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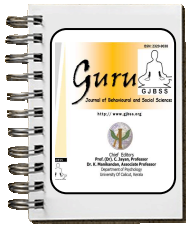

An exploration of obsessive beliefs and their Personality correlates in female young adults of Kerala

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Abstract

The study is an exploration into the nature and prevalence of obsessive beliefs in female young adults of Kerala and comparison of personality dimensions among individuals with stronger and weaker obsessive beliefs. The tools used were Obsessive Beliefs Questionnaire (OBQ-44) and the Calicut University Personality Inventory (CUPI). The Obsessive Beliefs Questionnaire (OBQ-44) was administered to the whole sample, based on whose scores, 30 high scorers and 30 low scorers were selected and were individually administered the CUPI subscales of Neuroticism and Conscientiousness. Results indicated that the prevalence of obsessive beliefs is significantly higher in this culture, even higher than the sample of Obsessive Compulsive patients in the West. Further analysis revealed that Neuroticism did not differ significantly in the subjects with stronger and weaker obsessive beliefs, while Conscientiousness differed significantly in the two groups

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Earliest attempts at understanding psychopathology, particularly neurotic states, have identified obsessions as one major psychological disturbance affecting man. The Oxford dictionary of Psychology (Tolman, 2009) defines the term obsession as a recurrent and persistent thought, impulse or idea that causes significant distress, is experienced as intrusive or inappropriate, is not merely an exaggerated worry about a genuine problem and is recognised by the afflicted person as internally generated. The classification systems of mental disorders and researchers studying psychopathology gave a prime position to obsessions. The pathological significance of obsessions was first pointed out by Sigmund Freud, who named the condition as obsessional neurosis. The modern day diagnosis of obsessive compulsive disorder (OCD) is represented by a diverse group of symptoms that include intrusive thoughts, rituals, preoccupations and compulsions, which occur recurrently and cause severe distress to the person. Specifically, Sadock, and Sadock (2007) points out that an obsession is a recurrent and intrusive thought, feeling, idea, image, or sensation, while a compulsion is a conscious, standardised, recurrent behaviour. The person identifies both obsessions and compulsions as irrational and unwanted, but cannot resist them due to the alarming anxiety associated with them. Though the purpose of a compulsive act is to reduce the anxiety associated with the obsession, it does not always succeed, and the completion of a compulsive act can even increase the anxiety. On the other hand, if the person resists carrying out a compulsion, anxiety is again increased (Sadock & Sadock, 2007). This continuous interplay of anxiety is the factor behind the extreme distress and impaired functioning experienced by a person having this disorder.

Cognitive Perspective on Obsessions

The cognitive perspective of looking at obsessions was put forward by the model suggested by Salkovskis and Harrison in 1984 (*cf* Sica, Taylor, Arrindell & Sanavio, 2006). The model begins with the well-established finding that cognitive intrusions (i.e. thoughts, images and impulses that intrude into the consciousness) are experienced by most of the people. But, it becomes obsessive (i.e. unwanted, distressing and difficult to remove from consciousness) to certain people only. Salkovskis argued that cognitive intrusions—whether wanted or unwanted—reflect the person's current concerns. The concerns are automatically triggered by

internal or external reminders. As an attempt to distinguish why only certain people experience these intrusions as disturbing, he proposed that intrusions develop into obsessions when they are perceived as posing a threat for which the individual is personally responsible (Sica et al, 2006). Misappraisal of threat leads to anxiety and the person develops desire to control or neutralise the intrusions by behavioural or mental ritualising. Such strategies paradoxically result in increased preoccupation with intrusions and prevent the person from learning that such thoughts are not actually indicative of harm (Woods, Tolin & Abramowitz, 2004).

For example, an intrusive image of stabbing one's own child may be triggered by seeing potentially dangerous objects like sharp kitchen knives. But people usually ignore the image by assuming it as unimportant and meaningless with no harm-related implications. But a person who appraises it as having serious consequences for which he or she is personally responsible, gets disturbed by the image, thus making it obsessive (Sica et al, 2006).

This brings into light the importance of cognitions that mediate the perception of intrusions as obsessions. It is not just an elevated sense of personal responsibility that underlies obsessions, but certain other cognitive phenomena are also involved. Efforts are taken by researchers to assess the cognitive phenomena underlying obsessive compulsive disorder. One remarkable work is by the Obsessive Compulsive Cognitions Working Group (OCCWG), which is an international group of researchers who study the cognitive aspects of OCD. They identified six specific cognitive domains that are important in the development and maintenance of obsessions (Obsessive Compulsive Cognitions Working Group [OCCWG], 2005).

