Associations between rumination and obsessive-compulsive symptom dimensions

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A B S T R A C T
In recent years there has been increased interest in understanding cognitive processes that play a role in the pathogenesis of obsessive-compulsive disorder (OCD). One cognitive factor that has received little attention is rumination. Rumination, defined as the tendency to repetitively analyze one's problems and feelings of distress, has been implicated in the development and maintenance of several mood and anxiety-related disorders. Thus, the primary aim of the current study was to examine the role of rumination in OCD symptoms using an unselected treatment-seeking sample (N = 105). Multiple regression analyses revealed a significant association between rumination and the unacceptable thoughts/neutralizing domain of OCD. These findings remained significant even after accounting for a relevant and related construct, in particular negative affect. These findings support a growing body of literature establishing rumination as a transdiagnostic risk factor. Further clinical and experimental research is needed to confirm these findings and expand our knowledge of metacognitive models of OCD.

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1. Introduction

Obsessive-compulsive disorder (OCD) is a psychiatric condition characterized by recurrent and persistent unwanted thoughts or images (i.e., obsessions) that bring about distress and/or impairment, as well as repetitive behaviors (i.e., compulsions) aimed at reducing or neutralizing the associated anxiety (American Psychiatric Association, 2013). OCD is estimated to affect around 2–3% of the population (Kessler et al., 2005) and has been associated with diminished quality of life as well as substantial impairment in social, occupational, and familial domains (Torres et al., 2006). Although the specific content of obsessions and compulsions may vary by individual, recent research on the multidimensional structure of OCD has identified four common symptom dimensions. These include: 1) contamination obsessions/washing compulsions, 2) responsibility for harm obsessions/checking compulsions, 3) unacceptable thoughts (sexual, religious, or violent in nature)/neutralizing or re-assurance seeking compulsions, and 4) symmetry, completeness, or ordering obsessions/arranging compulsions (Abramowitz et al., 2010). According to cognitive models of OCD, obsessions arise from unwanted intrusive thoughts or images followed by an appraisal of these thoughts as important, unacceptable, or as posing a threat for which the person is responsible (Abramowitz, Taylor, & McKay, 2009). While 80 to 90% of the general population experience intrusions, similar in form and content to those with OCD (Belloch, Morillo, Lucero, Cabedo, & Carrió, 2004), the misinterpretation of these otherwise normal intrusions are thought to play a key role in the pathogenesis of obsessions. Thus, research has attempted to understand cognitive processes that may underlie dysfunctional beliefs and appraisals (Raines, Oglesby, Capron, & Schmidt, 2014; Sarawgi, Oglesby, & Cougle, 2013). Whereas the metacognitive model of OCD proposes perseverative thinking such as rumination as one such factor (Wells, 2013), little research has examined the role of this cognitive construct in relation to obsessive-compulsive (OC) symptoms.

Rumination is defined as the tendency to repetitively and passively analyze one's problems, concerns, and feelings of distress without taking action to make positive changes (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Watkins, 2008). A ruminative thinking style (RTS) has been found to predict the severity and length of major depressive episodes (Just & Alloy, 1997), and most recently has been studied as a transdiagnostic maintenance factor within various anxiety disorders including generalized anxiety disorder, posttraumatic stress disorder, and social anxiety disorder (Abbott & Rapee, 2004; Ehlers & Clark, 2000; Fresco, Frankel, Mennin, Turk, & Heimberg, 2002). Across these disorders, rumination is thought to increase negative maladaptive thoughts, lead to the use of other maladaptive emotion regulation strategies, and lower problem solving abilities (Lyubomirsky, Kasri, Chang, & Chung, 2006; Lyubomirsky & Nolen-Hoeksema, 1993).

At first glance, rumination and obsessions may appear indistinct. Indeed, they both involve similar cognitive processes characterized by repetitiveness, intrusiveness, and uncontrollability. However, obsessions are largely intrusive and unwanted (American Psychiatric Association, 2013) whereas rumination is a mode of responding to distress that
involves repetitively focusing the causes and consequences of symp-
toms (Nolen-Hoeksema et al., 2008). We believe rumination may exac-
terate OC symptoms, in particular obsessive symptoms. Existing
models of obsessional symptoms posit that obsessions arise via misap-
praisals of naturally occurring intrusive thoughts as especially impor-
tant or meaningful (Abramowitz et al., 2009; Purdon, 2008). The
obessions are hypothesized to persist in the context of continued mis-
interpretations and subsequent attempts to control or suppress the
thoughts (Rachman, 1997). It is possible that ruminating about intru-
sive thoughts may lead to more internal negative appraisals of naturally
occurring intrusive thoughts. That is, OCD patients may be more likely
to attempt to understand the causes and consequences of their recur-
rent intrusions subsequently leading to more intrusive thoughts and
distress. Consistent with this conceptualization, Freeston and Ladouceur (1997) found that OCD patients were more likely to use ru-
nimative strategies such as over analyzing the nature and implications
of their obsessive thoughts as a way to cope with the distress brought
on by these unwanted cognitions. Thus, just as rumination exacerbates
distress and interferes with effective problem solving abilities in indi-
viduals with depression (Nolen-Hoeksema, 2000), rumination may also
amplify the distress brought on by the unwanted cognitive intru-
sions experienced in the context of OCD.

Despite suggested associations, only two studies to date have exam-
ined the relationship between a ruminative response style and OCD.
Using a sample of 116 patients with unipolar mood disorders, Watkins
(2009) found that the brooding aspect of rumination was significantly
associated with OCD status. Wahl, Ertle, Bohne, Zurovski, and Kordon
(2011) extended this research by examining the associations between
rumination and OCD symptom dimensions utilizing two independent,
non-clinical student samples. In both samples, the authors found a sig-
ificant association between students’ tendency to ruminate and the se-
verity of OC symptoms, particularly obsessive rumination. These
findings held even after controlling for overall levels of depression, sug-
gest this relationship is not merely due to co-occurring depressive
symptoms. The authors concluded that a ruminative response style and
obcessive rumination may share common processual properties.

