



Hoarding disorder and difficulties in emotion regulation

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ABSTRACT

The present study aimed to examine self-reported deficits in emotion regulation (ER) among individuals with hoarding disorder (HD). Seventy-seven adult outpatients with HD and 45 age- and gender-matched healthy control (HC) participants received a diagnostic assessment and completed self-report measures of hoarding severity, depression, and anxiety. In addition, participants completed the *Difficulties in Emotion Regulation Scale* (DERS), which measures lack of emotional clarity (*Clarity*), difficulty regulating behavior when distressed (*Impulse*), difficulty engaging in goal-directed cognition and behavior when distressed (*Goals*), unwillingness to accept emotional responses (*Accept*), and lack of access to strategies for feeling better when distressed (*Strategies*). The HD group scored higher on all DERS subscales than did the HC group; self-reported ER deficits remained evident when controlling for baseline depression, anxiety, and stress. The DERS correlated significantly with hoarding severity in the HD group: acquiring was significantly correlated with DERS *Impulse*, *Strategies*, and *Accept*; saving was significantly correlated with DERS *Accept*. Correlations remained significant when controlling for depression, anxiety, and stress. Results suggest that HD is characterized by self-reported deficits in ER, and that this relationship is not solely attributable to high levels of depression and anxiety.

1. Introduction

Hoarding disorder (HD) is characterized by a persistent difficulty discarding possessions, regardless of actual value (American Psychiatric Association, 2013). Most individuals with HD also engage in excessive acquiring of possessions (Frost, Tolin, Steketee, Fitch, & Selbo-Bruns, 2009). These behaviors result in the accumulation of significant clutter in the individual's home, compromising the ability to use the living spaces for their intended purpose (American Psychiatric Association, 2013). HD is common, with a reported prevalence of 2–5% (Cath, Nizar, Boomsma, & Mathews, 2017; Iervolino et al., 2009; Mueller, Mitchell, Crosby, Glaesmer, & de Zwaan, 2009; Nordsletten et al., 2013) and is associated with significant functional impairment (Ong, Pang, Sagayadevan, Chong, & Subramaniam, 2015) and public health cost (Tolin, Frost, Steketee, Gray, & Fitch, 2008).

The original cognitive-behavioral model of HD (Frost & Hartl, 1996) posits a critical role of emotional features such as fear and attachment. HD is strongly associated with the experience of negative emotions (Springer, Worden, & Tolin, in press). In addition to high baseline levels of anxiety and depression (Frost, Steketee, & Tolin, 2011; Wheaton, Timpano, Lasalle-Ricci, & Murphy, 2008), individuals with HD report strong feelings of anxiety and sadness elicited by the acts of sorting

personal possessions in the laboratory (Grisham, Norberg, Williams, Certoma, & Kadib, 2010) and making discarding decisions about possessions (Frost, Ong, Steketee, & Tolin, 2016; Tolin et al., 2012). Even a hoarding-unrelated negative mood induction elicits greater feelings of sadness among nonclinical volunteers with elevated HD symptoms vs. those without HD symptoms (Timpano, Shaw, Cogle, & Fitch, 2014), suggesting an underlying vulnerability to experience negative emotion.

The significant negative emotions associated with HD, as well as the behavioral sequelae of these emotions (difficulty discarding and acquiring), suggest a role for deficits in emotion regulation (ER). ER is broadly defined as the process of changing the experience or expression of emotion via a number of different strategies, including situation selection, situation modification, attentional deployment, cognitive change, and response modulation (Gross, 1998). Gratz and Roemer (2004) have suggested a model of ER deficits that, while distinct from the Gross (1998) model of ER, may have significant implications for clinical assessment and intervention. Using a self-report measure, the *Difficulties in Emotion Regulation Scale* (DERS), they found six components of self-reported ER difficulties: (1) lack of emotional awareness (*Awareness*), (2) lack of emotional clarity (*Clarity*), (3) difficulty regulating behavior when distressed (*Impulse*), (4) difficulty engaging in goal-directed cognition and behavior when distressed (*Goals*), (5)

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unwillingness to accept certain emotional responses (*Accept*), and (6) lack of access to strategies for feeling better when distressed (*Strategies*).

