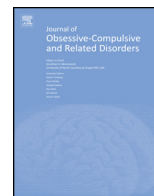




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Clinical report

The relationship between self-reported and objective neuropsychological impairments in patients with hoarding disorder

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ABSTRACT

Although hoarding disorder (HD) is characterized by self- and clinician-reported difficulties with cognitive functioning, studies of neuropsychological performance have yielded little evidence of consistent, clinical-level cognitive impairments. The aim of this study was to quantify this inconsistency and to examine whether this pattern is unique to HD. Fifty-three adults (20 with HD, 19 with obsessive compulsive disorder (OCD) and minimal hoarding symptoms, and 14 with OCD and a high degree of hoarding symptoms (OCD-H)) completed self-report and objective neuropsychological tests of inhibition, attention, and memory. The three groups differed significantly on self-reported attention and memory deficits, with the HD group reporting greater difficulties. However, the groups performed comparably on objective neuropsychological tests of inhibition, attention, immediate and delayed nonverbal memory, and immediate verbal memory. The OCD-H group demonstrated a greater rate of impairment on a test of delayed verbal memory. The HD group was characterized by lower concordance rates between self-report and objective memory impairment. The groups did not differ significantly in concordance rates for self-report and objective measures of attention and inhibition. Understanding the discrepancy between self-report and objective neuropsychological measures may help to better characterize the role of cognitive processes in HD.

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1. Introduction

Hoarding disorder (HD) is an obsessive-compulsive and related disorder characterized by significant difficulty discarding possessions which leads to sufficient clutter that precludes the functional use of living space (American Psychiatric Association, 2013). The cognitive behavioral model of HD has identified deficits in cognitive processing as a key feature in the development and maintenance of the disorder. Specifically, Frost and Hartl (1996) posited that HD results, at least in part, from problems with both memory and executive functioning (such as inattention, inhibition, and impaired planning abilities).

Consistent with this, patients with HD often self-report cognitive impairments that appear to contribute to the clinical features of hoarding. For example, poor memory confidence (Hartl et al.,

2004), high rates of cognitive failures (Grisham, Norberg, Williams, Certoma, & Kadib, 2010), inattention (Grisham et al., 2010) and indecisiveness (Frost, Tolin, Steketee, & Oh, 2011; Samuels et al., 2007) have characterized the self-reported phenomenology of HD patients. Additionally, experts in the field have observed impaired mental status, describing their hoarding clients as having poor insight, poor problem-solving skills, being easily distracted, and failing to answer questions appropriately (Tolin, Frost, & Steketee, 2012).

Although these findings suggest that HD patients would exhibit impairment on standardized neuropsychological tests of executive functioning and memory, there is a surprising lack of consistent evidence for impairments in these areas. In terms of executive functions such as attention and inhibition, patients with HD have performed worse than controls in some studies of sustained attention (Grisham, Brown, Savage, Steketee, & Barlow, 2007a; van der Werf-Elderling et al., 2011). Yet on tests of complex attention, working memory, and attention shifting, they perform as well or better than healthy control groups (Grisham et al., 2010; McMillan, Rees, & Pestell, 2013). HD patients perform similarly to psychiatric and non-psychiatric comparison groups on tests of response inhibition (Blom et al., 2011; Grisham et al., 2010; Tolin,

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Villavicencio, Umbach, & Kurtz, 2011). Importantly, even in studies in which HD patients show relative impairment in executive functions compared to other groups, few show true deficits (at least 1.5 standard deviations below published norms; Tolin et al., 2011).

There is also a lack of consistent evidence for an association between HD and memory impairment. Patients with HD perform comparably to comparison groups on tests of visual memory (Grisham, Brown, Savage, Steketee, & Barlow, 2007b; Mackin, Arian, Delucchi, & Mathews, 2011; Tolin et al., 2011). Although HD patients were found to have poorer delayed recall for visual information compared to controls in one study (Hartl et al., 2004), this finding has not been replicated (Tolin et al., 2011). Results of verbal memory tests have been mixed, with one study finding impaired recall for verbal information (Hartl et al., 2004), and another finding that HD patients performed comparably to OCD patients and healthy controls on the same test (Tolin et al., 2011).

So despite a general perception (shared by both the clients and the clinicians) that HD is characterized by cognitive impairments, individuals with HD do reasonably well on objective neuropsychological assessments. This research suggests that there is a low concordance (or agreement) between self-report and objective measures of cognitive performance; however, this observation has not yet been established empirically. The aim of the current study was to quantify this inconsistency and to determine empirically the extent to which self-reported impairments reflect objective impairments in individuals with HD. Further, we sought to determine the extent to which the predicted low concordance rate of self-reported and objective impairments is unique to patients with HD by comparing rates among patients with HD to those of patients with OCD and either minimal or a high degree of hoarding symptoms (OCD and OCD-H groups, respectively). It was predicted that the HD and OCD-H groups would have lower rates of concordance between self-reported and objective cognitive impairments than would those in the OCD group.

