



Contents lists available at ScienceDirect

Journal of Behavior Therapy and Experimental Psychiatry

journal homepage: www.elsevier.com/locate/jbtep

Anxiety sensitivity as a predictor of outcome in the treatment of obsessive-compulsive disorder



Shannon M. Blakey^{a,*}, Jonathan S. Abramowitz^a, Lillian Reuman^a, Rachel C. Leonard^b,
Bradley C. Riemann^b

^a University of North Carolina at Chapel Hill, Chapel Hill, NC, United States

^b Rogers Memorial Hospital, Oconomowoc, WI, United States

ARTICLE INFO

Article history:

Received 8 April 2016

Received in revised form

20 February 2017

Accepted 2 May 2017

Available online 6 May 2017

ABSTRACT

Background and objectives: To address the fact that not all individuals who receive cognitive-behavioral therapy (CBT) for obsessive-compulsive disorder (OCD) exhibit complete symptom reduction, research has examined factors that predict outcome; however, no studies have examined anxiety sensitivity (AS) as a predictor of outcome of CBT for OCD. AS refers to the fear of anxious arousal that results from mistaken beliefs about the dangerousness of anxiety-related body sensations. It is important to understand whether AS influences OCD treatment outcome, considering that (a) some obsessions directly relate to AS, and (b) OCD patients with high AS may be reluctant to engage in anxiety-provoking components of CBT for OCD.

Methods: Patients ($N = 187$) with a primary diagnosis of OCD who received residential CBT for OCD participated in this study, which involved completing a self-report battery at pre- and post-treatment. **Results:** Results supported study hypotheses, in that (a) baseline AS positively correlated with baseline OCD severity, and (b) greater baseline AS prospectively predicted higher posttreatment OCD symptom severity even after controlling for pretreatment OCD and depression severity.

Limitations: The study was limited by its use of an older measure of AS, reliance on self-report measures, and nonstandardized treatment across participants.

Conclusions: Findings highlight the importance of AS in the nature and treatment of OCD. Clinical implications and future directions are discussed.

© 2017 Elsevier Ltd. All rights reserved.

Obsessive-compulsive disorder (OCD) is characterized by distressing, unwanted intrusive thoughts, images, and doubts (i.e., obsessions) and/or urges to perform repetitive, deliberate rituals and other anxiety-reduction strategies to neutralize this distress (i.e., compulsions) (American Psychiatric Association [APA], 2013). Compulsive rituals are reinforced by the immediate decrease in anxiety they engender, yet the anxiety reduction is temporary and compulsions prevent the natural extinction of obsessional fear in the long term. Obsessive-compulsive symptoms cause considerable distress and functional impairment among the 2–3% of the population that experiences OCD at some point in their lifetime (Kessler et al., 2005).

Cognitive-behavioral therapy (CBT) using exposure and

response prevention (ERP) procedures can be an effective treatment for OCD (e.g., Olatunji, Cisler, & Deacon, 2010). Exposure entails repeated systematic confrontation with situations and stimuli that provoke obsessional anxiety; response prevention involves resisting urges to perform escape and avoidance behaviors (e.g., compulsive rituals) during and after exposure trials. Yet despite its established efficacy, response to this intervention varies widely and some individuals are not able to adhere or respond. Accordingly, researchers have sought to identify factors that predict outcome. Severe depression and baseline OCD symptoms, for example, have been associated with attenuated response to CBT for OCD across a large body of research (Abramowitz & Foa, 2000; Abramowitz, Franklin, Kozak, Street, & Foa, 2000; Farrell et al., 2016; Foa et al., 1983; Knopp, Knowles, Bee, Lovell, & Bower, 2013; Steketee, Chambless, & Tran, 2001), although the relationship between baseline depression and OCD treatment outcome is not consistent and does not appear to influence outcomes in the

* Corresponding author. University of North Carolina at Chapel Hill, C.B. # 3270 (Davie Hall), Chapel Hill, NC 27599, United States.

E-mail address: sblakey@unc.edu (S.M. Blakey).

long-term (e.g., [Anholt et al., 2011](#)).

To date, no studies have examined *anxiety sensitivity* (AS) as a predictor of CBT outcome in OCD. AS refers to mistaken beliefs about the dangerousness of anxiety-related body sensations that generate the fear of anxious arousal (e.g., [Reiss & McNally, 1985](#)). Specifically, individuals with elevated AS are hypervigilant to and (mis)appraise ambiguous body sensations as particularly dangerous. For example, someone with high anxiety sensitivity might misinterpret chest tightness as a sign of a heart attack, dizziness as a sign of “losing control,” or racing thoughts as an indicator that one is “going crazy” and about to do something embarrassing or harmful. Although AS is often associated with panic disorder, it is considered a transdiagnostic process ([Taylor, 1999](#)); moreover, AS has demonstrated moderate to strong associations with OCD symptom severity in individuals diagnosed with OCD (Pearson *rs* range 0.28–0.30; partial *rs* range 0.28–0.64; [Calamari, Rector, Woodard, Cohen, & Chik, 2008](#); [Deacon & Abramowitz, 2006](#); [Laposa, Collimore, Hawley, & Rector, 2015](#); [Norton, Sexton, Walker, & Norton, 2005](#); [Zinbarg, Barlow, & Brown, 1997](#); for a review see [Robinson & Freeston, 2014](#)) as well among nonclinical individuals (Pearson *rs* range 0.30–0.56; [David et al., 2009](#); [Keough, Riccardi, Timpano, Mitchell, & Schmidt, 2010](#); [Sexton, Norton, Walker, & Norton, 2003](#); [Wheaton, Deacon, McGrath, Berman, & Abramowitz, 2012](#)).