To date, one study has measured self-reported ER deficits using the DERS in HD patients. Fernandez de la Cruz et al. (2013) sampled 24 patients with HD, 19 with HD plus obsessive-compulsive disorder (OCD), 17 with OCD only, and 20 healthy control (HC) participants. Individuals with HD (with and without comorbid OCD) scored higher (more self-reported deficits) than did HC participants on the DERS subscales *Goals* and *Strategies* only. The DERS subscale scores did not correlate significantly with HD severity across the entire clinical sample (Fernandez de la Cruz et al., 2013). Several limitations of this study, however, complicate interpretation of the results. First, the study did not account for baseline negative emotion (e.g., depression and anxiety). This is important because HD is associated with high levels of negative emotion, as described above, and because DERS scores correlate strongly with measures of depression and anxiety (Bjureberg et al., 2016; Fowler et al., 2014). It is therefore not clear whether the obtained group differences reflect deficits in ER, or whether they are artifacts of negative emotions. Second, HD participants were significantly older than the HC participants (56 vs. 40 years; see Landau et al., 2011) and DERS scores tend to decrease (indicating less ER deficit) with age (Orgeta, 2009). It is therefore not clear whether stronger between-group differences would have been found with an age-matched control group. Finally, the study relied on the total score of a self-report measure of HD, the *Saving Inventory-Revised* (SI-R; Frost, Steketee, & Grisham, 2004), which combines reports of difficulty discarding, acquiring, and clutter. The inclusion of clutter, which is an environmental outcome of behavior rather than a behavior itself (such as saving or acquiring behaviors), may have obscured relationships between ER deficits and the core behavioral features of HD.

The aim of the present study was to address the limitations of previous studies in this field and examine self-reported deficits in ER in HD patients and age-matched HC participants. It was predicted that 1) HD patients would report greater global ER deficits than would HC participants; 2) DERS subscales would correlate significantly with HD-related behaviors; and 3) group comparisons and correlational analyses would remain significant even after controlling for baseline negative emotion.

2. Method

2.1. Participants

One hundred nineteen prospective HD patients were screened for inclusion criteria as part of a large clinical trial examining the neural mechanisms of CBT response in hoarding disorder. To be included in the study clinical participants were required to (1) have a primary diagnosis of HD of at least moderate severity according to DSM-5 (American Psychiatric Association, 2013) criteria; (2) be aged 18–65; (3) be unmedicated or on a stable dose of psychiatric medications for at least 8 weeks; (4) be willing and able to abstain from the use of stimulant or benzodiazepine medications on the day of testing; (5) be right-handed, and (6) be free of non-removable metal in the body, claustrophobia, or other factors that would preclude functional magnetic resonance imaging (fMRI). Of 119 prospective clinical participants, 32 were excluded due to failing to meet inclusion criteria; the most common reasons for exclusion were age and medication use. An additional 10 participants met inclusion criteria but discontinued prior to completing the study measures, leaving a final sample of 77 HD patients.

An additional 60 prospective healthy control (HC) participants were screened for eligibility. To be eligible for the study the HC participants were required to 1) have no current or past psychiatric diagnosis or treatment; (2) be aged 40–65 (for age matching to the HD sample); (3) be right-handed; and (4) be free of non-removable metal in the body, claustrophobia, or other factors that would preclude fMRI. Of the 60

prospective HC participants, 15 were excluded due to failing to meet inclusion criteria, leaving a final HC sample of 45 participants. The most common reason for exclusion in the HC sample was a history of psychiatric problems (current or past).

