



## Experiential avoidance and emotion regulation difficulties in hoarding disorder



Lorena Fernández de la Cruz<sup>\*,1</sup>, Danielle Landau<sup>1</sup>, Alessandra C. Iervolino, Susan Santo, Alberto Pertusa, Satwant Singh, David Mataix-Cols

King's College London, Institute of Psychiatry, London, England, UK

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### ABSTRACT

Experiential avoidance can be defined as the tendency to avoid contact with unwanted internal experiences. Current conceptualizations of pathological hoarding appear broadly consistent with an experiential avoidant model. Eighty participants in four groups, namely hoarding disorder (HD) without comorbid obsessive–compulsive disorder (OCD), HD with comorbid OCD, non-hoarding OCD, and healthy controls, were administered measures of experiential avoidance and emotion regulation difficulties. Hoarding individuals reported higher levels of experiential avoidance and difficulties in emotion regulation compared to healthy but not to OCD participants. Both experiential avoidance and emotion regulation difficulties were significantly more prominent when HD was comorbid with OCD than when HD occurred without comorbid OCD. Correlation analyses further showed that both experiential avoidance and emotion regulation were moderately but significantly associated with obsessive–compulsive but not hoarding symptoms. Thus, experiential avoidance and emotion regulation difficulties are not specifically relevant to HD but to a broad range of psychopathologies. However, despite the lack of specificity, the findings raise some potentially useful clinical implications for the treatment of HD.

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### 1. Introduction

Traditionally, hoarding has been considered a personality trait, and more recently, a symptom (or symptom dimension) of obsessive–compulsive disorder (OCD). However, recent conceptualizations suggest that, in most cases, hoarding appears to be a discrete diagnostic entity, named hoarding disorder (HD), which will be included in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (Mataix-Cols et al., 2010; Mataix-Cols, Billotti, Fernández de la Cruz, & Nordsletten, 2013). Diagnostic criteria for HD include a persistent difficulty discarding or parting with possessions (Criterion A), which is due to a perceived need to save the items and distress associated with discarding them (Criterion B); the accumulation of possessions that clutter active living areas of the home to the extent that their intended use is substantially compromised (Criterion C); significant distress or impairment (Criterion D); and symptoms not being attributable to another medical condition (Criterion E) and/or another DSM-5 disorder (Criterion

F). The presence of excessive acquisition and the degree of insight (good, poor, or absent) can be coded as specifiers for the diagnosis (Mataix-Cols et al., 2013).

*Experiential avoidance* is defined as the tendency to avoid contact with particular unwanted internal experiences, such as bodily sensations, emotions, thoughts, and memories (Hayes, Strosahl, & Wilson, 1999). It is hypothesized to functionally underlie much psychopathology and has been investigated in a number of psychological disorders such as OCD, generalized anxiety disorder, posttraumatic stress disorder, trichotillomania, and skin-picking (e.g., Abramowitz, Lackey, & Wheaton, 2009; Begotka, Woods, & Wetterneck, 2004; Chawla & Ostafin, 2007; Flessner & Woods, 2006; Kashdan & Kane, 2011; Newman & Llera, 2011).

Existing conceptualizations of pathological hoarding behaviour (e.g., Frost & Hartl, 1996; Steketee & Frost, 2003) appear broadly consistent with an experiential avoidance model. For example, they suggest that saving possessions (as opposed to discarding them) enables individuals to avoid distressing feelings associated with the action – or thought – of discarding such as loss, guilt, or fear of having made a mistake. However, this question has scarcely received empirical attention. Wheaton, Abramowitz, Franklin, Berman, and Fabricant (2011) found that experiential avoidance was significantly correlated with hoarding symptoms, measured with the Saving Inventory-Revised (SI-R; Frost, Steketee,

\* Corresponding author at: King's College London, PO 69, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK. Tel.: +44 2081 234 941; fax: +44 2078 480 379.

E-mail address: [lorena.fernandez.de\\_la\\_cruz@kcl.ac.uk](mailto:lorena.fernandez.de_la_cruz@kcl.ac.uk) (L. Fernández de la Cruz).

<sup>1</sup> Joint first authors.

& Grisham, 2004), in an unscreened student sample. In their regression analyses, experiential avoidance predicted SI-R total scores above and beyond general distress and depression symptoms, although the amount of variance uniquely explained by experiential avoidance was very small (1%). In a community-recruited sample of 47 people with clinically significant levels of compulsive buying, a construct closely related to hoarding, Williams (2012) found that this form of excessive acquisition was associated with higher levels of experiential avoidance. However, whether clinically diagnosed individuals meeting criteria for HD are characterized by high levels of experiential avoidance has not been investigated.

While experiential avoidance can be understood as a maladaptive strategy used by individuals to manage or regulate difficult emotions, *emotion regulation* (as an adaptive skill) is defined as the ability to monitor, evaluate, and modulate emotional reactions, especially in the context of goal-related behaviour (Gratz & Roemer, 2004). Inherent in this definition is the distinction between the modulation and avoidance of emotions—the former involving altering intensity or duration of emotional experience rather than attempting to avoid or extinguish negative emotions completely. Difficulties in emotion regulation are cited as a common factor across the spectrum of emotional problems (e.g., Barlow, Allen, & Choate, 2004; Berking & Wupperman, 2012; Mennin, 2005). Timpano, Buckner, Richey, Murphy, and Schimdt (2009) found that hoarding behaviours in a large sample of undergraduate students were associated with greater difficulties tolerating distress and greater fear of internal anxiety-related sensations.

