



Phenomenology and thematic content of intrusive imagery in bowel and bladder obsession



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ABSTRACT

Case reports and clinical experience suggest some individuals with anxiety-disorders experience an overwhelming fear of losing control of basic bodily functions in public. However, many features of bowel- and/or bladder-obsession, such as the accompanying cognitive processes or content, have not been described. Given the role of intrusive imagery in maintaining psychological disorders, this study examines mental imagery as a specific form of cognitive content in bowel/bladder obsession. Twenty participants reporting intrusive imagery linked to a fear of losing control of bowel or bladder function in public completed semi-structured interviews on the nature and characteristics of their mental imagery and its relationship to past events. Imagery was characterised by a predominance of physically-based and visual, 'flash-forward' mental events. This future-oriented imagery tended to end with the feared catastrophe (public incontinence) occurring, or was truncated, ending before the catastrophic event. Distressing past events significantly influenced the content of such imagery. Qualitative analysis of imagery interviews enabled a thorough thematic characterisation of imagery content and identification of seven coherent themes: visceral urgency, total exposure, self-as-inferior, absence-of-control, contamination/disgust, rejection-of-failing-self and judgemental-others. This first description of intrusive mental imagery in bowel/bladder obsession reveals thematic and phenomenological characteristics that may represent foci for novel imagery-based interventions.

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1. Introduction

Psychological therapists occasionally encounter patients who experience an overwhelming fear of losing control of basic bodily functions in a public place. The small number of existing studies of bowel and/or bladder obsession suggest shared features with social anxiety (Lelliott, McNamee, & Marks, 1991), obsessive compulsive disorder (OCD; Beidel & Bulik, 1990; Cosci, 2012; Hatch, 1997; Jenike, Vitagliano, Rabinowitz, Goff, & Baer, 1987; Porcelli & Leandro, 2007) and panic (Eldridge, Walker, & Holborn, 1993; Lelliott et al., 1991). These shared features include repetitive checking for visceral sensations and frequent and repeated use of the toilet to check for complete evacuation of the bowel/bladder (c.f. OCD), fear of negative social evaluation (c.f. social anxiety disorder), 'catastrophic' cognitions about bodily dysfunction (c.f. panic disorder). Other features of this syndrome include experiences of visceral urgency, vigilance to the location of toilets, and high levels of role impairment (Beidel & Bulik, 1990; Hatch, 1997; Jenike et al., 1987; Porcelli & Leandro, 2007).

Despite an absence of diagnostic criteria, advances in cognitive behavioural treatment of bowel/bladder obsession is likely to

proceed from a more detailed understanding of cognitive content (including imagery) and processes involved in problem-maintenance. There is also an increasing recognition of the importance of applying a symptom-focused, rather than a formal diagnostic understanding to psychological difficulties (Harvey, Watkins, Mansell, & Shafan, 2004) and this seems especially relevant to investigating a 'disorder' which has hitherto eluded categorisation.

One transdiagnostic phenomenon implicated in a variety of mood and anxiety disorders is the occurrence of intrusive mental imagery related to the individual's current concern (Brewin, Gregory, Lipton, Burgess, & Chris 2010). Our (SKK and SW) clinical observations in the course of treating people with bowel/bladder obsession suggests that intrusive imagery has special relevance to this presentation. Drawing on our clinical experience as well as the recent work on intrusive mental imagery in psychopathology (Brewin et al., 2010) our aim in this study is to characterise mental imagery in bowel/bladder obsession as an initial step to developing a more comprehensive cognitive behavioural conceptualization of this problem.

The characteristics of intrusive mental imagery have been described across a range of anxiety and mood disorders (Brewin et al., 2010) and also in conditions where physical symptoms predominate (e.g. Borna et al. 2011). For example the occurrence of intrusive imagery is involuntary, repetitive and associated with high levels of distress. Furthermore, these repetitive images are

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often thematically linked to distressing past experiences (Hackmann, Clark, & McManus, 2000; Price, Veale, & Brewin, 2012; Wheatley et al., 2007; Wild, Hackmann, & Clark, 2007, 2008). The content of mental imagery also has implications for self-concept and self-worth (Conway & Pleydell-Pearce, 2000; Hackmann et al., 2000; Wild et al., 2007, 2008). For instance, a central aspect of the cognitive behavioural model of social anxiety is 'processing of the self as a social object' (Clark & Wells, 1995). The outcome of this processing is the generation of a negative mental representation of the self, contributed to by the occurrence of spontaneous, distorted images of the self. These spontaneous images are characteristically experienced from an observer's perspective and their content often involves themes of failure, incompetence or the appearance of some undesirable physical characteristic (e.g. shaking uncontrollably, appearing very sweaty or possibly, an exaggerated facial expression or bodily posture denoting the urgent need to use the toilet; Clark, 2001).

In addition, as with verbal thoughts, catastrophic imagery is generally a distorted representation of past or future events, playing a key role in disorder maintenance (Hackmann et al., 2000; Pratt, Cooper, & Hackmann, 2004) while being maintained in turn through behavioural and cognitive avoidance (Hackmann, Bennett-Levy, & Holmes, 2011). In addition to potentially providing a metaphorical window into the mind of clients with bowel/bladder obsession, imagery represents a therapeutic target through rescripting (Hackmann et al., 2011). A more complete understanding of the characteristics of intrusive imagery in psychological disorders (e.g. their predominant sensory modality, view-point, vividness) is therefore relevant to development of such rescripting strategies.

