

Distress Tolerance in the Context of Emotional Reactivity and Learned Helplessness: A Case Study of Self-Damaging Behaviour in UAE

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ABSTRACT

Limited attention has been given to the individual differences in distress tolerance in the existing literature. Past studies suggest that the emotional reactivity and learned helplessness individual factors are distress tolerance. Specifically, in the context of self-damaging behavior, further investigation is required to identify the impacts of emotional reactivity and learned helplessness. This study is based on a field survey and the data was collected from 108 respondents of the United Arab Emirates (UAE) that measures learned helplessness, emotional reactivity, distress tolerance, and self-damaging behavior. Following Khosravani et al. (2021) and Ghasemzadeh et al. (2021), the “Structural Equation Modeling (SEM)” was applied to achieve the results. Findings suggest that together emotional reactivity and learned helplessness can explain the perceived variance in distress tolerance. Further, distress tolerance has a significant impact on self-damaging behavior. Our findings are in line with Sommers (2017). Furthermore, the findings will have implications for researchers studying distress tolerance and self-damaging behaviors, clinicians treating clients with difficulty managing distress, or self-damaging behaviors. The research recommends that emotional reactivity could be a key target of clinical involvement and preemptive learning.

KEYWORDS

Learned Helplessness, Preemptive Learning, United Arab Emirates

1. INTRODUCTION

The “distress tolerance” (DT) is referred to as the observed ability of an individual to withstand negative emotional states (Shorey *et al.*, 2017; del Valle *et al.*, 2020). Further, it is the concept of having significance across multiple diagnostic categories (Kiselica *et al.*, 2014; Daros & Williams, 2019). More specifically, a lower DT has been related to behavior that most directly mitigates one’s distress that might harm physically or psychologically over the long run (McHugh *et al.*, 2014;

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Carpenter *et al.*, 2019). Low DT is associated with behaviors such as eating disorders, “non-suicidal” self-injury, and suicidality (Andover *et al.*, 2010; Gandhi *et al.*, 2018). All these signs are critical to research as they lead to physical harm to those engaged in them. The scope of the current study is limited to a sub-set of self-damaging behavior; however, individuals engaged in these self-damaging behaviors might be categorized in broader diagnostic groups. For example, the one who is engaged in restricting behavior can meet the criteria for “anorexia nervosa”. Interestingly, this prevalence rate is unknown for females, however, less prevalent in males (Andover, *et al.*, 2010; Iskric *et al.*, 2020). “Anorexia Nervosa” is characterized by a multitude of severe consequences such as “social complications”, “academic issues”, “career difficulties”, “health problems”, and “death”. Theoretically, distress tolerance could have two shapes i.e. either the perceived capacity or the behavioral act (see Leyro *et al.*, 2010).

It is apparent that self-damaging behavior shows a critical and exorbitant common health concern and similarly poses significant functional outcomes for an individual’s indulging behaviors. As these self-damaging behaviors are linked with DT, it is an important construct for research in the clinical context. DT is considered to be supple in reaction to clinical intervention (Marshall *et al.*, 2008; Veilleux, 2019). DT skill training is combined with a variety of “therapeutic approaches” such as “Cognitive Behavioural Therapy”, “Dialectical Behaviour Therapy”, “Acceptance and Commitment Therapy”, and “DT-specific approaches”. Unfortunately, elements contributing to individual differences in the level of DT remained mainly unexplored (Feldman *et al.*, 2014). Overall, this study follows the work of Sommers (2017) and tries to determine whether his findings, techniques, and approach exist true in the unique setting of the UAE. Individual difference attributes are important to understand and refer to how individuals are different from one another (Greenberg, 2011), these attributes included: “personality traits”, “self-concept”, “physiological responses”, “sociability”, “risk-taking”, “personal interests”, “values”, and “attitudes”, in the inexistence of knowledge of these would certainly lead to increasing DT (Marshall *et al.*, 2008; Veilleux, 2019).

1.1 Research Problem

It is evident that though low DT is linked with several self-damaging behaviors all over the world and the UAE is not an exception, however, very limited knowledge is available regarding factors related to individual differences in this regard. The inhabitants living in the UAE are facing these challenges and it requires a serious research inquiry to address these issues there. Literature in both theoretical and empirical context (for instance see Ellis *et al.*, 2010; Ellis *et al.*, 2013; Winward *et al.*, 2014; Carbia *et al.*, 2018) explain that the “emotional reactivity” might be the individuals’ difference factor for DT. From both theoretical and empirical perspectives, the relevant constructs (for instance, Slee *et al.*, 2008; Yamamoto *et al.*, 2010; Yoon *et al.*, 2020) propose that “learned helplessness” might also be an individual’s difference factor in DT. Particularly, those who are suffering from both a high “emotional reactivity” and high “learned helplessness” might be more prone to a lower DT. Moreover, further studies are required to be conducted to explore the impact of “emotional reactivity” and “learned helplessness” on DT provided the context of “self-damaging” behavior. The findings from current research will add to the existing body of knowledge, particularly in the context of DT and its relationship with self-damaging behaviors.

1.2 The Rationale of the Study

Exploring the determinants of DT will help in having more information and will improve the DT intervention effort that would in turn increase the life quality of a client. For example, the knowledge about the determinants of DT might assist in the surface of the dimensions which are accountable for the effectiveness of prevailing interventions that have been identified to enhance DT. Similarly, knowledge about these indicators might also convey the development of prevention programs intended at building distress tolerance before clinical symptoms grow. The prevention program that teaches distress tolerance skills might lessen the load of low DT for individuals. These programs

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