

Five-year follow-up of people diagnosed with compulsive shopping disorder

Donald W. Black*, Martha Shaw, Jeff Allen

Department of Psychiatry, University of Iowa Roy J. and Lucille A. Carver College of Medicine, Iowa City, IA 52242

Abstract

Background: The authors assessed clinical symptoms and self-reported shopping and spending behavior in people diagnosed with compulsive shopping (CS) at a 5-year follow-up interview.

Methods: All met the criteria of McElroy et al. for lifetime CS and had the disorder for >1 year. Structured and semistructured instruments and self-report questionnaires were used to collect data.

Results: Of the original 26 subjects, 17 (65%) were interviewed and are the focus of this report. At follow-up, their ages ranged from 23 to 67 years (mean = 44 years). Lifetime psychiatric comorbidity was common, but few had current psychiatric disorders at follow-up. Interest in shopping and spending decreased for eight (47%), stayed the same for five (29%), and increased for four (24%) subjects. Eleven subjects (65%) reported having attempted to quit their CS and three (18%) reported successfully doing so. Triggers for returning to CS included feelings of pressure/excitement/tension to shop; boredom; negative feelings such as sadness, depression, frustration, or anger; and the desire for positive feelings like happiness, power, or elation. Mean scores on the Compulsive Buying Scale (CBS) and the shopping version of the Yale–Brown Obsessive–Compulsive Scale showed overall improvement in CS symptoms ($d = 1.16$ and $d = -1.19$, respectively); subjects were also less impulsive ($d = -0.48$). At baseline and follow-up, those with a lifetime mood disorder tended to have greater CS severity.

Conclusions: While the subjects showed overall improvement, most had ongoing symptoms of CS. The implications of the findings are discussed. © 2016 Elsevier Inc. All rights reserved.

Shopping is a major leisure activity that provides pleasure and relaxation for many yet, for some individuals, shopping is a costly and irresistible way of life [1–3]. Excessive shopping and spending have been recognized as a clinical condition since Kraepelin wrote of it in 1915 (“oniomania”) [4], work later cited by Bleuler [5]. People with this condition tend to organize their lives around a variety of shopping experiences with which they are preoccupied [2,3]. In this communication, we will refer to the condition as compulsive shopping (CS).

Despite this rich history, CS attracted little attention until interest was revived in the late 1980s and early 1990s by consumer behavior researchers [6,7] and clinicians interested

in compulsive behavior [8–10]. Each group of experts described a common yet persistent disorder that mainly affected women in early- to mid-adulthood, many of whom had substantial psychiatric comorbidity. CS is common and has a prevalence of nearly 6% in the adult population [11]. Experts have debated the appropriate classification of CS with some arguing that it is an impulse control disorder, others an obsessive–compulsive related disorder, a mood disorder variant, or an addiction [2]. CS is not included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* [12].

More recently, the concept of *behavioral addictions* has gained support to describe conditions in which poorly controlled and irresistible behaviors arise in the absence of alcohol or drugs, such as CS [13,14]. They can adversely affect interpersonal functioning, lead to marital and family problems, and contribute to adverse mental and physical health consequences [14]. While the cause of CS is unknown, genetic determinants may be relevant, and our group has shown a familial connection with pathological gambling [15,16]. Brand and coworkers [17] have recently

Funding: There was no external funding source.

Conflicts: Dr. Black receives royalties from American Psychiatric Publishing, Oxford University Press, and UpToDate. Ms. Shaw and Dr. Allen report no conflicts.

* Corresponding author at: 2-126B MEB/Psychiatry Research, University of Iowa Carver College of Medicine, Iowa City, IA 52242. Tel.: +1 319 353 4431; fax: +1 319 353 3003.

E-mail address: donald-black@uiowa.edu (D.W. Black).

described a model involving cue-reactivity and craving combined with reduced inhibitory control that may help explain the onset, maintenance, and subsidence of the disorder.

