Mental contamination: Relationship with psychopathology and transdiagnostic processes

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Abstract

Background: Mental contamination, the experience of feeling dirty in the absence of physical uncleanliness, is closely associated with obsessive compulsive disorder (OCD). Given that many features of OCD are found in other diagnoses, the primary aim of this study was to determine whether mental contamination is specific to OCD or whether it is also associated with psychopathology found in other disorders. We hypothesised that, in addition to OCD symptoms, mental contamination would be associated with other psychopathology, in particular symptoms of depression, anxiety and eating disorders, and with transdiagnostic processes such as perfectionism.

Methods: 120 participants (82%) completed measures of psychological disorders and transdiagnostic processes. Results were analysed using Pearson’s r correlations and a multiple regression analysis.

Results: Mental contamination was most strongly associated with symptoms of OCD but was also associated with eating disorder symptoms, depression and anxiety. It was also correlated with perfectionism, intolerance of uncertainty and fear of compassion. OCD, eating disorder symptoms, fear of compassion and low self-esteem were significant independent predictors of mental contamination.

Conclusions: Mental contamination is associated with a range of psychopathology but is most strongly associated with symptoms of OCD. Further research is warranted to advance treatment for mental contamination.

1. Introduction

Mental contamination is the experience of feeling dirty and polluted in the absence of physical contact with a contaminant. The construct of ‘Mental Pollution’ was described in the mid-1990s (Rachman, 1994) and elaborated on a decade later (Rachman, 2004). Both these classic papers and the subsequent book on the topic emphasised the construct of mental contamination within obsessive-compulsive disorder (OCD; Rachman, Coughtrey, Shafran, & Radomsky, 2014b). This emphasis of mental contamination was originally thought of as a transdiagnostic construct occurring across multiple disorders, but to date this has not been widely investigated (Rachman, 2004).

It is commonly acknowledged when diagnosing and classifying psychological disorders that it is not possible to ‘carve nature at its joints’ i.e. there have been challenges in identifying and establishing distinctions and discontinuities between clinical presentations (Cooper, 2015; Markon, Chmielewski, & Miller, 2011; Woods, 1979). Therefore there is growing interest in establishing which phenomena are present across diagnoses, and which are specific to a particular disorder. In fact, the vast majority of clinical phenomena occur across multiple disorders and very few are distinct. Those clinical phenomena that occur across multiple disorders are often termed ‘transdiagnostic’, although there is an important distinction between transdiagnostic processes that are considered to be shared mechanisms that contribute to the maintenance of psychopathology (Fairburn, Cooper, & Shafran, 2003) and transdiagnostic features or symptoms that simply occur across disorders.

Many of the symptoms of OCD do occur across disorders and could be considered transdiagnostic. For example, checking behaviour characterises Generalised Anxiety Disorder (GAD; Schut,
avoidance is a diagnostic feature that occurs across anxiety disorders (American Psychiatric Association, 2013), and at times, having repetitive, unwanted, intrusive thoughts can be hard to distinguish from rumination and worry (Macatee et al., 2016; Tolin, Worhunsky, & Maltby, 2006). Research on cleansing and morality suggests that while it is prominent in OCD (Reuten, Liberman, & Dar, 2013), the phenomenon is not restricted to this psychopathology (Kalanthroff, Aslan, & Dar, 2015; West & Zhong, 2015; Zhong & Liljenquist, 2006).

Furthermore, it is not only the symptoms or features of OCD that occur across disorders. There is now evidence that there are cognitive biases or beliefs that operate across disorders. For example, thought-action fusion, the belief that having an unwanted, unacceptable thought increases the likelihood that a specific adverse event will occur and that having such thoughts are the moral equivalent of carrying out that particular act, is a cognitive bias/belief that was first described in the context of OCD (Shafran & Rachman, 2004; Shafran, Thordarson, & Rachman, 1996). However, it quickly became apparent that thought-action fusion also occurred in GAD and other anxiety disorders (Thompson-Hollands, Farchione, & Barlow, 2013). Indeed, similar beliefs (‘thought shape fusion’) have been found in eating disorders (Kostopoulou, Varsou, & Stalikas, 2013). Conversely, constructs first considered in the context of other disorders (such as experiential avoidance) now appear to be relevant to OCD (Reuman, Jacoby, & Abramowitz, 2016).

The Obsessive Compulsive Cognitions Working Group identified six beliefs that characterised OCD but were transdiagnostic in that they occurred across disorders (Obsessive Compulsive Cognitions Working Group, 1997; Tolin et al., 2006). These beliefs included intolerance of uncertainty and perfectionism owing to the consensus of their clinical importance in the understanding and maintenance of OCD. The proposed importance of these transdiagnostic constructs has been borne out through subsequent empirical work; for example, intolerance of uncertainty and perfectionism were demonstrated to predict treatment outcome in a recent study of response to cognitive behaviour therapy for OCD (Kyrilos, Hordern, & Fassnacht, 2015). Intolerance of uncertainty can be defined as the excessive tendency to react negatively to an uncertain or ambiguous event or situation, even if the probability of such an event occurring or the likelihood of negative consequences is very low (Ladouceur, Gosselin, & Dugas, 2000). Experimental studies inducing uncertainty in subclinical people with obsessive compulsive symptoms demonstrate that such uncertainty leads to checking behaviour (Toffolo, Van den Hout, Hooge, Engelhard, & Cath, 2013) and there is considerable work demonstrating that, in turn, checking causes doubt (Radomsky, Dugas, Alcolado, & Lavoie, 2014a). In a large analogue sample, intolerance of uncertainty was found to mediate the relationship between perfectionism and OCD (Reuther et al., 2013). It is also elevated in people with eating disorders (Brown et al., 2017).

