cognitive perspective on obsessions draws parallels between obsessions and panic attacks. He wrote that both obsessions and panic attacks arise from catastrophic misinterpretations of normal phenomena. Whereas individuals with panic disorder tend to interpret normal bodily sensations as signs of imminent catastrophe (e.g., 'I will have a heart attack', 'I will faint') (Clark, 1986), individuals with OCD misinterpret intrusive thoughts as indicating that they are "mad, bad, or dangerous" (Rachman, 2003, p. 6), or are immoral, crazy, and likely to act on the thoughts. According to Rachman, "the obsessions persist as long as these interpretations continue and diminish when the misinterpretations are weakened" (Rachman, 1998, p. 385).

Cognitive approaches to repugnant obsessions,[1] which we define here as obsessions having sexual, aggressive, or religious themes, assume that obsessionals suffer from a pathological 'fear of intrusions' in much the same way that individuals with panic disorder suffer from a fear of bodily sensations. Further, such fears are mediated by cognitions regarding the personal significance of these thoughts. Though cognitive theorists have argued that repugnant intrusions are "upsetting, unacceptable, or otherwise unpleasant" (Salkovskis, 1999, p. S31) and, thus, may provoke some degree of distress even in individuals without OCD, this model also assumes that obsessionals react more anxiously to repugnant intrusions than individuals without obsessions and this increased anxiety in response to intrusions is mediated by catastrophic misinterpretations (Rachman, 1997, 1998). If this is the case, obsessionals, who would engage in more negative cognitive appraisals of mental intrusions, should display greater negative emotional reactions when compared to those without repugnant obsessions. Significant distress reactions in response to dirty stimuli are typically found among OC washers compared to non-washers (Radomsky & Rachman, 1999), and OC checkers also show greater distress associated with checking-related situations than non-checkers (Cougle, Salkovskis, & Thorpe, 2008). However, there is little evidence to suggest that obsessionals respond more anxiously to repugnant intrusions than individuals with other anxiety disorders or no anxiety problems.

Negative interpretations may not be necessary to account for emotional distress associated with obsessional intrusions (Jakes, 1989). Repugnant intrusions are not ambiguous, neutral stimuli similar to the experience of dizziness or lightheadedness or talking to an authority figure. Such intrusions may be more similar to a harsh, critical remark from a boss, which would almost invariably trigger negative emotional reactions. That is, they may represent experiences that would evoke a significant degree of distress in many, if not most people. As such, distressing reactions may be considered a normative response. Additionally, though certain individual difference factors, including self-perceptions and religiosity (Berman, Abramowitz, Pardue, & Wheaton, 2010; Rowa &

[1] We must emphasize that the critique in this section is specific to cognitive approaches to *repugnant obsessions* and does not apply to approaches to washing, checking, ordering, or other compulsions.