



Tolerance of negative emotion moderates the amplification of mental contamination following an evoking task: A randomized experimental study

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ABSTRACT

Background and objectives: Contamination is a near universal feeling, with mental contamination representing a contamination feeling in the absence of direct physical contact with a source. Extant research indicates that tolerance of negative emotion is important for understanding emotional reactions to images, thoughts, and memories, all of which are common sources of mental contamination. Extending research linking distress tolerance to mental contamination, this study examined if individual differences in the tolerance of negative emotion moderates the amplification of mental contamination following an evoking task.

Method: Unselected participants completed a self-report measure of tolerance of negative emotion during an online session. They later attended an in-person session and were randomized to an experimental scenario group: betrayal ($n = 49$) or control ($n = 49$). Participants imagined themselves in a scenario, with the betrayal scenario designed to evoke mental contamination. Mental contamination was assessed by self-report before and after the scenario.

Results: The betrayal, but not control, scenario caused an increase in mental contamination. Tolerance for negative emotion moderated the effect of group on mental contamination. Group differences in mental contamination evidenced at low, but not high, distress tolerance.

Limitations: A novel experimental manipulation and an unselected sample were used. Future research could assess tolerance of negative emotion using a behavioral task.

Conclusions: These results indicate that tolerance of negative emotion may be important for understanding when individuals experience mental contamination.

1. Introduction

Contamination is a near universal unpleasant feeling that signifies potential dirtiness, pollution, infection, or endangerment because of contact, either direct or indirect, with a stimulus (Rachman, 2004; Rachman, Coughtrey, Shafraan, & Radomsky, 2015). Contamination can be separated into at least two distinct, albeit related, dimensions (Coughtrey, Shafraan, Knibbs, & Rachman, 2012). One dimension, known as contact contamination, originates following physical contact with a source, whereas the other dimension, known as mental contamination, typically originates in the absence of direct physical contact with a source (Rachman, 2004; Rachman et al., 2015). A human, rather than an inanimate, source generally evokes mental contamination, with images, thoughts, and memories representing common sources of mental contamination (e.g., Elliott & Radomsky, 2009, 2012; Fairbrother, Newth, & Rachman, 2005; Herba & Rachman, 2007; Rachman, Radomsky, Elliott, & Zysk, 2012).

Mental contamination is putatively best conceptualized

dimensionally, ranging along a continuum of severity (Badour, Ojserkis, McKay, & Feldner, 2014), leading researchers to examine mental contamination using a full range of severity scores (e.g., Coughtrey, Shafraan, & Rachman, 2014; Elliott & Radomsky, 2009, 2012; Millar, Salkovskis, & Brown, 2016; Rachman et al., 2012; Radomsky & Elliott, 2009). The examination of mental contamination holds particular promise for extending our understanding of contamination-related obsessive-compulsive symptoms (Radomsky, Rachman, Shafraan, Coughtrey, & Barber, 2014). In addition, mental contamination appears relevant to posttraumatic stress symptoms following sexual trauma as well. For example, Fairbrother and Rachman (2004) found that nearly 60% of individuals who experienced sexual trauma reported aspects of mental contamination. Both obsessive-compulsive and posttraumatic stress symptoms are characterized by intrusion-related distress (Clark, 2004; Ehlers, 2010), with mental contamination being potentially important for understanding distress and reactions to images, thoughts, and memories. For example, the exacerbation of mental contamination following those cognitive events may lead to neutralization efforts that

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ultimately maintain mental contamination and distress surrounding the evoking source (Coughtrey et al., 2014). First-line psychological interventions for obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) involve exposure (Clark, 2004; McLean & Foa, 2011). Mental contamination typically does not abate following exposure (Coughtrey, Shafran, Lee, & Rachman, 2013) and, consequently, residual mental contamination may be present following exposure-based treatments for OCD and PTSD. Elucidating factors that contribute to the escalation of mental contamination thus holds promise for extending our understanding of multiple symptom presentations and intervention efforts.

Mental contamination relates to negative emotional states (e.g., Elliott & Radomsky, 2009, 2012; Fairbrother et al., 2005; Herba & Rachman, 2007; Rachman, 2010; Rachman et al., 2012). Relations between mental contamination and disgust are particularly robust; however, mental contamination relates to other negative emotions as well (e.g., anxiety, guilt, shame). An ex-consequencia reasoning bias may help explain those relations, as individuals may think they have done something wrong because of the presence of negative emotional states and, consequently, experience mental contamination (Coughtrey et al., 2013). Moreover, individuals may mislabel negative emotional states as feelings of dirtiness (Coughtrey et al., 2013). Both noted explanations raise the possibility that mental contamination could relate to adverse evaluations of negative emotional states. As described more fully below, such a possibility has led preliminary research to consider how individual differences in a variable known as *distress tolerance* relate to mental contamination. That line of research, coupled with observed relations between distress tolerance and intrusion-related distress, suggests that distress tolerance may be relevant for understanding when individuals experience mental contamination.