The six main obsessive beliefs identified by OCCWG as cited in Woods et al (2004) are 1) Inflated responsibility, 2) Overestimation of threat, 3) Beliefs about the Importance of thoughts, 4) Beliefs about the importance of controlling one's thoughts, 5) Intolerance of uncertainty, and 6) Perfectionism.

The Personality Dimensions Underlying Obsessions

Neuroticism, as a personality construct is believed to underlie all pathologies characterised by negative emotions. Eysenck presented a phenotypic taxonomy of personality traits, consisting of the three factors, Extraversion, Neuroticism and Psychoticism, which form the highest levels of the personality hierarchy. Neuroticism/ Negative Emotionality reflects individual differences in the extent to which a person perceives the world as threatening, problematic and distressing. High scores indicate elevated levels of negative emotions and a broad array of problems whereas those low on this trait are calm, emotionally stable and self-satisfied. (Clark & Watson, 2006).

Eysenck's followers came up with other models, all of which emphasised neuroticism. The latest models agree upon the Big Five personality traits, identified by McCrae and Costa (1987), which are Neuroticism versus Emotional Stability, Extraversion versus Introversion, Agreeableness versus Antagonism, Openness versus Closedness to experience and Conscientiousness versus Lack of direction. The Big Five dimension 'Neuroticism versus Emotional Stability' is identified to have six facets which are Anxiety, Angry Hostility, Depression, Self-consciousness, Impulsiveness and Vulnerability. They regard neuroticism as contrasting emotional stability and even-temperedness, resulting in feeling anxious, nervous, sad and tense. This five factor theory is based on the finding that all the five traits have a substantial genetic basis and are given a causal status. These traits are basic tendencies that refer to the abstract underlying potentials of the individual, whereas attitudes, roles, relationships and goals are characteristic adaptations that reflect the interaction between basic tendencies and environmental demands accumulated over time (John & Srivastava, 2006).

Yet another basic tendency or trait that is believed to be of relatively recent origin in the evolutionary history with serious implications in obsessions is Conscientiousness. In the Five

Factor Model, it is described as socially prescribed impulse control that facilitates task- and goal-directed behaviour such as thinking before acting, delaying gratification, following norms and rules, and planning, organising and prioritising tasks. Its facets involve Competence, Order, Dutifulness, Achievement striving, Self-discipline and Deliberation (John & Srivastava, 2006). The relatively complex social cognitive functions involved in this dimension, makes it more adaptable to environmental demands like culture.

A review of previous studies indicates that obsessive phenomenon and its psychological correlates have been a matter of close scrutiny for several decades. Several researchers have come up with results that show a significant relationship between the obsessive beliefs and obsessive- compulsive symptoms, mediated by culture-specific factors. In a preliminary cross–cultural study by Sica et al (2006) on Greek, Italian and U.S. individuals, there were high correlations between the beliefs and symptoms, but there were significant cross-cultural effects also. Some studies point out that many of those cultural differences are nurtured by the tendency to fuse thoughts and actions, which ultimately has its roots in religion. Among the personality dimensions, neuroticism seemed to be a significant predictor of OCD. In studies that examine the relationship between obsessive compulsive symptoms and vulnerability factors, findings reveal the role of culture and some common correlates such as neuroticism and certain types of metacognition, including appraisals of responsibility/threat estimation and perfectionism/need for certainty, as well as thought–action fusion. The research support for the link between Conscientiousness and obsessive character mostly centre on Obsessive Compulsive Personality Disorder. Though it is different from OCD, certain characteristics of this personality disorder such as perfectionism, preoccupation with details, rules, lists, order and organization, over-conscientiousness, scrupulosity, and inflexibility about matters of morality, ethics, or values (APA, 2013) manifest obsessive beliefs.

To conclude, obsessive beliefs maybe understood as one characteristic adaptation of the personality dimensions of Neuroticism and Conscientiousness and establishing a relationship among the dimensions and the beliefs might catch considerable research attention.

Objectives

1. To find out the prevalence of obsessive beliefs in post graduate female students and to compare it with the norms.
2. To find out if the strength of obsessive beliefs in the female students is significantly greater than that in the Western sample of OCD patients.
3. To find out if there is any difference in neuroticism and conscientiousness among the groups of students with high and low obsessive beliefs.

