



The relationship between anxiety sensitivity and obsessive-compulsive symptom dimensions

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ABSTRACT

Background and objectives: Anxiety sensitivity (AS), the tendency to fear arousal-related body sensations based on beliefs that they are dangerous, is a cognitive vulnerability factor for certain anxiety symptoms such as panic and posttraumatic stress symptoms. Very little research, however, has examined the relationship between AS and obsessive-compulsive (OC) symptoms, which was the objective of the current research.

Methods: We administered dimensional measures of AS and OC symptoms to a large sample of undergraduate students ($N = 636$). We also included measures of general distress and cognitive distortions related to OCD (i.e., obsessive beliefs) as control variables.

Results: Regression analyses indicated that AS was predictive of OC symptoms even after controlling for general distress and obsessive beliefs. In addition, the three domains of AS (physical, social, and cognitive concerns) were differentially associated with the four dimensions of OC symptoms (contamination, responsibility for harm, symmetry, and unacceptable thoughts).

Limitations: Our findings are based on a non-clinical student sample and their generalization to OCD requires replication with a sample of OCD patients.

Conclusions: These results provide preliminary evidence that AS plays a role in OC symptoms. Implications for clinical practice and for future research are discussed.

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1. Introduction

Anxiety sensitivity (AS; Reiss & McNally, 1985) refers to the tendency to fear body sensations associated with anxious arousal because of their perceived physical, psychological, or social consequences; for example, the belief that a racing heart portends a heart attack. Research demonstrates that AS is a multidimensional construct involving the fear of physical catastrophes, the fear of mental or cognitive dyscontrol, and concerns that anxiety symptoms will be publicly observable. Moreover, there is consistent evidence that AS plays an important role in the development and maintenance of anxious symptoms across the anxiety disorders (Taylor, 1999).

Previous research suggests that the three dimensions of AS (physical, social, cognitive) are differentially related to particular

types of anxiety symptoms. In line with conceptual accounts that panic attacks result from the catastrophic misinterpretation of arousal-related body sensations (Clark, 1986), the physical dimension of AS (e.g., “It scares me when my heart beats rapidly”) is particularly strongly related to panic (Deacon & Abramowitz, 2006; Rector, Szacun-Shimizu, & Leybman, 2007; Rodriguez, Bruce, Pagano, Spencer, & Keller, 2004). The social dimension of AS (e.g., fear of trembling in front of others) is most strongly related to fears of negative evaluation and the symptoms of social anxiety (Deacon & Abramowitz, 2006; McWilliams, Stewart, & MacPherson, 2000; Rector et al., 2007; Rodriguez et al., 2004; Zinbarg & Barlow, 1996). Lastly, the cognitive dimension of AS (e.g., fear of cognitive dyscontrol; Rector et al., 2007; Rodriguez et al., 2004) has most frequently been associated with pathological worry such as that which occurs in generalized anxiety disorder (GAD).

Little research, however, has addressed the relationship between the dimensions of AS and obsessive-compulsive disorder (OCD). OCD is characterized by recurrent unwanted thoughts, images or impulses (obsessions) that provoke anxiety, as well as efforts to resist or neutralize this obsessional anxiety through

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avoidance behavior and deliberate overt or covert actions (i.e., compulsive rituals; APA, 2000). A number of studies have demonstrated that patients diagnosed with OCD report greater levels of AS compared to healthy individuals without an anxiety disorder (e.g., Deacon & Abramowitz, 2006; Taylor, Koch, & McNally, 1992; Taylor et al., 2007; Wheaton, Deacon, McGrath, Berman, & Abramowitz, 2011). However, two studies reported that compared to other anxiety symptoms such as panic, social anxiety, and health anxiety, OC symptoms were more weakly related to the AS dimensions (Deacon & Abramowitz, 2006; Wheaton et al., 2011).

A limitation of the studies reviewed above, however, is that they considered OCD as a unitary construct, and used total scores on OC symptom inventories to index symptom severity. Yet, OCD is known for its heterogeneity, as there is a great deal of thematic diversity in obsessions and rituals (e.g., Foa & Kozak, 1995). It is therefore possible that AS is more important in some manifestations of OCD than in others. Consideration of OCD as a unitary construct might therefore obscure such fine-grained associations.

