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If I do it, it must be important: Integrating basic cognitive research findings with cognitive behavior theory of obsessive-compulsive disorder

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Summary

Cognitive behavior accounts of obsessive-compulsive disorder ascertain that the catastrophic interpretation of (normally occurring) intrusive thoughts as a sign of danger plays a major role in the etiology and maintenance of OCD. Various researchers have placed particular importance on metacognitive beliefs such as thought importance and control of thoughts as paramount forces driving such interpretations. Obsessive-compulsive patients and their family members have been found to show diminished capability of response inhibition relative to healthy controls. We propose that deficits in response inhibition are related to the development and maintenance of obsessive-compulsive metacognitive beliefs. We further suggest that patients observe their own behavioral tendencies and subtle reactions associated with intrusions and interpret these as indicating that the intrusions are important. Over time generalizations of this process are established in the form of metacognitive beliefs. Specific hypotheses for future research and clinical implications are suggested.

Keywords: *metacognitive beliefs, obsessive-compulsive disorder, response inhibition.*

Riassunto

Se lo faccio, deve essere importante: integrare i risultati della ricerca di base con la teoria cognitivo-comportamentale del disturbo ossessivo-compulsivo

Le spiegazioni cognitivo-comportamentali del disturbo ossessivo-compulsivo (DOC) rilevano che l'interpretazione catastrofica di pensieri intrusivi (che si presentano normalmente) come di segnali di

* Barbara Barcaccia and Francesco Mancini, Eds.

pericolo gioca un ampio ruolo nell'eziologia e nel mantenimento del disturbo ossessivo-compulsivo. Vari ricercatori hanno posto particolare attenzione sulle credenze metacognitive quali l'importanza e il controllo dei pensieri come forze supreme che determinano tali interpretazioni. I pazienti ossessivi e le loro famiglie mostrano una minore capacità di inibizione della risposta rispetto al gruppo di controllo sano. Noi proponiamo che tali deficit nell'inibizione della risposta siano legati allo sviluppo e al mantenimento delle credenze metacognitive ossessivo-compulsive. Sugeriamo inoltre che i pazienti osservino le loro tendenze comportamentali e le sottili reazioni associate alle intrusioni e che le interpretino come l'indicazione che le intrusioni siano importanti. Le generalizzazioni di questo processo sono stabilite col passare del tempo sotto forma di credenze metacognitive. Vengono suggerite ipotesi specifiche per la ricerca futura e le implicazioni cliniche.

Parole chiave: *credenze metacognitive, disturbo ossessivo-compulsivo, inibizione della risposta.*

OBSESSIVE-COMPULSIVE DISORDER AND COGNITIVE BEHAVIOR THERAPY

Obsessive-compulsive disorder (OCD) is an anxiety disorder with a lifetime prevalence of 2%-3% (Weissman et al., 1994). OCD is highly debilitating, negatively affecting quality of life and level of functioning (Huppert et al., 2009) and is involved with high rates of comorbidity as more than half the patients present with at least one other DSM-IV diagnosis (Steketee and Barlow, 2004). Cognitive behavior therapy (CBT) consisting of exposure and response prevention or cognitive therapy is the most efficacious psychological treatment of OCD (Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa and Marín-Martínez, 2008). Unfortunately, many patients drop out or do not benefit sufficiently from treatment, and once stringent criteria of recovery (i.e., minimal symptoms) are applied, only 25% reach recovery (Fisher and Wells, 2005). Therefore, there seems to be great room for improvement in our understanding and treatment of OCD.

A predominant psychological model to understand the symptoms of OCD is the cognitive behavioral model (Salkovskis, Forrester and Richards, 1998). Salkovskis (1999) presents the main tenets of this model as follows: (1) Intrusions occur in at least 90% of the general population; (2) The difference between normal intrusive cognitions and obsessional intrusive cognitions lies in their interpretation; (3) For the OCD patient the intrusive cognition is an indication that he is responsible for harm or its prevention. As a consequence of this interpretation, the OCD patient experiences anxiety, discomfort and engages in anxiety-neutralizing (compulsive) behavior. Further attempts of mental control elicit paradoxical effects of increasing these thoughts, perpetuating a vicious circle (Purdon and Clark, 2002). Wells and colleagues stress the importance of metacognitive beliefs (i.e. beliefs about thinking) in the catastrophic interpretation of thought crucial to the development and maintenance of OCD (Wells and Matthews, 1994; Solem, Myers, Fisher, Vogel and Wells, 2010). Metacognitive beliefs include domains such as overimportance of thoughts, in which the mere presence of a thought appears to give it status (e.g., «I think about a thought because it is important, and it is important because I think about it») and

beliefs about the importance of controlling one's thoughts (e.g., «One should (and can) exercise control over one's thoughts», Clark and Purdon, 1993; OCCWG, 1997). Other conceptualizations of metacognitive beliefs in OCD have referred to thought-action fusion which consists of two types of beliefs (1) that having an immoral thought equals to carrying it out (TAF morality), and (2) that having a thought increases the likelihood of its occurring in real life (TAF likelihood; Shafran, Thordarson and Rachman, 1996). Thus, for the OCD patient having a thought of harming his child equals to being a psychopath capable and maybe even desiring to do so.

