An examination of the role of intolerance of distress and uncertainty in hoarding symptoms

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Abstract

Background: Hoarding disorder (HD) is a common and debilitating disorder characterized by an accumulation of and failure to discard one’s possessions. The identification and examination of underlying factors that may contribute to hoarding symptoms are needed to elucidate the nature of the disorder and refine existing treatments. Two transdiagnostic vulnerability factors that have been associated with hoarding symptoms are distress intolerance (DI) and intolerance of uncertainty (IU).

Objectives: This study examined the relationships between DI, IU, and symptoms of hoarding in two samples consisting of outpatients and individuals recruited from Amazon’s Mechanical Turk. We hypothesized that DI and IU would show unique and interactive associations with hoarding symptoms.

Results: Across both samples, DI and IU were significantly associated with hoarding symptoms. However, DI and IU did not interact in their prediction of symptoms, and only IU remained a significant predictor, when accounting for relevant covariates.

Conclusions: Results suggest that IU is a robust predictor of hoarding symptoms and may be a promising and novel treatment target for HD.

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1. Introduction

Hoarding disorder (HD) is characterized by difficulty discarding one’s possessions and/or engaging in excessive acquiring of items, resulting in the accumulation of clutter that limits the use of functional living spaces [1]. HD is thought to affect approximately 2%–6% of the population and is associated with significant impairment, such as the inability to perform necessary household functions, health consequences due to unsafe or unsanitary household environments, social isolation, and even mortality due to dangerous living conditions [2,3]. Cognitive behavioral models of HD suggest that information-processing biases and dysfunctional beliefs about possessions contribute to maladaptive saving behaviors characteristic of the disorder [1,4,5]. Saving behaviors (i.e., acquiring or not discarding) act as avoidance strategies aimed to prevent emotional distress that may be associated with making decisions about a possession [1,6]. Though avoidance results in short-term reduction of distress, it ultimately exacerbates symptoms by negatively reinforcing the use of maladaptive saving behaviors. As such, identifying underlying factors that may contribute to this cycle is necessary in order to elucidate the nature of the disorder and refine existing treatments.

One construct that has been linked to avoidance across psychopathology and has garnered recent attention in the hoarding literature is distress intolerance (DI), defined as the perceived inability to tolerate aversive emotional states [7,8]. Individuals with elevated DI have difficulty tolerating, understanding, and managing distress. DI has been identified as a transdiagnostic vulnerability factor for a number of psychiatric conditions, including substance use [9], eating [10], anxiety [11], and obsessive-compulsive (OC) spectrum disorders [12,13]. A growing body of literature suggests that hoarding symptoms are associated with greater DI [14–18], such that individuals with hoarding symptoms may have difficulty discarding and/or not acquiring possessions due to difficulties tolerating the distress that may accompany such behaviors. Though DI is posited to be an important maintaining factor in hoarding, findings regarding the relationship between DI and other factors, such as intolerance of uncertainty, remain inconsistent and warrant further examination.
DI and hoarding symptoms remain mixed when controlling for anxiety and depression symptoms [16–18], suggesting that the influence of DI on hoarding symptoms may be confounded by other factors.

Another individual difference variable that may contribute to hoarding behaviors is intolerance of uncertainty (IU), defined as an individual’s perceived inability to endure an emotional response that is triggered by the absence of certain information and maintained by the subsequent perceived presence of uncertainty [19]. Though IU was first identified as a risk factor for generalized anxiety disorder (GAD) [20], it has more recently been associated with other anxiety and OC-spectrum disorders [21–24]. However, only two studies to date have examined the role of IU in hoarding symptoms. In the first study, Oglesby and colleagues [25] found that IU was associated with greater hoarding symptoms in an undergraduate sample, when controlling for anxiety and depression symptoms. A more recent study [26] replicated Oglesby’s findings in an undergraduate sample, accounting for anxiety and depression symptoms, as well as hoarding-related beliefs. Additionally, Wheaton and colleagues [26] found that individuals with HD reported significantly greater IU when compared to healthy controls, but comparable degrees of IU as compared to individuals with GAD and obsessive–compulsive disorder (OCD). Taken together, individuals with hoarding symptoms may hold on to and/or acquire possessions due to an inability to tolerate unknown outcomes that could accompany their decision to discard and/or not acquire.

