



Association of Metacognitive Beliefs, Obsessive Beliefs and Symptom Severity With Quality of Life in Obsessive–Compulsive Patients



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ABSTRACT

The aim of this study was to evaluate the association of obsessive beliefs, obsessive–compulsive disorder severity and metacognitive beliefs to the quality of life in patients with obsessive–compulsive disorder (OCD). Sixty one adults with a principal diagnosis of OCD were recruited for the study. Participants were assessed by trained clinicians using an unstructured clinical interview, the Obsessive Beliefs Questionnaire, the Yale–Brown Obsessive–Compulsive Scale, the Metacognitive Beliefs Questionnaire and the WHO Quality of Life Questionnaire. Data were analyzed using Pearson's of correlation coefficients and multiple regression analyses. Findings indicate that obsessive beliefs, severity total OCD and metacognitive beliefs were associated with total quality of life scores. Regression analysis revealed that while OCD total severity explained 40.1% of the variance in total quality of life, obsessive beliefs (perfectionism/certainty domain) and metacognitions (cognitive self-consciousness and negative beliefs about thoughts in general) explained an additional 13.7%, 7.7% and 5.4% of the variance in QoL. Findings indicate that the metacognitive beliefs associated with OCD symptom severity are different from that associated with quality of life. The implications are that metacognitive therapy aimed at symptom reduction may not necessarily result in improved QoL in OCD patients.

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Obsessive–Compulsive disorder (OCD) is a severely debilitating and usually chronic psychiatric disorder characterized by intrusive and unwanted thoughts, images or urges that are often accompanied by repetitive behaviors or mental acts. A 12-month prevalence of OCD in international settings is estimated to be 1.1% to 1.8% (American Psychiatric Association, 2013).

This multidimensional mental disorder is associated with significant functional impairment across various life domains, including reduced physical functioning, increased use of healthcare services, financial difficulty, and lower overall quality of life (QoL) (Vorstenbosch et al., 2012). Hou, Yen, Huang, Wang, and Yeh (2010) compared QoL (which was assessed through WHOQoL-BREF) of OCD and non-OCD patients. Their results show that the group with OCD had worse QoL in the general, physical, psychological and social relationships domains than the control group. However, no difference was found between the two groups for the environmental domain.

Some studies have found that QoL in patients with OCD is as bad as (Moritz, 2008), if not worse than (Stengler-Wenzke, Kroll, Riedel-Heller, Matschinger, & Angermeyer, 2007), that of patients with schizophrenia and even lower in comparison with people with severe depression, heroin addicts (Bobes et al., 2001) and chronic medical disease like diabetes (Srivastava, Bhatia, Thawani, & Jhanjee, 2011).

The QoL of patients with OCD has often been addressed by comparing the extent of impairment they experience in various domains of functioning. In such a consideration, QoL was found to be significantly lower in the physical, psychological well-being and social domains in OCD patients as compared to healthy controls (Fontenelle et al., 2010; Srivastava et al., 2011). Other studies have specifically explored the possible association between QoL and obsessive–compulsive symptoms. These studies have provided robust empirical evidence illustrating a correlation between different predominant symptoms of OCD and different domains of QoL in patients with OCD (Fontenelle et al., 2010; Kugler et al., 2013; Vorstenbosch et al., 2012). An inverse association between QoL and obsessive–compulsive symptom severity and number of symptoms (Eisen et al., 2006; Kugler et al., 2013; Masellis, Rector, & Richter, 2003; Moritz et al., 2005) has been reported. Other studies looking at the association of QoL with obsession and compulsion severity have found greater QoL impairment either with obsession severity (Eisen et al., 2006) or with compulsion severity (Moritz et al., 2005). QoL impairment in OCD has also been studied in association with clinical features. Current psychiatric comorbidity, such as co-morbid depression or anxiety, has been indicated as contributing to the impairment of quality of life seen in OCD (Eisen et al., 2006; Fontenelle et al., 2010; Masellis et al., 2003; Moritz et al., 2005; Niederauer, Braga, Souza, Meyer, & Cordioli, 2007; Rodriguez-Salgado et al., 2006; Stengler-Wenzke et al., 2007). Furthermore, OCD characterized by poor insight, low resistance, and reduced control towards their compulsions has been found to have a deteriorative course and poor clinical outcome (Kashyap et al., 2012).

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Few studies have evaluated the relationship between QoL and different dimensions of etiological factors contributing to OCD. The cognitive model of OCD suggests that dysfunctional beliefs lead to the emergence of the disorder. In this model beliefs regarding the overimportance of thoughts, need to control thoughts, overestimation of threat, perfectionism, and intolerance of uncertainty are believed to be important in the escalation of normal intrusive thoughts into clinical obsessions (Calkins, Berman, & Wilhelm, 2013; Smith, Wetterneck, Hart, Short, & Björgvinsson, 2012; Steketee, 2005).

Despite their role in the development and maintenance of OCD and associated distress, cognitive appraisals have not been explored thoroughly as regards their contribution to the QoL of patients with OCD (Kumar, Sharma, Kandavel, & Janardhan, 2012). Kumar et al. (2012) studied cognitive appraisals and QoL in patients with OCD. Their results revealed that thought control, importance of thoughts, and inflated responsibility correlated negatively with the psychological domain of QoL, implying that different dysfunctional cognitions may affect different domains of QoL. Their findings support the hypothesis that cognitive appraisals of obsessions contribute to poor QoL even after controlling for the severity of depression and OCD and duration of illness.