Hypotheses

1. There will be significant differences in the mean scores of the three types of obsessive beliefs, Responsibility/Threat Estimation, Perfectionism/Certainty and Importance/Control of thoughts, and the total score among the sample of the study and the standardised sample of OCD patients.
2. There will be a significant difference in the mean scores of neuroticism among the high scorers and the low scorers of obsessive beliefs.
3. There will be a significant difference in the mean scores of conscientiousness among the high scorers and the low scorers of obsessive beliefs.

Method

Participants

The sample of the study included 228 participants, covering the entire 2nd Semester Post Graduate female students residing in the Hostel, who were available at the time of the study. The participants belonged to the age group 20–25 years and represented 25 Departments of the

University of Calicut, Kerala, India, which include various Arts, Science and Professional subjects.

Instruments

1. Obsessive Beliefs Questionnaire (OBQ-44): OBQ-44 is the revised form of the 87 item Obsessive Beliefs Questionnaire developed by the Obsessive Compulsive Cognitions Working Group (OCCWG), developed and standardised by OCCWG in 2005. The obsessive beliefs measured by OBQ-44 are grouped into three major factors, Responsibility/Threat Estimation (16 items), Perfectionism/Certainty (16 items) and Importance/Control of Thoughts (12 items). Sum of all the item scores yields the OBQ total score. The norms for the questionnaire are given in table 1.

Table 1

Norms for Obsessive Beliefs Questionnaire (OBQ-44)

Obsessive beliefs	OCD Sample (n=244)		Anxious Controls (n=103)		Student Controls (n=284)		Community Controls (n=86)	
	Mean	S.d.	Mean	S.d.	Mean	S.d.	Mean	S.d.
Responsibility/Threat	64.5	22.4	59.8	22.8	48.4	18.7	34.2	13.0
Perfectionism/Certainty	69.9	22.1	65.7	21.7	55.5	20.1	41.4	18.1
Importance/Control of Thoughts	39.8	16.3	33.9	15.8	27.1	11.6	20.5	9.3
OBQ-44 Total	174.3	50.2	159.3	53.0	131.3	44.3	96.0	35.1

2. Calicut University Personality Inventory: Calicut University Personality Inventory is a 166 item self-report inventory that assesses the personality dimensions of the subjects. This inventory was developed by the M.Sc. Final Year students (2001-2007) of the Department of Psychology, University of Calicut, under the supervision of Dr. T. Sasidharan, based on the Five Factor Model postulated by McCrae and Costa (1985). It is a standardised test suitable for the Malayalam speaking population of Kerala. Since the objective of the present study was to assess the personality factors Neuroticism and Conscientiousness only, 70 items that correspond to these two factors were used in the study.

Procedure

The sample of the study was decided to be the 2nd Semester Post Graduate female students residing in the Ladies Hostel of University of Calicut. Then, all the participants were personally met in their hostel rooms and verbal consent was taken to participate in the study. They were first given the Obsessive Beliefs Questionnaire (OBQ-44) with prior instructions on the confidentiality and sincerity of the responses to be given. The 228 responses were scored to give separate scores for the three factors of OBQ-44 and OBQ Total score. Then, 30 participants who scored high on all the factors and 30 participants who scored relatively low on all the factors were selected. The two subscales of Calicut University Personality Inventory, corresponding to the Neuroticism and Conscientiousness factors, were administered individually to these 60 participants. The purpose of the Inventory was not revealed to the participants and also to the administrators, who were assigned by the investigator. The responses were collected back and scored as per the Manual. Statistical analyses were done to describe and make inferences from the data obtained. The study made use of descriptive statistics like mean and standard deviation and inferential statistics like t-test.

Results and Discussion

This section brings out the results of statistical analyses performed on the collected data and discusses the possible interpretations of the results.

Descriptive Analysis of Obsessive Beliefs

Descriptive information of the three broad types of obsessive beliefs and the total score are given in table 2.

Table 2

Sample size, lowest score, highest score, Mean and Standard Deviation of the four variables of obsessive beliefs

Variables	N	Lowest	Highest	Mean	S.d.
Responsibility/ Threat	228	32	104	73.53	14.030
Perfectionism/Certainty	228	37	108	77.41	13.965
Importance/Control of Thoughts	228	12	78	43.65	11.504
OBQ – Total	228	97	271	194.58	33.961

When comparing the above results with the norms of OBQ-44 given in Table I, it can be observed that the mean scores of all the four variables in the study are greater than the mean values of the sample of student controls, community controls, anxious controls and OCD patients, on whom the questionnaire was standardised. The result that the mean values are greater than that of OCD patients in the West is quite alarming. Its statistical significance needs to be established before interpretations are made, and therefore, inferential statistics that analyse the significance of mean differences are employed.