While informative, several limitations of this literature warrant fur-
ther investigation. First, Wahl et al. (2011) utilized a non-clinical under-
graduate sample. Although previous literature suggests OC symptoms
occur on a continuum and have their origin in largely normal human pro-
cesses (Gibbs, 1996), results may be exclusive to individuals on the non-
clinical end of this continuum. Second, whereas Watkins (2009) sample
was clinical in nature, all participants met criteria for a unipolar mood
disorder. Considering the robust relationship between rumination and depres-
sion (Nolen-Hoeksema et al., 2008), it is important to examine these
associations in samples not primarily comprised of depressed patients.

A third limitation of the previous literature includes the use of the Padua
Inventory, Revised (PI-R; German version by Emmelkamp & Van
Oosten, 2000; Van Oosten, Hoekstra, & Emmelkamp, 1995) to assess
OC symptoms. It has been argued that measurement of OC symptoms
using the PI-R is not ideal due to an underrepresentation of certain OC
dimensions and an overrepresentation of others (Abramowitz et al.,
2010). More specifically, the PI-R is comprised of an abundance of items
related to obsessions about harm, but no items related to symmetry concerns
and few assessing items related to unacceptable thoughts. This inconsisten-
cy of item content limits the ability to identify potential relationships be-
tween rumination and certain OC symptom dimensions.

Thus, the current study sought to extend the findings of Watkins
(2009) and Wahl et al. (2011) by examining the associations between
rumination and OC symptoms within a non-selected clinical sample
using the Dimensional Obsessive Compulsive Scale (DOCS;
Abramowitz et al., 2010), which was designed to capture the most com-
monly replicated OC symptom dimensions while also 1) taking into ac-
count various parameters of impairment/distress, 2) assessing for
avoidance related behaviors, and 3) assessing for obsessions and com-
pulsions equally across dimensions. To control for the possibility that
the associations among RTS and OC dimensions may better be
accounted for by an underlying depressive or anxiety temperament,
we also controlled for overall levels of negative affect (NA). Based on ex-
tant literature identifying rumination as a potentially important
transdiagnostic process that contributes to a number of anxiety and
mood-related disorders (Abbott & Rapee, 2004; Ehlers & Clark, 2000; Fresco et al., 2002), we hypothesized that frequent RTS would be asso-
ciated with increased OC symptoms above and beyond the effects
of NA. In particular, consistent with the findings of Wahl et al. (2011),
we predicted an association between RTS and the unacceptable
thoughts and neutralizing compulsions domain of OCD.

2. Methods

2.1. Participants and procedures

The sample consisted of 105 individuals receiving outpatient psy-
chological services and/or participating in research at the Florida State
University (FSU) Anxiety and Behavioral Health Clinic (ABHC). The
ABHC primarily serves individuals from the local community, though in-
dividuals suffering from psychotic and/or bipolar-spectrum disorders or
those who are an immediate danger to themselves or others are re-
ferred for services elsewhere. Participants were primarily female
(61%), ranging in age from 18 to 67 (M = 31.54, SD = 14.38). The
self-identified racial breakdown was as follows: 59% Caucasian, 22.9%
African American or Black, 1.9% Asian or Asian American, and 16.2% as
other (e.g., bi-racial). Of the total sample, 15.2% identified as Hispanic.
In terms of primary diagnoses 45% of the sample met for a primary anx-
iety disorder, 21% a primary depressive disorder, 20% a primary trauma-
and stressor-related disorder, 4% a primary obsessive-compulsive and
related disorder, 2% a primary substance use disorder, and 8% no prima-
ry diagnosis. Finally, 6% of the sample met for an OCD diagnosis regard-
less of whether it was the primary diagnosis.

All individuals in the current sample provided informed consent to
participate in the Institutional Review Board approved research being
conducted at the FSU ABHC. Diagnoses were determined by a structured
diagnostic interview and were later confirmed at weekly supervision
meetings with the director of the ABHC and a licensed clinical psychol-
ogist. After the diagnostic interview participants completed a battery of
questionnaires, including the DOCS, RRS, and NA subscale of the PANAS.

2.2. Materials

2.2.1. Structured Clinical Interview for the DSM-5 (SCID)

The SCID is a widely administered and well-validated semi-struc-
tured interview designed to assess for the presence of current and life-
time psychiatric conditions (First, Williams, Karg, & Spitzer, 2015). The
SCID was administered by highly trained, advanced clinical psychology
doctoral students. Training included review of SCID training tapes, live
observation of SCID administration, and conducting SCID interviews
with a trained interviewer. Feedback was provided to the trainee until
high reliability was demonstrated. Additionally, all SCIDs were present-
ed to and reviewed by the director of the ABHC and a licensed clinical psychol-
ogist. In the present study the rate of agreement was over 80%
with a kappa value of 0.77 (Timpano & Schmidt, 2012). The SCID was
administered upon intake to assess for potential psychiatric diagnoses
including OCD.

2.2.2. Dimensional Obsessive-Compulsive Scale (DOCS)

The DOCS is a 20-item self-report measure designed to assess the se-
verity of the most reliably found OCD symptom dimensions: contami-
nation, responsibility for harm and mistakes, symmetry/ordering, and
unacceptable thoughts (Abramowitz et al., 2010). Respondents rated
each item on a 5-point Likert-type scale with higher scores indicating
greater severity. The DOCS demonstrates excellent psychometric prop-
erties and has been validated in both clinical and non-clinical samples
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