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Relationships between thought–action fusion, thought suppression and obsessive–compulsive symptoms: a structural equation modeling approach

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Abstract

Research has shown that there are strong similarities in content between the obsessions and compulsions that characterize obsessive–compulsive disorder and nonclinical obsessions and compulsions. However, clinical and nonclinical obsessions and compulsions do differ with respect to characteristics like frequency, intensity, discomfort and elicited resistance. Two separate concepts have been invoked to explain how normal obsessions and compulsions may develop into clinical phenomena. First, it is suggested that thought–action fusion (TAF) contributes to obsessive–compulsive symptoms. Second, thought suppression may intensify obsessive–compulsive symptoms due to its paradoxical effect on intrusive thoughts. Although both phenomena have been found to contribute to obsessive–compulsive symptoms, possible interactions between these two have never been investigated. The current study explored how TAF and thought suppression interact in the development of obsessive–compulsive symptoms. Undergraduate psychology students ($N = 173$) completed questionnaires pertaining to TAF, thought suppression and obsessive–compulsive symptoms. Covariances between the scores on these questionnaires were analyzed by means of structural equation modeling. Results suggest that TAF triggers thought suppression, while thought suppression, in turn, promotes obsessive–compulsive symptoms.

Keywords: Obsessive–compulsive symptoms; Structural equation modeling; Thought–action fusion; Thought suppression

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1. Introduction

Obsessions and compulsions are the core features of obsessive–compulsive disorder (OCD). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994, p. 418) "obsessions are persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress". Most obsessions involve thoughts about contamination, repeated doubts, a need to have things in a particular order, aggressive impulses, or sexual imagery (Rachman & Hodgson, 1980). DSM-IV defines compulsions as "repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation" (APA, 1994, p. 418). The most common compulsions involve cleaning and checking (Rachman & Hodgson, 1980).

There is evidence to suggest that a majority of people experiences unpleasant intrusions similar to the obsessions seen in OCD. For example, Rachman and De Silva (1978) (see also Salkovskis & Harrison, 1984) examined obsessive thinking in nonclinical subjects and OCD patients. These authors noted that about 80% of the nonclinical subjects experienced obsessions. Furthermore, they found remarkable similarities between 'abnormal' and 'normal' obsessions as far as the content of these obsessions is concerned. However, abnormal obsessions were found to be more frequent, intense, of longer duration and to produce more discomfort than normal obsessions. Muris, Merckelbach and Clavan (1997) compared compulsive behaviors of OCD patients with rituals of normal subjects. In accordance with the studies on abnormal and normal obsessions, these authors found a close correspondence between the content of abnormal and normal compulsions. Again, however, abnormal compulsions were more frequent and intense, elicited more discomfort and were more often associated with distressing thoughts and negative mood than normal compulsions. Taken together, these studies seem to demonstrate that normal intrusions and rituals and their clinical counterparts constitute one dimension.

Researchers have speculated about the antecedents that may be involved in the transformation of normal intrusions and rituals. Two main research lines have addressed this issue in a systematic and well-articulated manner. The first can best be referred to as the cognitive theory of obsession (Salkovskis, 1985; Rachman, 1993, 1997, 1998). The core assumption of this approach is that the interpretation that a person gives to an intrusive thought determines the obsessive qualities of that intrusion. By this view, a person who feels extremely responsible for his or her thoughts, will experience more discomfort when an 'immoral' thought (e.g. about sex or violence) intrudes consciousness than a person without such an inflated sense of responsibility. Persons suffering from an exaggerated sense of responsibility may think that immoral intrusions indicate them to be bad. Such an appraisal may add obsessive qualities (e.g. increased discomfort, tension, anxiety and resistance) to intrusive thoughts. Rachman, Thordarson, Shafran and Woody (1995), presented a refined version of this cognitive account of OCD. That is, their work demonstrated that two types of cognitive biases are specifically associated with obsessive–compulsive symptoms. The first bias