PTSD Symptom Severity and Emotion Regulation Strategy Use During Trauma Cue Exposure Among Patients With Substance Use Disorders: Associations With Negative Affect, Craving, and Cortisol Reactivity

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The co-occurrence of posttraumatic stress disorder (PTSD) pathology with a substance use disorder (SUD) is associated with emotion regulation deficits. However, studies in this area generally rely on trait-based emotion regulation measures, and there is limited information on the relation of PTSD pathology to the use of specific emotion regulation strategies in response to trauma-related distress among SUD patients or the consequences of these strategies for trauma cue reactivity. This study examined the relation of PTSD symptom severity to the use of specific emotion regulation strategies during trauma cue exposure among trauma-exposed SUD patients, as well as the indirect relations of PTSD symptom severity to changes in negative affect, cravings, and cortisol levels pre-to posttrauma cue exposure through different emotion regulation strategies. Participants were 133 trauma-exposed SUD patients. Participants listened to a personalized trauma script and reported on emotion regulation strategies used during the script. Data on negative affect, cravings, and cortisol were collected pre- and postscript. PTSD symptom severity related positively to the use of more adaptive (e.g., distraction) and maladaptive (e.g., suppression) regulation strategies. Moreover, evidence for the indirect effects of PTSD symptom severity on negative affect and cortisol reactivity through both adaptive and maladaptive emotion regulation strategies was found. Implications of findings are discussed.

Keywords: emotional avoidance; emotion dysregulation; experimental psychopathology; comorbidity; substance use disorder

POSTTRAUMATIC STRESS DISORDER (PTSD) is characterized by reexperiencing symptoms, negative alterations in cognition and mood, avoidance, and hyperarousal symptoms following exposure to a traumatic event (American Psychiatric Association [APA], 2013). The lifetime prevalence of PTSD in the
general population is approximately 7% (Kessler et al., 2005). However, individuals with a substance use disorder (SUD) have been found to be at high risk for traumatic exposure (up to 95% of SUD patients report a history of traumatic exposure; Brown, Stout, & Mueller, 1999) and thus exhibit elevated rates of this disorder (Brady, Back, & Coffey, 2004). Specifically, the lifetime prevalence of PTSD among SUD patients ranges from 36%–50%, with current prevalence rates ranging from 25%–42% (Brady et al., 2004). Moreover, the co-occurrence of PTSD pathology with a SUD is clinically relevant, with studies finding that SUD patients with PTSD pathology are at high risk for SUD treatment dropout (Tull, Gratz, Coffey, Weiss, & McDermott, 2013), quicker relapse to substance use following treatment (Brown, Gratz, Coffey, Weiss, & McDermott, 2013), and more severe substance use (Najavits et al., 1998; Ouimette, Finney, & Moos, 1999), additional psychiatric disorders (Mills, Teesson, Ross, & Peters, 2006; Najavits et al., 1998), suicidal and nonsuicidal self-injurious behaviors (Harned, Najavits, & Weiss, 2006; Mills et al., 2006), and risk-taking behavior (Weiss, Tull, Viana, Anestis, & Gratz, 2012). Further, there is evidence to suggest that these negative outcomes are not due to the presence of any co-occurring pathology but PTSD pathology in particular (see Ouimette, Brown, & Najavits, 1998). Notably, and of particular relevance to the present article, a growing body of literature also indicates that the presence of PTSD pathology among SUD patients is associated with broad deficits in emotion regulation.

Emotion regulation can be conceptualized as a multidimensional construct involving the awareness, understanding, and acceptance of emotions; ability to control impulsive behaviors and engage in goal-directed behaviors when experiencing negative emotions; flexible use of nonavoidant situationally appropriate strategies to modulate the intensity and duration of emotional responses in order to meet individual goals and situational demands; and willingness to experience negative emotions in pursuit of meaningful activities in life (Gratz & Roemer, 2004). This conceptualization of emotion regulation is grounded in the idea that emotions are functional; thus, adaptive emotion regulation strategies are those that facilitate either the use of emotions as information about the self, others, or the environment or progress toward a desired goal (Gratz, Dixon, Kiel, & Tull, in press; Tull & Aldao, 2015).

By its very nature, PTSD is associated with the experience of frequent, intense, and reactive negative emotional experiences. Such emotional experiences may be more difficult to regulate (e.g., Flett, Blankstein, & Obertynski, 1996) and result in an overreliance on emotion regulation strategies generally considered to be maladaptive (e.g., emotional avoidance; Lynch, Robins, Morse, & Krause, 2001). In support of this notion, outside of the context of an SUD, PTSD is associated with emotional avoidance (Roemer, Litz, Orsillo, & Wagner, 2001), low distress tolerance (Marshall-Berenz, Vujanovic, Bonn-Miller, Bernstein, & Zvolensky, 2010; Vujanovic, Bonn-Miller, Potter, Marshall, & Zvolensky, 2011), low emotional clarity, difficulties engaging in goal-directed behaviors when distressed, difficulties controlling impulsive behaviors when distressed, limited access to effective emotion regulation strategies, and emotional nonacceptance (Ehren & Quack, 2010; Tull, Barrett, McMillan, & Roemer, 2007). Further, despite findings of elevated difficulties in emotion regulation among individuals with an SUD in general (Fox, Axelrod, Palival, Sleeper, & Sinha, 2007; Fox, Hong, & Sinha, 2008), the presence of co-occurring PTSD pathology among those with an SUD appears to exacerbate these difficulties. Specifically, relative to SUD patients without PTSD, SUD patients with PTSD are more likely to engage in emotional avoidance (Bardeen, Tull, Stevens, & Gratz, 2015), as well as report lower emotional clarity, greater difficulties engaging in goal-directed behaviors and controlling impulsive behaviors when distressed, greater difficulties accessing effective emotion regulation strategies, and greater nonacceptance of emotions (McDermott, Tull, Gratz, Daughters, & Lejuez, 2009; Weiss, Tull, Anestis, & Gratz, 2013).

Further research on emotion regulation difficulties among SUD patients with co-occurring PTSD pathology may improve our understanding of the ways in which PTSD pathology contributes to negative outcomes among SUD patients. Specifically, consistent with the affective processing model of negative reinforcement (Baker, Piper, McCarthy, Majeskie, & Fiore, 2004), the inability to effectively modulate, tolerate, or accept emotional distress may increase motivation to engage in behaviors that provide a quick escape from emotional distress, such as substance use, nonsuicidal self-injury, or other impulsive behaviors (e.g., risky sexual behavior). Although these behaviors may alleviate distress in the short term, a reliance on these behaviors to regulate emotions may contribute to future negative consequences, including addiction, functional impairment, and further heightening of emotional distress (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Consistent with this theory, difficulties in the regulation of emotion have been linked to numerous negative outcomes among SUD patients with PTSD pathology, including treatment dropout, nonsuicidal self-injury, and risky behaviors in general (see Dixon-Gordon, Tull, & Gratz, 2014; Tull et al., 2013; Weiss et al., 2012). Likewise, difficulties

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