While research has led to having a better understanding of CS and more coherent clinical description, its natural history remains elusive [18,19]. Cross-sectional studies suggest that CS is chronic or recurrent, and the findings of three studies that address this issue are remarkably similar. McElroy et al. [9] found that 12 of 20 (60%) subjects had a chronic course with 40% reporting an episodic course. Schlosser et al. [8] reported that 27 of 46 (59%) subjects described their course as continuous; 41% reported an episodic course. Finally, Christenson et al. [10] found that 14 of 24 (58%) subjects reported that the disorder had been continuous since onset with 42% reporting an episodic course with periods of abstinence lasting 2 months to 2 years. In contrast, Aboujaoude et al. [20] reported that persons who responded to treatment with citalopram were likely to remain in remission during a 1-year follow-up. Similarly, Mueller et al. [21] reported that treatment with cognitive-behavior therapy led to improvement that was sustained over a 6-month follow up. These two studies suggest that treatment can alter the natural history of the disorder. We have interviewed subjects who reported that their CS behaviors had been continuous since onset, and for one individual this had lasted for over 70 years.

We recently had an opportunity to re-interview people with CS 5 years after participating in a neuropsychology study [22]. We re-contacted the subjects with the goal of determining the course and outcome of their CS. Based on our own observations and the literature, we expected subjects to report that their CS preoccupations and behaviors had been continuous or recurrent.

1. Subjects and methods

The original study was conducted between April and September 2010. We had recruited 26 subjects (23 women, 3 men) via newspaper advertisements and word-of-mouth. They were ≥ 18 years and met the CS criteria of McElroy et al. [9] for >1 year. Subjects were also required to score ≥ 2 standard deviations below the mean on the Compulsive Buying Scale (CBS) [6], shown to differentiate compulsive from non-compulsive buyers. The presence of CS was confirmed through administration of the Minnesota Impulsive Disorders Interview (MIDI) [10], which assesses the presence of impulse control disorders. Exclusions included having a current or past diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, or a primary neurological disorder (e.g., Parkinson's disease); major depression within the last 3 months; a substance use disorder in the past 3 months (except tobacco dependence); evidence of cognitive impairment (i.e., had a Mini Mental State Score <23) [23]; or a history of head injury with loss of consciousness

lasting >10 minutes. Subjects gave written, informed consent according to procedures approved by the University of Iowa Institutional Review Board and were compensated. For this follow-up study, subjects were re-contacted after receiving IRB permission to do so. The interviews took place from October 2014 to April 2015.

For those agreeing to be interviewed, in addition to the MIDI, we re-administered the Mini International Neuropsychiatric Interview-Plus (MINI) [24] to assess *DSM-IV* disorders, and both the CBS and Yale-Brown Obsessive-Compulsive Scale-Shopping Version (YBOCS-SV) [25] to assess CS severity. Self-report instruments included the Beck Depression Inventory (BDI) [26], the Barratt Impulsiveness Scale (BIS) [27]; the ADHD Rating Scale [28], and a version of the Temperament and Character Inventory (TCI) to assess novelty seeking, harm avoidance, and reward dependence [29]. All psychiatric diagnoses are based on *DSM-IV* [30].

We collected relevant sociodemographic data, and administered a follow-up questionnaire to assess changes in the person's interest in shopping and spending, their current problematic shopping behaviors, money spent on problematic shopping, time spent on problematic shopping; as well as attempts to quit, abstinence, and triggers of problematic shopping.

1.1. Statistical analysis

We first compared the 17 subjects who participated in the study to those who did not on demographic and clinical variables collected at baseline. Responses from the follow-up questionnaire, changes in CS severity (measured by the CBS and YBOCS-SV), and risk factors from baseline to follow-up are also described. Means and standard deviations are shown for baseline and follow-up, and an effect size (d) is calculated as the difference between the baseline and follow-up mean, divided by the pooled standard deviation. The Wilcoxon signed rank test was used to test for change from baseline to follow-up. Correlations of changes in the risk factors and changes in CS severity (measured by the CBS) were examined, as were correlations of changes in CS risk factors and self-reported changes in interest in shopping and spending, problematic shopping behaviors, money spent on problematic shopping, and time spent on CS. Because self-reported changes are reported on ordinal scales, the Spearman rank correlation was used to measure the associations between the two sets of measures. This analysis also examined correlations of the self-reported changes with changes in CS severity measured by the CBS and YBOCS-SV. SAS statistical software was used for all analyses, and results with P -values below 0.05 were interpreted as significant [31].

2. Results

Of the original sample of 26 individuals (3 men, 23 women), 17 (3 men, 14 women) consented to the follow-up

Download English Version:

<https://daneshyari.com/en/article/6789449>

Download Persian Version:

<https://daneshyari.com/article/6789449>

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