The role of emotional suppression has received much research attention, with evidence that attempts to avoid internal experiences may paradoxically increase frequency of unwanted experiences and emotional distress (e.g., Purdon, 1999; Wegner, Schneider, Carter, & White, 1987). Particularly relevant are, in light of the information-processing deficits and memory impairment among hoarders (see Mataix-Cols, Pertusa, & Snowden, 2011 for a review), the findings that behavioural and emotional suppression are linked with poorer performance on cognitive tasks and quicker disengagement from frustrating or distressing tasks (Baumeister, Bratslavsky, Muraven, & Tice, 1998; Muraven, Tice, & Baumeister, 1998). Elucidating a link between emotion regulation strategies and HD may therefore provide further insights into the difficulties hoarders encounter when trying to discard possessions.

Exploring these two psychological constructs – namely experiential avoidance and emotion regulation – may have important treatment implications for a wide range of clinical disorders, including HD. For instance, the literature supporting the role of emotional avoidance in anxiety disorders suggests that exposure therapies may be improved by targeting the wider domain of emotional avoidance (e.g., Abramowitz et al., 2009; Orsillo & Batten, 2005). For example, exposure-based therapies could be augmented by helping individuals to accept/approach emotions, perhaps prior to undertaking a situational exposure intervention (Jaycox, Foa, & Morral, 1998; Tull, Barrett, McMillan, & Roemer, 2007). Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), a ‘third wave’ behavioural therapy, is explicitly designed to reduce experiential avoidance through acceptance, mindfulness, and cognitive defusion (or distancing) techniques, while encouraging clients to implement behavioural changes that are consistent with their personal values. Research suggests that acceptance and defusion interventions in ACT may reduce the aversiveness of exposure to difficult events (Gutiérrez, Luciano, Rodríguez, & Fink, 2004; Levitt, Brown, Orsillo, & Barlow, 2004). Since hoarding has proved difficult to treat with exposure and response prevention (Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002), acceptance-based treatments such as ACT may prove more effective, although this remains to be tested.

The purpose of this study was to further investigate the relationship between HD and experiential avoidance as well as difficulties in emotion regulation, controlling for the presence of OCD. To this end, we recruited samples of HD without comorbid OCD, HD with comorbid OCD, OCD without hoarding symptoms, and non-clinical controls. Based on the current cognitive-behavioural conceptualizations of HD (e.g., Frost & Hartl, 1996; Steketee & Frost, 2003), as well as the abovementioned literature (Wheaton et al., 2011; Williams, 2012), we hypothesized that hoarders (regardless of the presence of comorbid OCD) would report higher levels of experiential avoidance and difficulties in emotion regulation compared to the non-hoarding OCD group, and that both clinical groups would have higher difficulties than the healthy control group. Further, we predicted that experiential avoidance and emotional regulation difficulties would be positively correlated to the severity of hoarding symptoms.

## 2. Materials and methods

### 2.1. Participants

We recruited 80 participants belonging to the following four groups: hoarding disorder without comorbid OCD (HD;  $N=24$ ), hoarding disorder with comorbid OCD (HD+OCD;  $N=19$ ), OCD without hoarding symptoms (OCD;  $N=17$ ), and non-clinical controls (Control;  $N=20$ ). The 3 clinical groups were recruited via advertisements in patient organization newsletters or websites, from hoarding support groups, and from a hoarding conference. Some of these participants took part in a previous study (Pertusa et al., 2008) but were completely reassessed for the current study to ensure they still had clinically significant symptoms. Non-clinical controls were recruited via a circular email to non-academic university staff at King's College London.

All participants were interviewed either face-to-face or over the telephone, using validated structured interviews, in order to confirm diagnosis and suitability for the study. In cases of diagnostic uncertainty, the research team met to discuss the case and reach a consensus. Participants were excluded if they met DSM-IV criteria for dementia (or showed signs of cognitive impairment), psychosis, bipolar I disorder or substance abuse. Hoarding cases fulfilled the criteria proposed by Frost and Hartl (1996). Additionally, other general medical conditions and other mental disorders that could account for the hoarding behaviour were carefully excluded, as described elsewhere (e.g., Pertusa et al., 2008). Although the study was designed before the current DSM-5 diagnostic criteria for HD were published, our inclusion/exclusion criteria are a nearly perfect match to these criteria (Mataix-Cols et al., 2010, 2013). All individuals in the HD group had long-standing hoarding problems, with an average duration of clinically impairing discarding difficulties of 21.5 years ( $SD=10.2$ ), an average duration of clutter problems of 18.1 years ( $SD=8.6$ ), and an average duration of excessive acquisition problems of 23.4 years ( $SD=11.6$ ).

Individuals who fulfilled criteria for HD were then divided into two groups (HD or HD+OCD) based on the presence or absence of clinically significant prototypical OCD symptoms of sufficient intensity to meet DSM-IV diagnostic criteria for OCD (Pertusa et al., 2008). Individuals were assigned to the non-hoarding OCD group (OCD) if they met diagnostic criteria for OCD but did not meet criteria for HD. Individuals in the non-clinical control group did not meet current criteria for any mental disorder according to the structured psychopathological interview. Ten participants were excluded from the study after the screening interview because they were diagnosed with bipolar disorder ( $N=2$ ) or their symptoms were not severe enough to meet criteria for HD and/or OCD ( $N=8$ ).

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