The definition of perfectionism has long been debated. Frost and colleagues defined perfectionism as the “setting of excessively high standards for performance accompanied by overly critical self-evaluation” (Frost, Marten, Lahart, & Rosenblate, 1990, p. 450). More recently the term ‘clinical perfectionism’ has been described as “the overdependence of self-evaluation on the determined pursuit of personally demanding self-imposed standards in at least one highly salient domain despite adverse consequences” (Shafran, Cooper, & Fairburn, 2002, p. 778). Although several studies report a strong relationship between OCD and perfectionism (see Martinelli, Chasson, Wetterneck, Hart, & Bjorgvinsson, 2014), it should be noted that one of the subscales of perfectionism (‘Doubts About Actions’) on the commonly used Frost Multidimensional Perfectionism Measure (Frost et al., 1990) was actually taken directly from the Maudsley Obsessive Compulsive Inventory (Hodgson & Rachman, 1977), a measure of OCD. Studies showing associations between this subscale and OCD severity (e.g., Martinelli et al., 2014) are really demonstrating the overlap in symptoms between OCD and perfectionism. However, other research excluding the doubts about actions subscale have also highlighted that individuals with OCD have significantly elevated perfectionism and that this interferes with their ability to successfully engage in treatment and predicts treatment outcome (Egan, Wade, & Shafran, 2011).

Given the clear relationship between mental contamination and OCD, and between OCD and both intolerance of uncertainty and perfectionism, it is likely that intolerance of uncertainty and perfectionism are also related to mental contamination. Clinically, patients with mental contamination fears often report both intolerance of uncertainty (e.g., they experience high levels of anxiety in situations where there is ambiguity over whether contamination may have occurred) and perfectionism (e.g., they have high moral standards) and it is likely that these processes are also related to mental contamination (Rachman, 2004). Intolerance of Uncertainty and Perfectionism are not the only two transdiagnostic constructs that are of potential relevance to OCD and mental contamination. There has been an important and growing research literature on the role of the ‘self’ in OCD with data suggesting that part of the motivation for compulsive behaviour may be the restorative impact on self-esteem (Ahern, Kyrilos, & Meyer, 2015). Related work on self-compassion (the ability to experience empathy and feelings of kindness, warmth and gentleness towards oneself, particularly in times of difficulty; Gilbert, 2009, 2010) indicates that people with OCD are relatively low in self-compassion (Wetterneck, Lee, Smith, & Hart, 2013; Wetterneck, Singh, & Hart, 2014), which could both contribute to, and be a consequence of, OCD. Given that the treatment of mental contamination is relatively new (Rachman et al., 2014), it is important to know whether mental contamination is related to other transdiagnostic processes and to symptoms of other disorders beyond OCD, in order to ensure that future treatment developments are effective. This is particularly relevant as a recent meta-analysis has demonstrated that transdiagnostic treatments for anxiety are efficacious (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015).

Taken together, it is possible that treating underlying transdiagnostic processes such as perfectionism, intolerance of uncertainty, self-esteem and self-compassion may improve outcome rates for anxiety disorders. Therefore, the first aim of the current study was to test the hypothesis that mental contamination would be associated with perfectionism, intolerance of uncertainty, self-esteem and self-compassion and, specifically, that these transdiagnostic constructs would predict levels of mental contamination.

Given that so many of the features of OCD are found in other diagnoses, it is also of interest to determine whether mental contamination is specific to this disorder or whether it is associated with psychopathology found in other disorders. There has already been work demonstrating the association between trauma, disgust and mental contamination (e.g., Badour, Bown, Adams, Bunaciuc, & Feldner, 2012; Badour, Ojesrisk, McKay, & Feldner, 2014), and there is some indication that the relationship between trauma and mental contamination is moderated by tolerance of negative emotions (Fergus & Bardeen, 2016). In addition, given the high comorbidity between OCD and depression (Overbeek, Schruers, & Griez, 2002), anxiety (Crino & Andrews, 1996), and eating disorders (Altman & Shankman, 2009), it would be anticipated that there would be a close relationship between mental contamination and the psychopathology of each of these disorders. The second aim of the current study was to examine the associations between mental contamination and symptoms of OCD, depression, anxiety and eating disorders. In addition to examining simple associations, exploratory analyses were conducted in order to examine the unique contributions of these transdiagnostic constructs and symptom measures with mental contamination (above and beyond the other study variables).
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