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Incremental specificity of disgust propensity and sensitivity in the prediction of health anxiety dimensions

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ABSTRACT

The present study sought to determine the incremental specificity of disgust propensity and sensitivity in the prediction of symptoms of health anxiety in a large nonclinical sample ($N = 498$). Exploratory factor analysis identified Illness Likelihood, Illness Severity, and Body Vigilance as dimensions of health anxiety symptoms that significantly correlated with disgust propensity and sensitivity. Negative affect and the fear of contamination were also significantly correlated with the three health anxiety symptom dimensions. Regression analyses did show that disgust propensity and sensitivity predicted overall health anxiety symptoms independent of negative affect and fear of contamination. However, the unique association between disgust propensity and sensitivity and symptoms of health anxiety was specific to the Body Vigilance dimension. These findings suggest that disgust propensity and sensitivity may be a unique vulnerability for the vigilance for bodily sensations/changes aspect of health anxiety but not necessarily other (perceived probability/severity of having a serious illness) aspects of health anxiety. The clinical and research implications of these findings for conceptualizing disgust propensity and sensitivity as a vulnerability for excessive health anxiety are discussed.

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Theoretical developments and empirical research has implicated the role of disgust propensity and sensitivity in the development and maintenance of specific anxiety-related conditions (Olatunji & Sawchuk, 2005; Woody & Teachman, 2001). The majority of such research has focused on specific

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phobia with studies demonstrating that self-report measures of disgust propensity and sensitivity positively correlate with measures of small animal fears (de Jong & Merckelbach, 1998; Matchett & Davey, 1991; Olatunji, 2006) and blood-injection injury (BII) phobia (Olatunji, Sawchuk, de Jong, & Lohr, 2006; Schienle, Stark, Walter, & Vaitl, 2003; Tolin, Lohr, Sawchuk, & Lee, 1997). Studies incorporating behavioral assessments also suggest that disgust propensity and sensitivity may be a unique motivator of avoidance in spider (Olatunji & Deacon, 2008; Woody, McLean, & Klassen, 2005) and BII (Koch, O'Neill, Sawchuk, & Connolly, 2002; Olatunji, Connolly, & David, 2008) phobia. Spider phobic individuals have also been found to respond with greater disgust-specific facial EMG activity than controls when exposed to spiders (de Jong, Peters, & Vanderhallen, 2002) and disgust-specific physiological responding has been associated with the unique fainting response observed in BII phobia (Page, 2003).

Extensions of this program of research have also shown that self-report measures of disgust propensity and sensitivity positively correlate with measures of contamination-based obsessive-compulsive disorder (OCD; Mancini, Gragnani, & D'Olimpio, 2001; Tolin, Woods, & Abramowitz, 2006) independent of negative affect. Resent research has also shown that avoidance of contaminants is largely accounted for by levels of disgust propensity and sensitivity in contamination-based OCD (Olatunji, Lohr, Sawchuk, & Tolin, 2007). Neuroimaging studies also suggest that the neurocircuits (e.g., insula) involved in the processing of disgust eliciting stimuli may be relevant to OCD and, in particular, contamination obsessions and washing compulsions (Husted, Shapira, & Goodman, 2006). However, it has been suggested that the diagnostic category of "OCD" may be broader and consist of other clinical syndromes (i.e., eating disorders, hypochondriasis) that share phenomenological and functional similarities (i.e., obsessive thinking and/or compulsive behaviors) with symptoms of OCD (McElroy, Phillips, & Keck, 1994). Evaluating common vulnerabilities for disorders that share phenomenological similarities with OCD (i.e., 'OC-spectrum disorders'; Stein & Lochner, 2006) is of considerable importance, and could potentially clarify issues relating to the etiological origins of these conditions.

Disgust propensity and sensitivity may be a common vulnerability for some OC-spectrum disorders. In fact, some studies have found that the propensity towards experiencing disgust towards foods and body products correlates with eating disorder symptoms (Davey, Buckland, Tantow, & Dallos, 1998; Troop, Murphy, Bramon, & Treasure, 2000; Troop, Treasure, & Serpell, 2002). Only recently, however, have researchers begun to examine the potential role of disgust propensity and sensitivity in hypochondriasis. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), the cardinal feature of hypochondriasis is a preoccupation with the inaccurate belief that one has, or is in danger of developing, a serious medical condition. Given topographical and functional overlap with the anxiety disorders, particularly OCD, hypochondriasis is increasingly being conceptualized as a form of severe health anxiety (Abramowitz, Schwartz, & Whiteside, 2002; Warwick & Salkovskis, 1990).

A disease-avoidance model may account for the proposed association between disgust propensity and sensitivity and health anxiety. Originally proposed to explain avoidance of aversive, but non-predatory animals (Matchett & Davey, 1991), the disease-avoidance model suggests that experiencing disgust may motivate avoidance of some stimuli due to concerns of contamination (rather than concerns of physical harm). The adaptive function of disgust is to protect the organism from contact with contaminated stimuli and individuals with excessive health anxiety may mobilize disgust to avoid disease (Olatunji & Sawchuk, 2005; Rozin & Fallon, 1987). Disgust propensity and sensitivity may then be viewed as a mechanism to promote fitness and health (Consedine & Moskowitz, 2007). Consistent with this view, recent research has shown that disgust propensity and sensitivity mediates the association between contamination cognitions (the tendency to overestimate the likelihood and severity of contamination) and behavioral avoidance of potential sources of infection and disease (Deacon & Olatunji, 2007). Individuals high in disgust propensity and sensitivity may also be more vigilant and consequently misinterpret bodily functions, particularly ambiguous physical sensations that are more disgust-relevant (e.g., feeling queasy), as an indication that one may have a serious disease (e.g., stomach cancer).

Indirect evidence implicating disgust propensity and sensitivity in health anxiety has been reported in the literature. For example, health anxiety is characterized by an excessive fear of death (Noyes, Stuart, Longley, Langbehn, & Hapel, 2002) which has been shown to be related to disgust propensity and sensitivity (Haidt, McCauley, & Rozin, 1994). Furthermore, it has been shown that a reminder of

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