2.2. Measures

DSM-5 diagnoses were assessed using the *Diagnostic Interview for Anxiety, Mood, and Obsessive-Compulsive and Related Neuropsychiatric Disorders* (DIAMOND; Tolin et al., 2018), a semi-structured clinical interview. The DIAMOND HD diagnosis shows excellent inter-rater reliability ($\kappa = 0.86$), very good test-retest reliability ($\kappa = 0.64$), and strong convergence with the SI-R (Tolin et al., 2018).

Hoarding symptom severity was assessed with the *Saving Inventory-Revised* (SI-R; Frost et al., 2004), a 23-item self-report measure that yields a total score as well as three subscales: *Clutter* ($\alpha = .98$ in the present sample), *Saving* ($\alpha = .96$ in the present sample), and *Acquiring* ($\alpha = .94$ in the present sample). The SI-R readily discriminates HD from OCD patients and community controls, and correlates significantly with ratings of clutter and impairment (Frost et al., 2004). We also administered the *Hoarding Rating Scale-Interview* (HRS-I; Tolin, Frost, & Steketee, 2010), a 5-item clinician-rated interview of the severity of clutter, difficulty discarding, acquisition, distress, and impairment ($\alpha = .97$ in the present sample). The HRS has good convergent validity and reliably differentiates HD patients from those with OCD and HCs (Tolin et al., 2010; Tolin et al., in press).

Affective symptoms were measured using the *Depression Anxiety Stress Scales* (DASS; Lovibond & Lovibond, 1995), a 42-item self-report measure assessing three subscales of negative emotion: depression, anxiety, and stress/tension. Each item is rated on a 4 point scale assessing symptom frequency over the past week. Subscales of the DASS show high internal consistency ($\alpha = .89 - .96$) and good discriminant and divergent validity (Brown, Chorpita, Korotitsch, & Barlow, 1997). The depression (DASS-D, $\alpha = .95$), anxiety (DASS-A, $\alpha = .91$) and stress (DASS-S, $\alpha = .95$) subscales showed excellent internal consistency in the present sample.

Self-reported trait-level ER difficulties were assessed using the *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004). Higher DERS scores reflect greater subjective impairment or dysregulation. As described above, the DERS subscales reflect lack of emotional awareness (*Awareness*; e.g., “I am attentive to my feelings;” $\alpha = .88$ in the present sample); b) lack of emotional clarity (*Clarity*; e.g., “I have difficulty making sense out of my feelings;” $\alpha = .87$ in the present sample); difficulty regulating behavior when distressed (*Impulse*; e.g., “When I’m upset, I become out of control;” $\alpha = .88$ in the present sample); difficulty engaging in goal-directed cognition and behavior when distressed (*Goals*; e.g., “When I’m upset, I have difficulty getting work done;” $\alpha = .90$ in the present sample); unwillingness to accept certain emotional responses (*Accept*; e.g., “When I’m upset, I become angry at myself for feeling that way;” $\alpha = .70$ in the present sample); and lack of access to strategies for feeling better when distressed (*Strategies*; e.g., “When I’m upset, I believe there is nothing I can do to feel better;” $\alpha = .93$ in the present sample). Validation studies have confirmed that the DERS has generally strong psychometric properties in community (Ritschel, Tone, Schoemann, & Lim, 2015) and clinical samples (Osborne, Michonski, Sayrs, Welch, & Anderson, 2017). One exception is that the *Awareness* subscale, which psychometric studies have reliably identified as having inadequate incremental and construct validity, including the absence of expected factor loadings, poor convergence with the other DERS subscales, and weak or absent associations with theoretically relevant symptoms of psychopathology (Bardeen, Fergus, Hannan, & Orcutt, 2016; Hallion, Steinman, Tolin, & Diefenbach, under review; Osborne et al., 2017). Consequently, there is an emerging consensus that the *Awareness* subscale should be excluded in most cases, including the exclusion of *Awareness* items from the total score (e.g., Bardeen et al., 2016; Hallion et al., under review). For

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