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Obsessive–compulsive symptoms: The contribution of obsessional beliefs and experiential avoidance

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ABSTRACT

Experiential (emotional) avoidance (EA), a core concept in acceptance and commitment therapy, involves an unwillingness to endure upsetting emotions, thoughts, memories, and other private experiences; and is hypothesized to play a role in obsessive–compulsive disorder (OCD). The present study examined how well EA, relative to traditional cognitive–behavioral theoretical constructs such as dysfunctional core beliefs about intrusive thoughts, predicts obsessive–compulsive (OC) symptoms. A sample of 353 non-clinical participants completed measures of EA, core "obsessive" beliefs, and OC symptoms. Individuals reporting greater levels of OC symptoms endorsed more obsessive beliefs and EA relative those with lower levels of OC symptoms, even when accounting for general levels of psychological distress. Among those with more OC symptoms, EA did not show relationships with obsessive beliefs. Moreover, EA did not add significantly to the prediction of OC symptom dimensions over and above the contribution of general distress and obsessive beliefs. Obsessive beliefs, meanwhile, contributed significantly to the prediction of OC checking and obsessing symptoms after accounting for EA. It appears the construct of EA is too general to explain OC symptoms over and above cognitive–behavioral constructs such as core obsessive beliefs, which are more specific.

Experiential (emotional) avoidance (EA), a core concept in the field of acceptance and commitment therapy (ACT), involves an unwillingness to endure upsetting emotions, thoughts, memories, and other private experiences (e.g., body sensations). This unwillingness leads to unhealthy efforts to resist, escape, and avoid such experiences (Hayes, Wilson, Gifford, Follette, & Stroahl, 1996). EA is thought to play an important role in maladaptive behaviors and psychopathology (Zvolensky & Forsyth, 2002), and accordingly, is receiving increased research attention. Findings from this emerging body of work suggest EA is associated with depression, anxiety, trauma, and reduced quality of life (Hayes et al., 2004). EA has also been hypothesized to play a role in several psychological disorders, including substance abuse, post-traumatic stress disorder, trichotillomania, generalized anxiety disorder and panic (e.g., Chawla & Ostafin, 2007).

Some authors (Eifert & Forsyth, 2005) have suggested that EA plays an important role in obsessive–compulsive disorder (OCD). The symptoms of OCD include (a) unwanted, anxiety-evoking thoughts, images, and impulses (*obsessions*; e.g., images of germs, thoughts of violence), and (b) urges to perform behavioral or mental acts (*neutralizing* and *compulsive rituals*; e.g., hand washing, reassurance-seeking, thought suppression) in effort to resist the obsession and reduce the associated anxiety. Looking at this definition, it could be argued that EA is a main characteristic of OCD since this disorder involves resistance to, and escape from, upsetting private experiences—in this case, unwanted obsessional thoughts. In the only empirical study addressing OCD from an EA perspective, Twohig, Hayes, and Masuda (2006) tested an eight-session ACT treatment with four individuals with OCD and anecdotally reported that OCD symptom reduction was associated with reductions in EA. Because of the small sample, however, the relationship between EA and OCD symptoms was not systematically explored. The purpose of the present study, therefore, was to examine this relationship more precisely. We specifically sought to evaluate how well the construct of EA, relative to other well-researched cognitive–behavioral theoretical constructs, predicts obsessive–compulsive (OC) symptoms.

Cognitive–behavioral formulations of OCD (e.g., Rachman, 1997, 1998; Salkovskis, 1996) propose that clinical obsessions arise from maladaptive interpretations of otherwise normal negative intrusive (unwanted) thoughts. Research indicates that up to 90% of the population at large experiences the same kinds of cognitive intrusions as do those with OCD (Rachman & de Silva, 1978). Whereas individuals *without* OCD recognize the senseless

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nature of unwanted intrusions, those *with* OCD appraise these intrusions as highly significant, threatening, and needing to be controlled. Following Beck's (1976) cognitive theory of emotion, these appraisals are thought to be based on dysfunctional core beliefs overestimating threat, personal responsibility, the importance of (and need to control) thoughts, and the need for perfectionism and certainty (i.e., so-called *obsessive beliefs*; Obsessive Compulsive Cognitions Working Group, 2001, 2003, 2005). The misinterpretations of intrusive thoughts lead to obssesional anxiety, as well as efforts to reduce such distress via avoidance, neutralizing, and compulsive rituals. These responses end up being counterproductive because they cue additional intrusive thoughts and reinforce assumptions about the significance and dangerousness of the intrusion, thus perpetuating a vicious cycle.

Three lines of empirical evidence provide strong support for the cognitive–behavioral model of OCD. First, cross-sectional studies of clinical and non-clinical samples indicate that OC symptoms are associated with obsessive beliefs and interpretations of intrusive thoughts as significant, threatening, and in terms of responsibility for harm (e.g., OCCWG, 2003; Salkovskis et al., 2000; Shafran, Thordarson, & Rachman, 1996). Second, laboratory experiments in which misinterpretations of intrusive thoughts were experimentally induced (e.g., Rassin, Merckelbach, Muris, & Spaan, 1999) indicate that the presence of obsessive beliefs evoke distress and neutralizing behaviors similar to that observed in individuals with OCD. Third, prospective studies suggest that obsessive beliefs serve as risk factors for the development of OC symptoms following a stressful event such as giving birth and becoming a parent (e.g., Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006, Abramowitz, Nelson, Rygwall, & Khandker, 2007; Coles & Horng, 2006).