The aim of the current study is to provide the first detailed phenomenological description of anxiety-related imagery in people with bowel/bladder obsession. The inspiration for this study comes from similar recent description of mental imagery in anxiety and mood disorders (e.g. Day, Holmes & Hackmann, 2004; Muse, McManus, Hackmann & Williams, 2010; Patel et al., 2007; Price et al., 2012; Speckens, Hackmann, Ehlers & Cuthbert, 2007). These descriptions have led to novel, theory-based imagery rescripting interventions (e.g. Wild et al., 2007, 2008), which in some cases circumvent the traditional verbal reappraisal strategies used in cognitive therapy (e.g. Wheatley et al., 2007).

Consistent with the literature on mental imagery in mood and anxiety disorders, our primary aim was to elicit and describe the content and phenomenological features of mental imagery, using an adapted version of an established semi-structured interview (Hackmann et al., 2000). Since this interview schedule has been used in the majority of studies examining intrusive mental imagery in psychopathology (Brewin et al., 2010) we retained its main components to allow easy comparison between our study and previous ones. However, in contrast to most previous studies, we also employed a detailed thematic analysis of imagery content. An inductive approach to determine coherent themes within the intrusive imagery is especially important for bowel/bladder obsession given an absence of studies focusing on beliefs and meaning-making in people with these difficulties. As the extent of distress and impairment associated with bowel/bladder obsession is also unclear, a number of measures of general psychopathology were used to supplement the qualitative and other descriptive features of bowel/bladder obsession outlined here.

2. Method

2.1. Participants: recruitment and screening

Ethical approval for this study was obtained through University College London/University College London Hospital ethics committee.

A self-selecting community sample was recruited through internet advertisement placed on UK-based websites. Participants responding to the advert were initially screened for inclusion on the basis of their responses to the internet survey

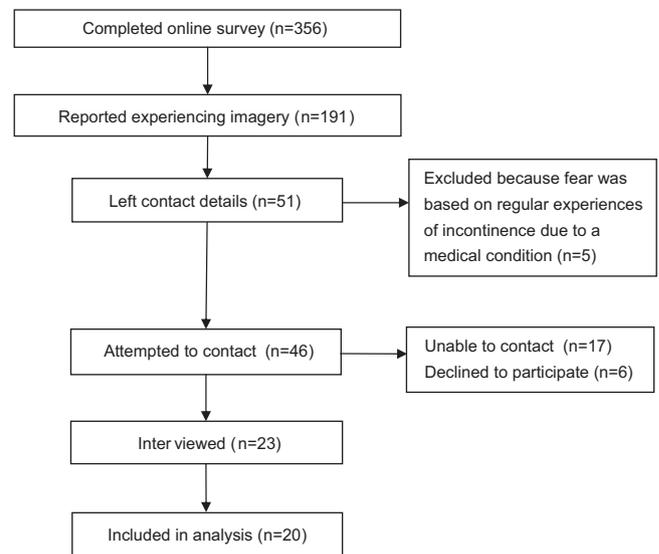


Fig. 1. Flowchart of recruitment process.

which was accessed via a link on the advertisement. Inclusion criteria included age 18–65, presence of a fear of incontinence in the absence of a medical disorder and presence of mental imagery related to bowel/bladder obsession. Participants were also required to be fluent in English and to be able to provide informed consent. Exclusion criteria included an indication of the presence of a medical condition associated with relatively frequent incontinence. If participants met inclusion criteria and were willing to participate further, they provided their contact details on the survey form. The flow of included participants through the study is outlined in Fig. 1.

Online recruitment was the most appropriate source of participants for this study given that prevalence of bowel/bladder obsession is unknown and may be low (hence difficult to recruit from primary care services) and was predicted to be associated with high levels of shame and concealment. Online advertisements explicitly referred to *fear* (rather than experiences) of incontinence. Advertisements also referred to the high levels of distress and impairment caused by this fear with the aim of encouraging responses from those who experienced higher levels of disruption. In order to target recruitment as far as possible towards individuals with difficulties resembling bowel/bladder obsession, which has been conceptualised as an anxiety-related problem, advertisements were placed on anxiety disorder websites (e.g. Anxiety UK, No More Panic) although more general online advertisement resources (Gumtree, Facebook) were also used. Efforts were made to screen participants specifically for *fear* rather than *regular experiences* of incontinence, by individually reviewing online survey responses (i.e. participants' beliefs about the causes of their fear of losing bowel/bladder control).

Twenty three participants were contactable, met inclusion criteria, and agreed to participate (see Fig. 1) in the imagery interview. Two participants were subsequently excluded as a result of disclosure during the imagery interview of a medical problem that might cause incontinence. These had not previously been indicated in their online survey responses. Poor line quality during the third interview made transcription impossible, leaving a final total of $n=20$.

Participants received a small monetary compensation for their time.

2.2. Online survey

Initial details about participants' fear of losing bladder/bowel control were obtained through the online survey referred to above. This contained basic demographic, as well as bowel/bladder obsession-specific questions and measures of panic, avoidance and role impairment. Participants provided their contact details including telephone number and address if they wished to continue with the imagery study. The survey inquired about participants' predominant concern (bowel control, bladder control, or both), whether they had ever discussed their fear (i.e. their bowel/bladder obsession) with anyone and whether they had sought help for their fear. As noted above, they were also asked to indicate the presence of any physical condition associated with the actual and frequent occurrence of incontinence (e.g. inflammatory bowel disease, stress and urge incontinence).

The survey also inquired about the presence/absence of panic attacks. The nature of panic attacks was described in detail (the sudden nature of the increase in anxiety and the presence of at least four of the thirteen panic symptoms outlined in DSM IV; American Psychiatric Association, 1994) prompting participants to indicate the presence/absence of panic attacks. Those who experienced panic then indicated their frequency in the past two weeks on a five-point scale (0 = no panic attacks; 4 = one or more panic attacks per day; Wells, 1997).

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