Although research in this area is limited, a few studies have highlighted relationships between specific *dimensions* of AS (i.e., the fear of anxiety and/or anxious arousal because of feared physical, mental, or social consequences) and OCD symptoms (e.g., [Wheaton, Mahaffey, Timpano, Berman, & Abramowitz, 2012](#)). Previous investigators have posited that the cognitive dimension of AS in particular is strongly related to OCD given that misappraisals of one's own thinking (e.g., overestimating the importance of thoughts) are a cardinal feature of OCD ([Rachman, 1997, 1998](#)). Although some research supports this hypothesis (e.g., [Cox, Borger, & Enns, 1999](#); [Sexton et al., 2003](#); [Wheaton et al., 2012](#)), aggregate findings are inconsistent ([Deacon & Abramowitz, 2006](#)). Moreover, the cross-sectional nature of previous studies precludes investigators from determining whether AS predicts changes in OCD symptom severity *over time* (e.g., following treatment).

There are a number of reasons to examine AS as a predictor of poorer outcome with CBT for OCD. First, anxious arousal is often provoked during exposure therapy. Thus, individuals with high AS are apt to become afraid not only of exposure stimuli per se, but also the arousal sensations induced when conducting exposures. Given that AS is a strong predictor of panic attacks (e.g., [Schmidt, Zvolensky, & Maner, 2006](#)), OCD patients with high AS might be prone to experiencing panic episodes during exposure, which could lead to avoidance behavior and hamper both adherence and confidence in the treatment techniques, thereby leading to suboptimal outcome. Furthermore, some patients' obsessions might directly relate to ambiguous somatic sensations; for example, a patient who presents with contamination-related OCD may be especially hypervigilant for (and anxious in response to) feelings of nausea, which often accompany anxious arousal.

One methodological obstacle to examining predictors of outcome in OCD is that patients with high levels of concurrent anxiety and depression (i.e., comorbidity) are often excluded from randomized controlled trials (RCTs) in efforts to maximize the internal validity of such studies. Yet this restricts the range of comorbid psychopathology variables (e.g., depression, AS), potentially obscuring relationships in secondary analyses of outcome predictors. We addressed this issue in the present investigation by using a large sample of individuals with OCD seeking treatment outside the context of an RCT. Our data were collected within a residential program specializing in CBT for OCD in which

individuals often met criteria for comorbid conditions (e.g., major depression) and were concurrently using psychotropic medication. Although these sample characteristics might attenuate internal validity (e.g., treatment was less standardized than in controlled studies), it afforded the best opportunity to observe the effects of AS on CBT response in a diverse OCD clinical sample receiving CBT in a service setting.

The present study was designed to examine the extent to which baseline levels of AS predict treatment outcome in a sample of individuals with a clinical diagnosis of OCD undergoing CBT above and beyond established predictors of attenuated response (i.e., baseline OCD and depressive symptom severity). On the basis of previous research and the conceptual considerations noted above, we expected that baseline AS would be positively correlated with baseline OCD severity. We also hypothesized that greater baseline levels of AS would prospectively predict higher posttreatment OCD symptom severity above and beyond pretreatment OCD and depression severity.

1. Method

1.1. Participants

Participants were considered eligible to participate in the current study if they (a) had a primary diagnosis of OCD, (b) were admitted for residential treatment at the Obsessive-Compulsive Disorders Center at Rogers Memorial Hospital (RMH) in Oconomowoc, Wisconsin, (c) provided informed consent to participate, and (d) had completed pre- and post-treatment assessments. Patients with comorbid psychotic symptoms or current substance abuse were considered ineligible. On average, approximately 28.5 h of ERP were completed per week, including both staff-assisted and self-directed exposure practice. Most participants ($n = 163$; 87.2%) were also taking psychiatric medications; primarily, selective serotonin reuptake inhibitors (SSRIs; $n = 125$; 66.8%). Psychiatric medications were adjusted upon the on-site psychiatrist's assessments of the patient's needs (information on the precise number of participants whose medication changed during the course of CBT was unfortunately not available). The majority ($n = 153$; 81.8%) had secondary diagnoses, which are shown in [Table 1](#).

The final sample included 187 adults (51.9% women; $n = 97$) who had a mean age of 30.49 years ($SD = 12.24$) and had received

Table 1
Secondary diagnosis of study participants.

Secondary diagnosis	<i>n</i>	(%)
Mood disorders	62	(33.2)
Major depressive disorder	10	(5.3)
Bipolar I disorder	1	(0.5)
Other mood disorder	51	(27.3)
Anxiety-related disorders	36	(19.3)
Panic disorder	4	(2.1)
Posttraumatic stress disorder	1	(0.5)
Social anxiety disorder	10	(5.3)
General anxiety disorder	21	(11.2)
Obsessive-compulsive and related disorders	5	(2.7)
Trichotillomania	1	(0.5)
Tic disorder/Tourette's syndrome	1	(0.5)
Body dysmorphic disorder	3	(1.6)
Developmental disorders	2	(1.1)
Attention deficit/hyperactivity disorder	1	(0.5)
Learning disability	1	(0.5)
Eating disorders	3	(1.6)
Anorexia nervosa	1	(0.5)
Bulimia nervosa	1	(0.5)
Other eating disorder	1	(0.5)
Other psychological disorder	45	(24.1)

Download English Version:

<https://daneshyari.com/en/article/5039025>

Download Persian Version:

<https://daneshyari.com/article/5039025>

[Daneshyari.com](https://daneshyari.com)