Simons and Gaher (2005) defined distress tolerance as evaluations and expectations of experiencing negative emotional states, including perceived tolerability, misappraisals, absorption, and regulation efforts when experiencing negative emotion. Whereas the definition of distress tolerance has since been expanded to include the perceived capacity to tolerate other aversive states (Leyro, Zvolensky, & Bernstein, 2010), the term *distress tolerance* will be used to refer to the tolerance of negative emotion following Simons and Gaher's definition in this study. The most commonly used index of distress tolerance has been Simons and Gaher's Distress Tolerance Scale (DTS). Higher DTS scores indicate a greater ability to tolerate negative emotional states. Existing research supports associations between distress tolerance, as assessed using the DTS, and indices of emotional distress. For example, the DTS negatively correlates with anxiety ($r_s = -0.44$ and -0.51), depressive ($r = -0.45$), obsessive-compulsive (r_s ranging from -0.17 to -0.44), and posttraumatic stress (r_s ranging from -0.29 to -0.46) symptoms (Cogle, Timpano, & Goetz, 2012; Vujanovic, Bonn-Miller, Potter, Marshall, & Zvolensky, 2011). Whereas the DTS negatively correlates with negative affect as well ($r = -0.45$), Vujanovic et al. (2011) found that the association between the DTS and posttraumatic stress symptoms was independent of shared variance with negative affect. This line of research suggests that the DTS consistently evidences correlations with indices of emotional distress; however, those correlations are not so strong as to suggest redundancy. Additionally, those correlations do not appear to be the byproduct of shared variance with the tendency to experience negative emotional states.

Extant findings indicate that distress tolerance is important for understanding intrusion-related distress. For example, Fetzner, Peluso, and Asmundson (2014) found a unique relation between distress tolerance, as assessed using the DTS, and the severity of intrusion symptoms of posttraumatic stress. Fetzner et al. noted that diminished distress tolerance could weaken the ability to cope with aversive cognitive events, leading to negative emotional reactions. Indeed, Cogle, Timpano, Fitch, and Hawkins (2011) found a unique relation between distress tolerance, as assessed using the DTS, and the severity of intrusive thoughts. Cogle et al. further found that distress tolerance

predicted residual changes in the one-month severity of intrusive thoughts. Cogle et al. noted that diminished distress tolerance may lead to prolonged intrusion-related distress, with the relevance of distress tolerance to intrusion-related distress being replicated in other studies as well (Cogle et al., 2012; Macatee, Capron, Schmidt, & Cogle, 2013).

As noted, images, thoughts, and memories are common sources of mental contamination. Given the observed relevance of distress tolerance to intrusion-related distress, distress tolerance could be relevant to mental contamination. Indeed, Fergus and Bardeen (2016) found that distress tolerance, as assessed using the DTS, shared a negative association with mental contamination ($r = -0.38$). These researchers further found that mental contamination only related to intrusion symptoms of posttraumatic stress when coupled with diminished distress tolerance. A limitation of the study was the use of a non-experimental study method; nevertheless, these study findings indicate that low tolerance of negative emotion may be a necessary condition by which mental contamination relates to intrusion-related distress.

Following from the reviewed lines of research, individuals with low distress tolerance may be more likely to experience mental contamination following an evoking source. This possibility would represent an extension of prior research that has focused on manipulating aspects of provoking sources (e.g., betrayal, immorality) and correlates of mental contamination following provocations (e.g., Elliott & Radomsky, 2009, 2012; Fairbrother et al., 2005; Herba & Rachman, 2007; Rachman, 2010; Rachman et al., 2012). Although informative, those findings do not directly address if the effects of an evoking source on mental contamination are impacted by a potentially modifiable individual difference variable, such as distress tolerance. If the moderating effect of distress tolerance is supported, future research may ultimately consider targeting distress tolerance in the service of reducing mental contamination.

In the present study, it was predicted that the causal effect of an evoking source on mental contamination would depend upon individual differences in distress tolerance, such that group differences in mental contamination would be seen at low, but not high, distress tolerance. To ensure the predicted results were not attributable to trait or state affect (e.g., Elliott & Radomsky, 2009; Radomsky & Elliott, 2009), main study analyses accounted for anxiety. More precisely, trait anxiety—a central feature of negative affect (Watson & Clark, 1984)—was included as a covariate to account for the propensity to experience general distress (e.g., Tellegen et al., 2006). A state index of anxiety was included to help ensure study predictions were not the result of general distress experienced by participants at the start of the study session.

2. Method

2.1. Participants

A total of 98 undergraduate students from a southern U.S. university who were enrolled in psychology courses participated in the study. The sample had a mean of 19.1 years ($SD = 0.98$), with the majority identifying as female (71.4%). Approximately 61.2% of the sample identified as White, 17.3% as Latino, 8.2% as African American, 8.2% as Asian, 4.1% as bi- or multi-racial, and 1.0% as “other” race/ethnicity. An equal number of participants were randomized to the two groups: betrayal ($n = 49$) and control ($n = 49$). There were no significant age ($t_{(96)} = 0.61, p = 0.541$), racial/ethnic ($\chi^2_{(5)} = 1.60, p = 0.902$), or gender ($\chi^2_{(1)} = 0.80, p = 0.371$) differences among the groups.

2.2. Measures

2.2.1. Distress Tolerance Scale (DTS)

The DTS (Simons & Gaher, 2005) is a 15-item measure that assesses

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