In the only study to-date to examine the relationship between AS and specific OC symptoms, Calamari, Rector, Woodard, Cohen, and Chik (2008) divided a sample of OCD patients on the basis of their primary symptom presentation into seven subgroups: (a) contamination-washing, (b) harming (aggressive obsessions and checking compulsions), (c) hoarding, (d) obsessionals (miscellaneous obsessions and compulsions), (e) symmetry, (f) certainty (elevations across all OC categories but relating to need for certainty), and (g) contamination/harming (elevated on both contamination and aggressive obsessions). The authors reported that AS was related to OC symptom severity among all patient groups except for the hoarding and obsessional groups. They also found that patients in their combined contamination-harming subgroup had higher levels of AS than did the other subgroups. Although these findings are informative, approaches that group patients with OCD into mutually exclusive subtypes are limited in the analyses that can be conducted (e.g., Mataix-Cols, 2006). Most contemporary approaches conceptualize the thematic diversity of OC symptoms as dimensional, rather than categorical (Mataix-Cols, Rosario-Campos, & Leckman, 2005; McKay et al., 2004), with potentially overlapping symptom dimensions that are continuous in nature and occur in OCD patients as well as in the general population. Dimensional measurement of OC symptoms also improves upon measures that assess specific forms of symptoms (e.g., “checking”), which may cut across dimensions (e.g., checking could be done to ensure one has not caused harm, or that foods are free of contaminants; Abramowitz et al., 2010). Dimensional measures may therefore be better equipped to elucidate relationships between specific OC dimensions and other variables (Wheaton, Abramowitz, Berman, Riemann, & Hale, 2010). Accordingly, in the present study, we sought to extend previous work by examining the relationship between the dimensions of AS and OC symptom dimensions.

The most recent and consistent data on the multidimensional structure of OC symptoms suggest four symptom dimensions: (a) obsessions about contamination/cleaning and “de-contamination” rituals, (b) obsessional doubts about being responsible for harm or making mistakes and checking rituals, (c) obsessions about the need for symmetry or exactness and ordering or arranging rituals, and (d) unacceptable thoughts pertaining to violent, sexual, and religious themes and mental or reassurance-seeking rituals (Abramowitz et al., 2010). Although some researchers (e.g., Cox, Borger, & Enns, 1999; Sexton, Norton, Walker, & Norton, 2003) have suggested an association between the cognitive dimension of AS and OC symptoms on the basis of OCD patients’ beliefs about the need to control intrusive thoughts, elevations on cognitive AS have not consistently been found in OCD patients (Deacon &

Abramowitz, 2006). Perhaps the fear of cognitive dyscontrol is only particularly relevant in some OC symptom dimensions. For example, some OCD patients are upset at their inability to stop themselves from having personally abhorrent thoughts (e.g., blasphemous thoughts) while others fear that they will act on unwanted impulses (i.e., an unwanted impulse to harm a loved one). Still other OCD sufferers are primarily beset by doubts (e.g., about having caused harm), and find themselves unable to dismiss such concerns. In all of these instances, cognitive AS concerns (e.g., “It scares me when my thoughts race”, “when my mind speeds up I’m afraid I’ll lose control”) might be particularly relevant. Therefore, we hypothesized that the cognitive concerns AS dimension would be especially related to the unacceptable thoughts and responsibility for harm OC symptom dimensions, which are typically characterized by distressing thoughts about aggression, violence, immorality, and sacrilege.

Previous theoretical and empirical work has connected contamination-related OC symptoms to fears of contracting an illness (Rachman, 2004; Wheaton, Abramowitz, Berman, Fabricant, & Olatunji, *in press*). Given that illness fears and health anxiety have been linked to the physical dimension of AS (Cox et al., 1999; Deacon & Abramowitz, 2008; Wheaton, Berman, Franklin, & Abramowitz, 2010), we hypothesized that contamination fears would also be especially related to this AS dimension. Specifically, contamination fearful individuals may attend closely to bodily sensations because of the fear of illness. Moreover, they might misinterpret the sensations of anxiety (e.g., upset stomach) as signs of physical illness. We did not form any specific a priori hypotheses regarding the symmetry symptoms, given the dearth of research addressing the relationship between this OC dimension and AS.

To test these hypotheses, we conducted a series of analyses using dimensional measures of both AS and OC symptoms. Specifically, we used the Anxiety Sensitivity Index-3 (ASI-3; Taylor et al., 2007), which is ideal for assessing the three AS dimensions and has a more stable factor structure and improved psychometric properties compared to the original Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986; see also Osman et al., 2009; Taylor et al., 2007) used in the previous study by Calamari et al. (2008). We also used the Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010) to assess the four empirically supported OC symptom dimensions. To control for the possibility that the relationship between AS and OC symptoms can be accounted for by variance attributable to other constructs, we also included measures of general distress and obsessive beliefs (e.g., inflated responsibility, need to control thoughts), a set of established cognitive distortions that serve as vulnerability factors for OC symptoms (e.g., Frost & Steketee, 2002).

2. Method

2.1. Participants

We elected to test our hypotheses in a diverse, unselected sample, which bears particular mention. Taxometric studies suggest that OC symptoms are continuous in nature (Olatunji, Williams, Haslam, Abramowitz, & Tolin, 2008), indicating that that findings in non-clinical samples are relevant to clinical samples. One review noted that associations between OC symptoms and cognitions are comparable in OCD and non-clinical samples (Gibbs, 1996). For the present study, a sample of 636 self-selected undergraduates enrolled in Introductory Psychology courses at a large university in the Southeast United States completed a computer-administered online questionnaire packet. This group included 424 women (66.7%) and 212 men (33.3%), which approximates the gender distribution of our Introductory

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