While the important role of cognitive appraisals in the development and maintenance of OCD is undeniable, Wells (1997) has posited that in OCD symptomatology the role of metacognitive beliefs may be more important than cognitive beliefs, since metacognitive beliefs trigger the cognitive beliefs (Solem, Myers, Fisher, Vogel, & Wells, 2010). Wells and Matthews (1994) have explained this process. In their metacognitive model of obsessive-compulsive disorder, self-regulatory executive function (S-REF), they propose that obsessive thoughts are negatively interpreted as a result of metacognitive beliefs. The metacognitive model considers three types of metacognitive knowledge: thought–fusion beliefs, beliefs about the need to perform rituals, and stop signals or criteria for terminating the rituals. In the metacognitive model, interpretation of an intrusion depends upon the activation of thought–fusion beliefs, which fall into three domains: thought–action fusion (TAF), thought–event fusion (TEF) and thought–object fusion (TOF). In Wells' model, TAF refers to the fusion between thoughts and actions, TEF refers to the belief that a thought can cause an event or can be in itself evidence that an event has occurred, and TOF refers to the belief that thoughts, feelings or memories can be passed to other people or into objects (Önen et al., 2013). According to the S-REF model, a thought or intrusion triggers the fusion beliefs leading to negative appraisals which in turn activate beliefs about rituals. Beliefs about rituals are assumptions regarding the need to perform rituals and neutralizing actions in response to intrusions. The rituals and neutralizing behaviors are carried out until some internal subjective criteria, or stop signals, are met (Wells, 2000). So metacognitive beliefs about the meaning and danger associated with having specific thoughts lead to obsessive thoughts (Önen, Karakaş Uğurlu, & Çayköylü, 2013).

Cartwright-Hatton and Wells (1997) described five empirically distinct and relative dimensions of metacognition: 1) positive beliefs about worry, 2) negative beliefs about the controllability of thoughts and corresponding danger, 3) cognitive confidence, 4) negative beliefs about thoughts in general, and 5) cognitive self-consciousness. In the metacognitive model, metacognitive beliefs about thoughts and thought processes are a critical component of the dysfunctional cognitive process that drives OCD symptoms.

Patients with OCD have been characterized by their metacognitive functioning. Papanicolaou and Wells (1999) and Hermans et al. (2008) demonstrated that OCD patients lack confidence in their cognitions, which augments doubts and ultimately compulsions. Exner et al. (2009) pointed out that patients with OCD possess a metacognitive characteristic termed cognitive self-consciousness, a heightened tendency to focus on their own mental processes, which makes them vulnerable to obsessions. Solem et al. (2010) identified the metacognitive need to control thoughts as triggering OCD symptoms, while Moritz,

Peters, Laro, and Lincoln (2010) reported negative beliefs about the malleability of worry as well as high need to control thoughts as features of patients with OCD.

Although there is a large body of research providing support for the association of metacognitions and cognitions with OCD symptoms, no study has explored the role of these concepts as regards the QoL of OCD patients. Substantial impairment in QoL appears to persist in OCD patients even after successful reduction of symptoms with treatment (Bystritsky et al., 1999). We hypothesize that this is possibly due to persisting negative cognitive appraisals and, metacognitions. As diminished QoL is characteristic of most persons with OCD, treatment of OCD should consider improvements in QoL as a desirable outcome for which a thorough understanding of the complete clinical picture of OCD is essential. Therefore, the aim of this study was to examine the relative contributions of cognitions, metacognitions and symptom severity to the quality of life in OCD patients. Although a broad construct, QoL is often defined by two primary components: an individual's functional status and an individual's subjective determination of how their health impacts their life (Rapaport, Clary, Fayyad, & Endicott, 2005). Since measures of QoL generally depend on self-report, estimates of functional status are also a function of the individual's subjective experience of impairment. For the purposes of this study, QoL is defined as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. QoL is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment (WHO, 1997).

MATERIALS & METHOD

Participants

Sixty one adults with a principal diagnosis of OCD were recruited for the study. Participants were assessed by trained clinicians using an unstructured clinical interview. All patients were selected from those seeking treatment at two private clinics. The inclusion criteria used were i) a primary diagnosis of OCD according to DSM-5 criteria; ii) patients between the ages of 20 and 55 years; iii) minimum educational level of 8th grade. Exclusion criteria were i) patients with a history of psychosis, ii) patients with severe comorbid depression or anxiety. Using these criteria, a total of 78 patients were sampled. But 17 patients did not fulfill the inclusion criteria and were excluded from the study; 4 patients had had only 5 years of schooling, 7 had severe co-morbid depression, and 1 patient refused to participate in the study. From among the 61 patients, 21 were males and 40 were females. All patients ranged in age from 20 to 52 years. Patients' education levels ranged from 8 years to 16 years of schooling.

Instruments

Yale–Brown Obsessive–Compulsive Scale (Y-BOCS)

The Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) is a semi-structured interview including 10 items for the measurement of OCD severity, 5 items pertaining to compulsions and 5 items to obsessions. Items are rated on a five point Likert scale from 0 (no symptoms) to 4 (extreme symptoms). These items assess time occupied, interference with activities, distress, resistance, and control. The psychometric properties including internal consistency and interrater reliability for the Y-BOCS have been found to be satisfactory (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). The internal consistency (Cronbach's α) for this study was found to be .82.

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