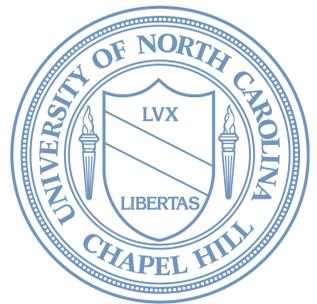


# Experiential Avoidance, Cognitive Fusion, and Health Cognitions as Predictors of Health Anxiety Symptoms



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## Introduction

- Cognitive-behavioral models of health anxiety (HA), although empirically supported and widely-accepted, do not entirely explain the variability in HA symptoms (Abramowitz & Braddock, 2008).
- Constructs derived from Relational Frame Theory (RFT) may improve our understanding of HA and, accordingly, the explanatory power of existing models.
- Two such constructs are *experiential avoidance* (EA), which is defined as the tendency to resist unpleasant internal experiences, and *cognitive fusion*, the tendency to take thoughts literally rather than view them as random mental events.
- The current study investigates and compares the degree to which maladaptive cognitions about ones health and the RFT constructs experiential avoidance (EA) and cognitive fusion are predictors of health anxiety.

### HYPOTHESIS:

- RFT constructs will significantly contribute to explaining variability in HA symptoms *above and beyond* cognitive-behavioral constructs.

## Method

### Participants

- 194 undergraduate participants
- 75.8% female; 69.1% White
- *M* age = 18.8 years (*SD* = 2.4 years)

### Self-Report Measures

- Short Health Anxiety Index (SHAI)
- Health Cognitions Questionnaire (HCQ-30)
- Cognitive Fusion Questionnaire (CFQ)
- Acceptance and Action Questionnaire-II (AAQ-II)
- Depression Anxiety and Stress Scale (DASS-21)

## Results

Table 1. Group mean scores on study measures

Measure	Mean	SD
SHAI	13.74	5.73
HCQ		
Coping	22.03	5.73
Medical Services	9.96	2.86
Likelihood	10.67	3.52
Awfulness	15.24	2.95
CFQ	24.75	8.79
AAQ-II	48.99	10.13
DASS Total	23.95	19.61
DASS Stress	11.11	7.89
DASS Anxiety	6.32	6.56
DASS Depression	6.52	7.51

- Bivariate correlation analyses revealed that all CBT and RFT constructs were moderately to strongly associated with HA symptoms (see Table 2; *r*s ranging from .14 to .60, *p*s < .05).
- HCQ-Likelihood and HCQ-Coping both emerged as significant and unique predictors of HA when entered into Step 2 of the regression model (see Table 3).

Table 2. Correlations between study measures

	1	2	3	4	5	6	7	8
1. HCQ-Coping	--							
2. HCQ-Medical Services	.34	--						
3. HCQ-Likelihood	.11	.27	--					
4. HCQ-Awfulness	.29	-.12	.06	--				
5. DASS-Total	.38	.24	.43	.20	--			
6. CFQ	.36	.194	.39	.35	.68	--		
7. AAQ-II	-.45	-.25	-.44	-.20	-.76	-.73	--	
8. SHAI	.39	.33	.49	.14	.60	.53	-.57	--

## Results

Table 3. Regression Statistics for DASS, HCQ, AAQ-II, and CFQ Predicting Health Anxiety Symptoms

	R <sup>2</sup>	β	t	p
Final Model	.42			<.001
Step 1: DASS Stress		.20	2.72	<.01
Step 2: HCQ				
Coping		.16	2.48	.01
Medical Services		.11	1.80	.07
Likelihood		.27	4.38	<.001
Awfulness		-.02	-.31	.76
Step 3: RFT measures				
CFQ		.13	1.45	.15
AAQ-II		-.13	-1.32	.19

- Regression analyses showed that RFT constructs, taken together, explained unique variance above and beyond cognitive behavioral constructs in the prediction of HA symptoms ( $\Delta R^2 = .024$ ,  $p = .02$ ).

## Discussion

- Results supported our hypothesis that RFT constructs significantly contribute to explaining variability in HA symptoms above and beyond cognitive-behavioral constructs.
- Results suggest that RFT may offer additional explanatory power in helping to understand symptoms of HA.
- Additionally, they suggest that clinicians should not only target cognitions pertaining to an individual's health, but also consider addressing EA and cognitive fusion in the treatment of clinical HA.
- Study limitations include the cross-sectional design, reliance on self-report measures, and use of a healthy undergraduate sample.
- Future research should examine the relationship between other RFT constructs and HA, as well as the relationship between RFT constructs and other anxiety-related disorders.