To clarify differences between the cognitive–behavioral and EA approaches, the cognitive–behavioral approach concerns the misinterpretation of intrusive thoughts as threatening based on mistaken beliefs (i.e., obsessive beliefs), whereas EA emphasizes an unwillingness to endure unpleasant internal stimuli such as negative emotions and intrusive thoughts. To further illustrate the difference in emphasis, consider Eifert and Forsyth's (2005) explanation of the EA approach to OCD: "...when people with obsessive–compulsive disorder avoiding touching a doorknob that might have germs on it, they are not doing so to avoid being contaminated. What they are doing is avoiding the negative affect associated with touching the doorknob" (p. 8). This emphasis on avoidance of negative affect is in contrast to the cognitive–behavioral perspective, which attempts to explain why the negative affect occurs in the first place (e.g., because of faulty beliefs and interpretations of the probability of contamination). EA forms the basis of ACT, which is considered to be distinct from cognitive–behavioral therapy (CBT) (Eifert & Forsyth, 2005; Twohig et al., 2006); the treatment derived from the cognitive–behavioral model (e.g., Clark, 2004).

Although the cognitive–behavioral model is empirically supported, existing studies indicate that obsessive beliefs do not account for all of the variability in OC symptoms. Thus, it is worth attending to theoretical proposals that offer unique perspectives on psychological factors that might also contribute to OCD. Due to the increased interest in EA, and to the intuitive overlaps between this construct and OC symptoms (e.g., resistance to obsessional thoughts), we examined the independent and relative contributions of obsessive beliefs and EA to the prediction of OC symptoms. In addition, as OC symptoms are highly heterogeneous (e.g., McKay et al., 2004), we considered relationships between predictor variables and individual OC symptom dimensions.

Given that EA involves resistance to remaining in contact with unpleasant internal stimuli such as intrusive thoughts, we hypothesized that individuals with more severe OC symptoms would show higher scores on a measure of this construct as compared to those with less severe OC symptoms. We also predicted that among individuals with high levels of OC symptoms, EA would show relationships with obsessive beliefs and with the various dimensions of obsessive–compulsive symptomatology. On the basis of previous research demonstrating relationships between obsessive beliefs and certain OC symptoms (e.g., OCCWG, 2005), we hypothesized that obsessive beliefs would be differentially associated with various OC symptom dimensions, except for hoarding; the status of which as an OC symptom has recently been questioned (e.g., Wu & Watson, 2005). Given that no research has examined the relative contributions of EA and obsessive beliefs in the prediction of OC symptoms, we considered our analyses addressing this issue as exploratory.

1. Method

1.1. Participants

We tested our hypotheses using a large sample of college students who scored $\geq$21 on the Obsessive–Compulsive Inventory-Revised (Foa et al., 2002, described below). An important issue concerns whether study of analogue OCD samples is relevant to understanding OCD per se. Burns, Formea, Keortge, and Sternberger (1995) conducted a series of investigations on this issue and found that nontreatment-seeking individuals scoring highly on self report measures of OC symptoms (a) often met diagnostic criteria for OCD, (b) evidenced stability of symptoms over time, and (c) exhibited similar associated features (e.g., depression and generalized anxiety) as patients diagnosed with OCD. Thus, they concluded that results of psychopathology studies using analogue OC samples as described above are relevant to understanding the symptoms of patients diagnosed with OCD. Moreover, because a sensitive and specific clinical cutoff score on the OCI-R has been identified (Foa et al., 2002), we elected to use this approach.

A sample of 353 self-selected undergraduates enrolled in introductory psychology courses at a large university in the Southeast United States completed a computer-administered online questionnaire packet for this study. This group included 247 women (70.0%) and 106 men (30.0%) (which is identical to the gender distribution of the introductory psychology participant pool at large) and had a mean age of 19.3 years (S.D. = 2.75). From this initial pool, two groups of participants were formed on the basis of scores on the OCI-R. The first group of highly obsessive–compulsive individuals (High-OC) included participants whose total OCI-R score was $\geq$21 (n = 91). The second group was comprised of those scoring $<$21 on the OCI-R (Low-OC; n = 263). This score was chosen because Foa et al. (2002) determined it was the optimal OCI-R total score for correctly classifying individuals with OCD and nonanxious individuals (sensitivity = 65.6%, specificity of 63.9%). Demographic characteristics of each group are presented in Table 1. As can be seen, there were no differences in age, gender make-up, or ethnic diversity across the two groups.

1.2. Procedure

Participation in this study was available to all undergraduate students enrolled in introductory psychology classes at the study site. These classes include a research participation requirement and all participants received course credit for their participation in the study. The study was reviewed and approved by the University IRB.

After signing up for the experiment via an Internet-based software program, participants provided consent to participate