DI and IU are both characterized by one’s inability to tolerate negatively perceived stimuli, and research has shown that they are moderately correlated [27–30]. However, despite the shared association between DI and IU, they are conceptually distinct, such that DI reflects a broad inability to tolerate aversive emotional states, whereas IU reflects a more circumscribed inability to tolerate the unknown [31]. Importantly, theorists suggest that IU may exacerbate the influence of DI on behavioral responses and may be an important component of treatment aimed to reduce DI [19]. Indeed, extant literature suggests that risk factors, in general, may differentially influence symptoms in the presence of other risk factors [32]. Specifically, the interaction between two risk factors may contribute to more severe symptoms, such that the elevation of one risk factor may exacerbate the influence of the other, thereby resulting in greater overall distress and difficulty coping with perceived difficulties [33]. Therefore, it may be that individuals who are intolerant of both emotional distress and uncertainty are at greater risk for developing more severe hoarding symptoms. However, no study to date has examined whether these constructs act independently or synergistically in their influence on symptoms. Elucidating the nature of these constructs may help to clarify the relative importance of each in the maintenance of hoarding symptoms, thereby aiding in the refinement of existing treatments.

As such, the current study aimed to examine the relative contribution of and potential interaction between DI and IU in the prediction of hoarding symptoms. We hypothesized that a) DI and IU would be positively associated with overall and specific hoarding symptoms (i.e., difficulty discarding, acquiring, clutter), and b) DI and IU would interact in their influence on hoarding symptoms, such that individuals with elevated DI and IU would report the most severe symptoms.

2. Study 1 method

2.1. Participants

The sample consisted of 254 individuals (57.5% female) presenting for psychological treatment or research at the Anxiety and Behavioral Health Clinic (ABHC) at Florida State University between October 2013 and September 2015. Individuals presenting to the ABHC are referred elsewhere only if there is a presence of a current psychotic and/or bipolar-spectrum disorder or serious suicidal intent. The average age of the sample was 33.85 years (SD = 15.11, range = 18–82). Of the sample, 65.7%自我-identified as white/Caucasian, 20.9% as African American, 1.6% as Asian, 0.8% as Pacific Islander, 0.4% as American Indian/Native American, and 10.6% as other (e.g., biracial). Additionally, 11.4% of the sample self-identified as Hispanic. In regards to education background, 55.1% of the sample received some college education, 19.3% graduated from a four-year college, 11.4% received a graduate degree, 10.2% graduated from high school or received an equivalent degree, 2.0% graduated from a trade or technical school, and 2.0% did not graduate from high school.

Of the sample, 42.5% met diagnostic criteria for a primary anxiety disorder diagnosis, 29.2% met criteria for a primary mood disorder, 9.1% met criteria for a primary trauma and stressor-related diagnosis, 3.6% met criteria for a primary OC-spectrum disorder diagnosis, 3.2% met criteria for a primary substance use disorder, 3.2% met for other disorders (e.g., eating disorder), and 9.1% did not meet criteria for any psychological disorders. Regardless of primary diagnosis, 1.2% of the sample met criteria for HD. The sample showed significant variability in hoarding symptoms, with scores on the Saving Inventory-Revised (SIR) [34] ranging from 0 to 72. The average SIR score was 21.93 (SD = 18.00), and 17.7% of the sample scored above the clinical cut-off on the SIR (≥41), which is comparable to prior studies utilizing outpatient samples [35]. Of note, the rate of individuals meeting diagnostic criteria for HD was lower than the rate of those endorsing clinically significant hoarding symptoms. This discrepancy is consistent with research suggesting that hoarding symptoms are dimensional in nature [36] and may, therefore, be clinically significant even in the absence of a diagnosis.

2.2. Measures

Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I) [37]. The SCID-I is a semi-structured clinical interview that assesses the presence of psychiatric conditions. All interviews were administered by doctoral level clinical
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