An explorative study on metacognition in obsessive-compulsive disorder and panic disorder

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Abstract

Objective: To test the hypothesis that dysfunctional metacognitions might be a general vulnerability factor for anxiety disorder, metacognitive beliefs among patients with obsessive-compulsive disorder (OCD), patients with panic disorder (PD), and healthy subjects (HS) were studied. Correlations between metacognitive beliefs, OCD, and PD symptoms were also investigated.

Methods: Patients with OCD (n = 114), patients with PD (n = 119), and HS (n = 101) were assessed with the Metacognition Questionnaire (MCQ).

Results: Patients with OCD and those with PD scored significantly higher than HS on the MCQ in 2 dimensions: negative beliefs about worry concerning uncontrollability and danger as well as beliefs about the need to control thoughts dimensions. No difference in MCQ scores was observed between the OCD and PD groups. The former 2 MCQ dimensions were positively correlated with the degree of indecisiveness in patients with OCD, whereas the MCQ negative beliefs about worry positively correlated with the average intensity of anticipatory anxiety in patients with PD.

Conclusions: The presence of dysfunctional metacognitions in both patients with OCD and those with PD suggests that such beliefs can represent not only generic vulnerability factors for anxiety disorders but also elements that contribute to maintaining the disorder, as evidenced by their associations with aspects of OCD and PD symptoms.

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1. Introduction

Metacognition is the process of “thinking about thinking,” knowing about “what we know” and “what we don’t know” [1]. It refers to the psychologic structures, knowledge, events, and processes that are involved in the control, modification, and interpretation of thinking [2].

According to Wells’ theory of Self-Regulatory Executive Function (S-REF) [3,4], metacognition is a major factor in the development and progression of psychopathology. The basic assumption of this approach posits that, in psychiatric disorder, beliefs represent the metacognitive component guiding the activity of thinking and coping. Individuals have positive and negative beliefs about thinking that influence appraisals, but also, they have implicit procedural metacognitions that create plans or programs that drive cognition and action. This metacognitive element is thought to be a major factor contributing to maladaptive response styles, which in turn favors the development and persistence of psychopathology. Consistent with the S-REF model, research on metacognition has investigated generalized anxiety disorder [5], posttraumatic stress disorder [6], psychosis [7], and depression [8].

Furthermore, metacognition has been investigated in specific anxiety disorders, for example, obsessive-compulsive disorder (OCD) and panic disorder (PD) [7,9]. Studies using nonclinical samples [10–13], experimental manipulations [14], and patient group comparisons [15] demonstrate relationships between OCD symptoms and metacognitive beliefs.

Several instruments are available to assess the various dimensions of metacognition. One of those is the Penn State Worry Questionnaire [16], a scale that measures individual differences in the tendency “to worry.” In addition, there are also specific instruments assessing metacognition in specific anxiety disorders, especially for OCD. One of those instruments is the Obsessive Beliefs Questionnaire—44
emphasized the importance of thoughts and the control of the Obsessive Compulsive Cognition Working Group has shown to be a critical prerequisite for the phenomena to emerge and play a central role in the development of the disorder [2,15]. Dysfunctional metacognitions might represent the general population. Finally, we predicted that there would be associations among MCQ dimensions and PD and OCD symptoms, which could suggest that metacognitive dysfunctions play a role in maintaining the disorders and important for treatment.

2. Methods

2.1. Participants

Patients with OCD (n = 114) and those with PD (n = 119) were consecutively recruited from the Department of Clinical Neurosciences, Scientific Institute, and University Vita-Salute San Raffaele in Milan, Italy. All subjects were given an assessment, which took approximately 1 hour and included a diagnostic and anamnestic interview. Then, in the afternoon of the same day, another 1-hour session with the administration of the MCQ and the clinical...
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