2. Method

2.1. Participants

Participants were 53 adults (20 diagnosed with HD, 19 with OCD with minimal hoarding symptoms, and 14 with OCD and a high degree of hoarding symptoms) over the age of 18 who were recruited from an outpatient treatment clinic or from one of three larger treatment studies for HD or OCD. In addition to having a diagnosis of HD, the hoarding group was required to score ≥ 41 on the Saving Inventory-Revised (SI-R; Frost, Steketee, & Grisham, 2004), which has previously been shown to indicate clinically significant symptoms of hoarding. In order to better understand the distinct processes associated with hoarding, patients with HD were excluded if they had comorbid OCD. A portion of the HD group ($n = 15$) was enrolled as part of a larger study that required as inclusion a score of ≥ 9 on the Inattention subscale of the Attention Deficit Hyperactivity Disorder Symptom Scale (ADHDSS; Barkley & Murphy, 1998).

The OCD group consisted of 19 individuals who met diagnostic criteria for OCD and reported symptoms of OCD of at least moderate severity (≥ 16) according to the Yale–Brown Obsessive–Compulsive Scale (YBOCS; Goodman et al., 1989). All individuals in the OCD group scored < 6 on the Hoarding subscale of the Obsessive Compulsive Inventory-Revised (OCI-R; Foa et al., 2002). The OCD-H group ($n = 14$) met criteria for OCD, scored at least 16 on the YBOCS, and scored ≥ 6 on the Hoarding subscale of the OCI-R (as recommended by Wootton et al. (2015)). Participants with psychotic or bipolar disorders were excluded, as were those with a

history of seizure disorder, other organic brain disorders, or traumatic brain injury.

2.2. Measures

2.2.1. Diagnostic measures

The majority of the HD group was assessed prior to the publication of DSM-5; therefore, interviewing tools for DSM-5 were unable to be used to assess hoarding symptoms. However, chart review was used to establish that the HD sample matched DSM-5 criteria for HD as closely as possible. The Hoarding Rating Scale – Interview (HRS-I; Tolin, Frost, & Steketee, 2010) was used (within the HD group only) as the primary tool for assessment of HD symptoms and diagnosis of HD. The HRS-I is a 5-item structured interview that assesses the presence and severity of hoarding symptoms, including the severity of clutter, difficulty discarding, acquiring, distress from symptoms, and impairment from symptoms. A diagnosis of HD was made if participants scored “moderate” or above on the three HRS-I items which assess difficulty discarding, clutter which compromises the use of living spaces, and distress or impairment related to difficulty discarding and/or clutter (matching closely with criterion A, C, and D in DSM-5). The MINI International Neuropsychiatric Interview (MINI; Sheehan et al. (1997)) was administered to all HD patients to rule out hoarding behavior better explained by symptoms of another mental disorder (criterion F in DSM-5). Participants were excluded on the basis of any significant medical and neurological conditions, making it very unlikely that their hoarding behaviors were due to another medical condition (criterion E in DSM-5). However, data were not available to confirm that participants met criterion B from DSM-5 (the difficulty with clutter is due to a perceived need to save the items and to distress associated with discarding them; American Psychiatric Association (2013)).

Diagnosis in the OCD and OCD-H groups was established using the MINI International Neuropsychiatric Interview (MINI; Sheehan et al. (1997)). The Adult ADHD Investigator Symptom Rating Scale (AISRS; Spencer & Adler, 2004), a clinician-rated checklist based on DSM-IV-TR criteria, was used to assess for ADHD in 15 of the participants with HD as part of a larger treatment study; all other participants received assessment for ADHD using the MINI.

2.2.2. Symptom severity measures

In the HD group only, HD symptom severity was assessed using the Saving Inventory-Revised (Frost et al., 2004), a 23-item questionnaire assessing 3 domains of hoarding (clutter, difficulty discarding, and excessive acquisition). The clinician-rated Yale Brown Obsessive Compulsive Scale (YBOCS; Goodman et al. (1989)) was used to assess OCD symptom severity in the OCD and OCD-H groups.

2.2.3. Self-report measures of cognitive performance

Self-reported symptoms of inattention and hyperactivity/impulsivity were assessed via self-report using the Attention Deficit Hyperactivity Disorder Symptom Scale (ADHDSS; Barkley & Murphy, 1998) a self-report measure which contains two subscales; inattention and hyperactivity/impulsivity. Higher scores on each subscale indicate greater impairment. Self-reported memory functioning was assessed using the memory subscale of the Cognitive Failures Questionnaire (CFQ; Broadbent, Cooper, FitzGerald, & Parkes, 1982). Higher scores on the CFQ indicate greater impairment.

2.2.4. Neuropsychological assessment

Neuropsychological assessment was completed using NeuroTrax (NeuroTrax “NeuroTrax,” Bellaire, TX), a computerized neuropsychological battery which has been found to be comparable to traditional paper and pencil tests for detecting cognitive deficits (e.g., Dwolatzky et al. (2003)). Participants completed the

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