Analysis for the Significance of Mean Differences

In order to understand the significance of the differences between the means, t test was done by comparing the mean values obtained for the above four variables, between the sample of the study and the three different groups of subjects of the standardised sample - OCD patients, Student controls and Community controls. The results of the t test are given below as table 3.

Table 3
Sample size, Mean, Standard Deviation and 't' values corresponding to the four variables of obsessive beliefs when compared to the standardised samples of OCD patients, student controls, and community controls.

Variables	Group	N	Mean	S.d.	't'
Responsibility / Threat Estimation	Study Sample	228	73.53	14.03	5.285**
	OCD Sample	244	64.5	22.4	
	Study Sample	228	73.53	14.03	17.364**
	Student Controls	284	48.4	18.7	
	Study Sample	228	73.53	14.03	23.386**
	Community Controls	86	34.2	13.0	
Perfectionism / Certainty	Study Sample	228	77.41	13.96	4.443**
	OCD Sample	244	69.9	22.1	
	Study Sample	228	77.41	13.96	14.517**
	Student Controls	284	55.5	20.1	
	Study Sample	228	77.41	13.96	16.673**
	Community Controls	86	41.4	18.1	
Importance / Control of Thoughts	Study Sample	228	43.65	11.50	2.980**
	OCD Sample	244	39.8	16.3	
	Study Sample	228	43.65	11.504	16.118**
	Student Controls	284	27.1	11.6	
	Study Sample	228	43.65	11.50	18.381**
	Community Controls	86	20.5	9.3	
OBQ Total	Study Sample	228	194.58	33.96	5.170**
	OCD Sample	244	174.3	50.2	
	Study Sample	228	194.58	33.96	18.291**
	Student Controls	284	131.3	44.3	
	Study Sample	228	194.58	33.96	22.390**
	Community Controls	86	96.0	35.1	

**p< .01

From table 3, it can be seen that all the t-values are significant at 0.01 level. Specifically, this means that for the variables, Responsibility/Threat Estimation, Perfectionism/Certainty, Importance/Control of Thoughts, and the OBQ Total score, the means of the study sample are significantly greater than the corresponding means obtained for community controls, student controls and even OCD sample. The role played by culture may be considered as a possible explanation. However, the significance of the mean differences between the sample of the study and the group of OCD patients established on all the four variables is indicative of a more intricate role of culture in the development of the belief systems of individuals. This is because, when generalising the results of the present study to the young adult female population of Kerala, the extent to which they carry obsessive beliefs is found to be greater than that of the Western population of individuals with clinically significant obsessions.

The most important finding of the study is that this considerably greater strength of obsessive beliefs is not identified as pathological in the Kerala population, rather it is not

expressed as a mental disorder. This may be because many of those beliefs are culturally sanctioned in our population. The role played by culture in the development of obsessive beliefs has been highlighted in several studies. The work of Sica et al (2006) has clearly pointed out cross cultural differences in the relationship between obsessive beliefs and OC symptoms. As a reason, they suggest the role of mediating factors, which vary among cultures.

Thus, this study offers empirical support to the fact that there are indeed cultural differences in the extent to which obsessive beliefs are nurtured in individuals. Also, it suggests that the potency of the obsessive beliefs in developing obsessions vary among cultures. However, an inference that the population to which the sample of the study belongs, is at high risk of developing clinically significant obsessions requires considerable support from other realms of the individual personality and functioning. As a result, rather than accounting for the cultural determinants that nurture obsessive beliefs in the Kerala population, the present study attempts to find out whether the existence of stronger obsessive beliefs is related to the two personality factors- neuroticism and conscientiousness - that are found to implicate in obsessive compulsive phenomena.

Analysis of Personality Factors

Thirty subjects who scored high on all the obsessive beliefs and 30 subjects who scored low on all the obsessive beliefs were assessed on the two personality factors, Neuroticism (N) and Conscientiousness (C). To compare the significance of the mean differences between the low scorers and high scorers on the two variables t-test was carried out and the results are presented in table 4.

