

Exploring the role of metacognition in obsessive–compulsive and anxiety symptoms

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Abstract

This study tests three hypotheses, predicting first that metacognition is highly correlated with anxiety and obsessive–compulsive (O–C) symptoms, second that it mediates the relationship between O–C symptoms and anxiety, and third that the meta-cognitive predictors of anxiety are different from the meta-cognitive predictors of O–C symptoms. The sample of the present study was 850 students selected from various universities in Turkey. Significant correlations between metacognition, O–C symptoms and anxiety were observed. Also, mediation analysis confirmed that metacognition fully mediated the relationship between O–C symptoms and anxiety. Consistent with our hypothesis, trait anxiety and O–C symptoms had different meta-cognitive predictors. Although, we expected that meta-cognitive beliefs would vary based on the sub-type of O–C symptoms, meta-cognitive beliefs did not differ according to the O–C symptom subtypes. We discussed results with reference to the literature of meta-cognition, anxiety and O–C 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,” and the ability to control our own thoughts. It refers to the psychological structures, knowledge, events and processes that are involved in the control, modification and interpretation of thinking itself (Wells & Cartwright-Hatton, 2004). Metacognition has been considered an important factor in the development and maintenance of various psychological disorders (Wells & Mathews, 1996), especially in

generalized anxiety disorder (GAD) (Wells, 2005) and obsessive–compulsive disorder (OCD) (Wells & Papageorgiou, 1998). Hence, researchers have developed a number of cognitive models in order to explain the origin and etiology of obsessive–compulsive (O–C) symptoms. They also have emphasized the interpretation or appraisal of intrusive thoughts as well as beliefs about the importance of such thoughts (Jacobi, Calamari, & Woodard, 2006). Salkovskis (1985, 1989) was among the first to propose that individuals with OCD possess dysfunctional beliefs involving blame and responsibility for harm that occurs to themselves and others. Similarly, Rachman (1993, 1997, 1998) argued that obsessions are caused by the catastrophic misinterpretations of the significance of one’s intrusive thoughts. Further, Rachman (1993) suggested that some individuals with OCD suffer thought–action fusion (TAF), indicating the belief

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that thoughts can influence events and are equivalent to actions. Clark and Purdon (1995) then refined cognitive formulations of OCD, focusing on meta-cognitive processes. They stressed that individuals with OCD misinterpret the consequences of failure in controlling unwanted intrusive thoughts. First, Wells and Mathews (1994) and then Wells (1997) reformulated the role of metacognition in psychological disorder, especially in OCD. They argued that meta-cognitive belief about thoughts and thought processes is a critical component of the dysfunctional cognitive process that drives OCD symptoms. Besides, there are some models of OCD which do not regard dysfunctional beliefs as playing an important role. Some authors suggested that there are etiologically distinct forms of OCD and dysfunctional beliefs play an etiological role in its one form, and these beliefs are not posited as etiological variable in its other form (Taylor, Abramowitz, & McKay, 2005; Taylor et al., 2006).

The meta-cognitive model of OCD known as “Self-Regulatory Executive Function (S-REF)” (Wells & Mathews, 1994) proposes that obsessive thoughts are negatively interpreted as a result of meta-cognitive beliefs about the meaning and/or dangerous consequences of having a specific thought or thoughts. According to these authors, the meta-cognitive system is designed to regulate the self by means of beliefs about the self. Distortions in meta-cognitive beliefs affect the meanings and functioning of cognition. Therefore, distortion of S-REF’s control on affective regulation may bring about ruminations and active worry.

Gwilliam, Wells, and Cartwright-Hatton (2004) suggest that there are two broad fields of beliefs in S-REF: (i) beliefs about the importance/meaning and power of thoughts and (ii) beliefs about the need to control thoughts and/or to perform rituals. In the first field, themes are of beliefs about intrusions which may include TAF, thought–event fusion (TEF, i.e., the belief that an obsessional thought or doubt alone can cause a negative external event) and thought–object fusion (TOF, i.e., the belief that thoughts and feelings can be transferred into objects). In the second field, they include beliefs concerning the rituals that need to be used to attenuate the appraised consequences associated with obsessional thoughts.

Using the conceptual framework of the S-REF theory, Cartwright-Hatton and Wells (1997) constructed a 65-item scale (the meta-cognitions questionnaire; MCQ) to assess beliefs about worry and intrusive thoughts. The MCQ assesses a range of metacognitions relevant to worry and intrusive thoughts, although it primarily focuses on beliefs about worry. The ques-

tionnaire comprises five correlated but conceptually distinct factors that assess three domains, such as positive and negative meta-cognitive beliefs, meta-cognitive monitoring and judgments of cognitive confidence (Wells & Cartwright-Hatton, 2004). These factors are: (1) positive beliefs about worry (the belief that worrying helps to solve problems and avoid unpleasant situations), (2) negative beliefs about thoughts concerning uncontrollability and danger (the belief that it is necessary to control ones worrying in order to function well as a person, including beliefs about the mental and physical dangers of worrying), (3) cognitive confidence (assessing confidence in attention and memory), (4) negative beliefs about thoughts including themes of superstition, punishment and responsibility (superstitions which imply that the individual could be punished for having or not having certain thoughts) and (5) cognitive self-consciousness (the tendency to focus attention on thought processes) (Cartwright-Hatton & Wells, 1997). Meta-cognitive factors assessed with the MCQ have been found to be positively associated with O–C symptoms (Hermans, Martens, De Cort, Pieters, & Eelen, 2003; Janeck, Calamari, Riemann, & Heffelfinger, 2003; Wells & Papageorgiou, 1998), pathological worry (Wells & Papageorgiou, 1998), predisposition to auditory hallucinations (Baker & Morrison, 1998; Morrison & Wells, 2003) and depression (Papageorgiou & Wells, 2003).

Cartwright-Hatton and Wells (1997) found that GAD and OCD patients were significantly different from a control group consisting of both participants with other emotional disorders (non-anxiety) and normal controls on two subscales of the MCQ, namely the uncontrollability of thoughts and danger, and the negative beliefs about thoughts. They also reported that cognitive self-consciousness (CSC; the tendency to focus attention on thought) was the only subscale on which OCD and GAD participants differed from each other. Similarly, De Bruin, Rassin, and Muris (2005) have shown that CSC was moderately correlated ($r = .57$) with meta-worry, and both were positively associated with the symptoms of worry and obsessional thoughts.

Excessive attention toward one’s own process of thinking has been considered to be the characteristic of patients with OCD, if compared to other beliefs about worry and intrusive thoughts. Some researches reported positive associations between dimensions of metacognition and proneness to pathological worry and O–C symptoms (Cartwright-Hatton & Wells, 1997; Wells & Papageorgiou, 1998). Wells and Papageorgiou (1998) found that when overlaps between worry and O–C symptoms were controlled, there was evidence of

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