Several lines of empirical evidence support the importance of metacognitive beliefs to the development and maintenance of OCD. For example, in a study using a student population, participants were asked to write the sentence «I hope that X is in a car accident» and then insert the name of a loved one (Rachman, Shafran, Mitchell, Trant and Teachman, 1996). Participants high on thought action fusion demonstrated increased anxiety and urge to neutralize (e.g., by destroying the paper). Metacognitive beliefs were found to differentiate between OCD patients and community controls (Solem, Myers, Fisher, Vogel and Wells, 2010). Further, an analysis of treatment predictors of behavior and response prevention for OCD patients has demonstrated that only changes in metacognition were significant when overlap between predictors was controlled for (Solem, Håland, Vogel, Hansen and Wells, 2009).

Little is known about the etiological basis for meta-cognitive beliefs of OCD patients. Shafran (2005) suggested several factors that might contribute to the development of these beliefs: (1) Rigid and extreme codes of conduct and duty (e.g., the religious belief «sin by thought, sin by deed»), (2) an incident in which it appeared that one's thoughts and/or actions or inaction contributed to a serious misfortune (e.g., wishing someone was dead and finding out that they died later that day), and (3) experiences involving criticism or blame, as well as situational increases in responsibility (e.g., birth of a child/having an infant; Abramowitz, Schwartz and Moore, 2003). However, these factors are mostly descriptive and provide limited explanation for individual differences in proneness to develop these beliefs. Little is known about basic cognitive processes or deficits related to the development of metacognitive beliefs.

OBSESSIVE-COMPULSIVE DISORDER AND RESPONSE INHIBITION

Neuropsychological research of OCD patients has indicated that they show various deficits in executive functions (Abramovitch, Dar, Schweiger and Hermesh, 2011). One of the functions most extensively investigated is response inhibition; OCD patients were found to perform poorly on response inhibition relative to control subjects (Bannon, Gonsalvez, Croft and Boyce, 2002; Penades et al., 2007). Perhaps the most common task of response inhibition, demonstrating deficits in OCD patients and their families relative to health controls, is the stop signal task (Chamberlain, Fineberg, Blackwell, Robbins, and Sahakian, 2006; Menzies et al., 2007; Morein-Zamir, Fineberg, Robbins and Sahakian, 2010). The stop-signal task (Logan, 1994; Logan and Cowan, 1984) examines the ability to suppress an already initiated action or thought that is no longer appropriate. In the common version

of the task, participants are asked to address a visual stimulus (go signal) with a motor response as fast as possible. In about one third of the trials, an auditory stimulus (stop signal) comes right after the visual go signal. Participants are instructed to inhibit their motor response when they hear the stop signal. The duration between the visual stimulus and the stop signal (stop-signal delay; SSD) changes from one trial to the next by a tracking procedure and is based on the participant's success in inhibiting his response. When participants succeed in response inhibition, the next stopping trial is more difficult (the SSD is longer) and when participants fail to inhibit their response, the next stopping trial is easier (the SSD is shorter). Eventually, it is possible to estimate the stop-signal reaction time (SSRT), which is the time needed for successful inhibition. Stop-signal reaction time has proven to be an important measure of cognitive control (Verbruggen and Logan, 2008).

INTEGRATING FINDINGS OF RESPONSE INHIBITION DEFICITS WITH COGNITIVE BEHAVIOR THEORY

We suggest that inhibition difficulties in OCD patients may serve an etiological role in the development and maintenance of metacognitive beliefs, and possibly serve as a predictor for treatment response. Our theory follows a similar logic to one of the classical emotion theories in the field of psychology, that of William James (Ellsworth, 1994). James questioned the temporal logic of our understanding of relations between physiological reactions, emotion and behavior. He suggested that «Common-sense says we lose our fortune, are sorry and weep; we meet a bear, are frightened and run; we are insulted by a rival, are angry and strike. The hypothesis here to be defended says that this order of sequence is incorrect, that the one mental state is not immediately induced by the other, that the bodily manifestations must first be interposed between, and that the more rational statement is that we feel sorry because we cry, angry because we strike, afraid because we tremble» (James, 1884/1969; 1890/1950). OCD patients may experience the behavioral tendencies associated with thoughts as more difficult to inhibit and encounter more instances in which (subtle) reactions to thoughts occur. These phenomena may be later interpreted as a sign that the associated thoughts have special significance. Over time, general metacognitive beliefs about importance of intrusive thoughts and need to control these thoughts may arise. A growing body of research supports the notion that a variety of motor movements such as facial expressions (e.g., Buck, 1980), posture (e.g., Stepper and Strack, 1993) and arm movements (e.g., Förster and Strack, 1997) can influence individuals' thoughts and feelings (Chandler and Schwartz, 2009). Imagine for example an OCD patient having the thought that a loved one might die in a car accident and touching something as a consequence. Observing her own behavior, this patient may be inclined to (implicitly) make the interpretation that «if I reacted to this thought it must be important and therefore my loved one is really in danger». In a sense, OCD patients do indeed have thought action fusion; the distance between thoughts and behavior in these patients is decreased since inhibition capability is diminished.