Table 4

Sample size, Lowest score, highest score, Mean, Standard Deviation and t-values of the two personality factors among the low and high groups

Variable	Group	N	Lowest	Highest	Mean	Sd	't'
Neuroticism	High	30	0	34	10.47	8.303	0.75
	Low	30	1	20	9.10	5.542	
Conscientiousness	High	30	9	30	20.40	5.928	2.189*
	Low	30	9	24	17.40	4.606	

*p< .05

From the table, it can be seen that the Neuroticism means of high and low groups are 10.47 and 9.10 respectively, which lie within the range given in norms (Mean = 12.06, SD = 8.30). Also, the Conscientiousness means of the two groups are 20.40 and 17.40 respectively, which lie within the range given in norms (Mean = 18.65, SD = 5.14). Thus the subjects of the present study cannot be considered to have extreme tendencies of Neuroticism and Conscientiousness.

The t-value corresponding to Neuroticism is not significant, which means that the high scorers and low scorers did not differ significantly along the dimension of Neuroticism. On the other hand, the personality factor, Conscientiousness is found to have a t- value that is significant at 0.05 level. This shows that there is a significant difference between the Conscientiousness of students with stronger obsessive beliefs and those with weaker obsessive beliefs, even though the difference between the means is not too large. Altogether, table 4 yields the results that Neuroticism, or the tendency to experience negative affect is neither significantly high, nor significantly related to obsessive beliefs. But Conscientiousness, though not significantly high, contributes much to the development of these beliefs.

Anxiety, which is an important companion of obsessions, serves as the area where neuroticism as a personality factor risks an individual's adequate functioning. Several studies have validated the role of Neuroticism as an essential prerequisite of anxiety. The strength of neuroticism is found to be average in the present sample and is not found to differ considerably among high scorers and low scorers. Since the individuals do not exhibit neurotic tendencies, the susceptibility to develop obsessions cannot be inferred. As of now, such tendencies are not found to be present in the normal student young adult population of Kerala.

It has been already mentioned that Conscientiousness is a personality dimension that involves complex social- cognitive functions and its manifestations are determined a lot by the environment and the culture that nurtured it. From the result that obsessive beliefs are present at a greater strength when compared to the Western cultures and the t-test results, it is clear that our culture sanctions conscientiousness as a personality trait and it has a significant effect on the development of these beliefs.

Hence, the interplay of these two personality variables on obsessive beliefs can be concluded in the following way. The presence of stronger obsessive beliefs is the result of a society that nurtures conscientiousness in its people. But, those people are not susceptible to develop obsessions in the absence of emotional instability, i.e., neuroticism. However, conscientiousness of the society may offer breeding grounds for neuroticism, if at all it develops, to easily end up in obsessions and compulsions.

Conclusion

The study is an exploration into the nature and prevalence of obsessive beliefs in female young adults of Kerala and comparison of personality dimensions among individuals with stronger and weaker obsessive beliefs. It was conducted on a sample of 228 post graduate female students using Obsessive Beliefs Questionnaire (OBQ-44) and the Calicut University Personality Inventory (CUPI), the former administered to the whole sample, based on whose scores, 30 high scorers and 30 low scorers were selected and were individually administered the CUPI subscales of Neuroticism and Conscientiousness. Statistical analyses were done to interpret the scores obtained.

The first and the foremost finding of the study is that the strength of obsessive beliefs is significantly high in our culture, even higher than the Western population of OCD patients. The best explanation for this deals with the role of culture in the development of such beliefs. The relatively higher strength of these beliefs is not expressed as a psychological problem, because for any behaviour to be identified pathological, it must stand out of the norms of the culture in which the behaviour occurs. To further explore this, the present study attempted to uncover the personality dimensions underlying those beliefs in our culture. Both Neuroticism and Conscientiousness scores of the subjects having strong obsessive beliefs and those having relatively weaker beliefs were found to lie within the average range, when compared to the norms. However, the mean difference of conscientiousness is significant among the high and low scoring groups. Thus, conscientiousness, as a personality trait, can be understood to contribute significantly to the development and maintenance of obsessive beliefs.

To conclude, our society tends to build conscientiousness in its individuals, mainly through its beliefs, moral values and religious faiths. Its proneness to develop obsessive beliefs like responsibility and perfectionism has been proved to be right in the present study. However, it cannot by itself result in pathology unless neuroticism is present, since obsessions are considered pathological owing to the anxiety associated with it. Thus, it may be implied that the way our culture brings up its generations make them predisposed to develop obsessive beliefs, but not necessarily obsessions. The way these beliefs express themselves now remains a question, since the chance of a pathological expression is ruled out with the results of the present study.

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