Alternatively, inhibition difficulties in OCD patients may be related to task control. Cognitive control is involved in solving task conflict; performing one task while playing

down irrelevant tasks. Usually irrelevant tasks consist of automatic triggers. This corresponds with findings that demonstrate that stimuli may trigger performance of tasks that have strong associations with them (Allport and Wylie, 2000; Rogers and Monsell, 1995; Waszak, Hommel and Allport, 2003). In recent years, studies demonstrated the existence of task conflict in various tasks: e.g., Goldfarb and Henik (2007) with the Stroop task; Braverman and Meiran (2010) with the task switching paradigm; La Heij, Boelens and Kuipers (2010) with the object interference task). La Heij and Boelens (2011) and Kalantrhroff, Goldfarb and Henik (in preparation) argued that task control should be conceptualized as inhibition of pre-potent responses and that task conflict is stronger when this control is low. We suggest that a deficit in inhibitory control makes it harder for OCD patients to inhibit irrelevant automatic tasks that are usually suppressed without awareness. As mention earlier, the performance of these behaviors later receives meaning.

DIRECTIONS

Several interesting predictions for future research arise as consequence of the ideas we suggest. First, we expect that thoughts that will be experimentally paired with irrelevant motor actions (thus artificially forming thoughts that possess behavioral tendencies) will be perceived as more significant and likely to occur than thoughts that have not been paired with such motor actions. This hypothesis stems from the observation that OCD phenomena are often senseless and even irrelevant for the tasks related to the intrusive thoughts (e.g., Zor et al., 2009). Second, measures of response inhibition (indices of the stop signal task) are expected to correlate with measures of OCD beliefs, particularly beliefs about importance of thoughts and control of thoughts. Third, we expect significant clinical implications for the treatment of OCD through the training of response inhibition. We expect that training of inhibition would aid in the treatment of OCD by (1) changing of metacognitive beliefs about the importance of thoughts and thought control, and (2) improving efficacy of exposure and response prevention (enhancing self-control). Fourth, we suggest that differences in response inhibition may predict differential responses to induced compulsive-like behaviors. van den Hout's seminal work (van den Hout and Kindt, 2003; van den Hout, Engelhard, de Boer, du Bois and Dek, 2008) has demonstrated that compulsive-like behaviors such as checking or staring induce uncertainty in healthy controls. However, these experiments do not suggest etiological factors explaining why some people are more prone to engage in these behaviors and become entangled in the vicious circle of doubt, uncertainty and compulsive behaviors. We suggest that subjects with low inhibition as measured by the stop signal paradigm may exhibit more uncertainty on tasks inducing compulsive behaviors than subjects with strong inhibition capabilities. Furthermore, we hypothesize that subjects who perform these compulsive-like tasks may show decreased inhibition on the stop signal paradigm once it adjusted to contain the same stimuli (e.g., a virtual gas stove).

It has to be noted that some researchers have not found inhibition difficulties in OCD patients (e.g., Moritz, Kloss and Jelinek, 2009; though they have investigated cognitive inhibition and not response inhibition). Moritz and colleagues (2009) have argued that a

fundamental inhibition deficit is unlikely in OCD since (1) patients are troubled only by some thoughts and cognitions, and (2) patients can resist acting according to these urges. In response to these concerns we suggest that emotional valence may interact with response inhibition difficulties and accentuate subtle dysfunctions. Furthermore, we suggest that the mere experience of a strong behavioral tendency or the execution of subtle responses suffice for the increase in the personal relevance of intrusive thoughts. Our hypothesis does not contradict the intact ability of OCD patients to control themselves from performing the full behaviors portrayed by their intrusive thoughts. We suggest that research effort should not concentrate on cognitive control as intrusions are a naturally occurring phenomenon but rather on (failures in) response inhibition. This parallels the CBT rationale in the sense that intrusions (representing cognitive control) are not the target of intervention (on the contrary, suppressing thoughts is discouraged) but reactions to intrusions are prevented (thus, response inhibition is being promoted).

In conclusion, we suggest that impaired response inhibition is related to the development of OCD metacognitive beliefs. The experience of difficulty to inhibit behavior tendencies related to intrusive thoughts may lead to the perceptions of these thoughts as important and likely to occur. As a consequence, these patients may engage in thought suppression as well as compulsive behavior, and become entangled in a vicious circle. Impaired response inhibition may be a basic cognitive process underlying vulnerability to develop OCD symptoms and may become exacerbated when high valences emotional stimuli are encountered.

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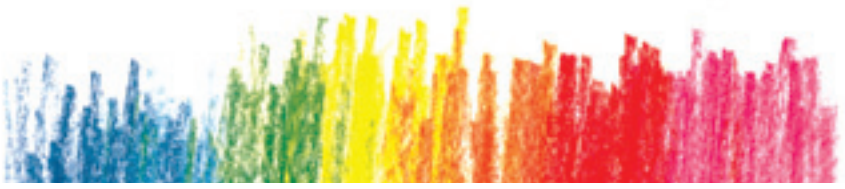
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