



# Emotion dysregulation facets as mediators of the relationship between PTSD and alcohol misuse



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## HIGHLIGHTS

- PTSD, emotion dysregulation, and alcohol misuse were correlated in an OEF/OIF/OND veteran sample
- Emotion dysregulation was not a mediator between PTSD and alcohol misuse for the full sample
- For men, Impulse Control Difficulties when Upset and Lack of Emotional Clarity were mediators

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## ABSTRACT

**Introduction:** Posttraumatic stress disorder (PTSD) and alcohol misuse, which frequently co-occur among combat veterans, have been linked to emotion dysregulation. Emotion dysregulation may explain the link between PTSD and alcohol misuse, and this investigation tested emotion dysregulation as a mediator of that relationship.

**Method:** Correlations between PTSD symptoms and cluster symptoms, emotion dysregulation full and subscales, and alcohol misuse were examined in a sample of 139 combat Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn veterans (45% African American; 89% men). Emotion dysregulation full scale and subscales were examined as mediators of the relationship between PTSD symptoms and alcohol misuse for the full sample and men only.

**Results:** PTSD symptoms and symptom clusters, emotion dysregulation, and alcohol misuse showed positive correlations for the full sample and men only. Neither the full scale of emotion dysregulation nor the facets of emotion dysregulation mediated the relationship between PTSD symptoms and alcohol misuse for the full sample; among men, the Impulse Control Difficulties when Upset and Lack of Emotional Clarity subscales were mediators of that relationship.

**Conclusions:** Impulse control difficulties and lack of emotional clarity may play an important role in the link between PTSD and alcohol misuse for male veterans and should be an important target in treatment for individuals with both disorders. Addressing impulse control difficulties and lack of emotional clarity in those with PTSD and alcohol misuse may improve outcomes by helping individuals identify and describe upsetting emotions and develop healthy coping alternatives to alcohol misuse.

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## 1. Introduction

Posttraumatic stress disorder (PTSD) and substance misuse are commonly co-occurring disorders, with epidemiological studies showing that about one-third to one-half of individuals with lifetime PTSD also have lifetime substance or alcohol dependence (AD; Blanco et al., 2013; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Rates of current co-occurring PTSD and alcohol use disorder among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans range from 15.9% (McDevitt-Murphy et al.,

2010) to 24.9% (National Center for PTSD (Producer), 2012). In comparison, the estimated 10-year incidence of PTSD and alcohol abuse or dependence in the United States general population is 15.8% (Breslau, Davis, & Schultz, 2003). It is important to note though, that this longitudinal study found that neither PTSD nor exposure to trauma in the absence of PTSD predicted subsequent onset of alcohol abuse or dependence. This differs from research done in combat personnel, which has found that combat deployments increase the risk of heavy drinking (Jacobson et al., 2008). Individuals with comorbid PTSD and AD endorse more severe PTSD and AD than those with PTSD or AD only, characterized by higher levels of PTSD symptoms, a higher likelihood of using substances to alleviate PTSD symptoms, a higher number of lifetime psychiatric co-morbidities, more AD symptoms, and higher disability (Blanco et al., 2013).

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It is possible that PTSD resulting from combat deployments leads to alcohol misuse. Jacobson et al. (2008) found that veterans with a diagnosis of combat-related PTSD were more likely than those without PTSD to engage in new onset post-deployment problematic alcohol use. This study also found that new rates of onset heavy weekly drinking, binge drinking, and other alcohol-related problems post-combat deployment were 8.8%, 25.6%, and 7.1% in Reserve or National Guard personnel and 6.0%, 26.6%, and 4.8% in active duty personnel, respectively. Further, Reserve and National Guard personnel were significantly more likely to experience new onset heavy drinking, binge drinking, and other alcohol-related problems compared to non-deployed personnel (Jacobson et al., 2008). In another study of active-duty personnel aged 18 to 64, 20% reported heavy drinking compared to only 14% of same-aged civilians (Bray et al., 2008). Various causal pathways have been suggested to explain the high rates of co-occurring PTSD and alcohol misuse, and “self-medication” is often noted as an important aspect of the relationship between PTSD and substance misuse (Leeies, Pagura, Sareen, & Bolton, 2010; Simpson, Stappenbeck, Varra, Moore, & Kaysen, 2012). Many studies suggest that alcohol use may function as a coping mechanism for individuals who have difficulty regulating negative emotional states that result from PTSD symptoms such as hypervigilance or numbing (Gil-Rivas, Prause, & Grella, 2009; Ouimette, Coolhart, Funderburk, Wade, & Brown, 2007; Waldrop, Back, Verduin, & Brady, 2007). This explanation does not address why some individuals with PTSD would adopt alcohol misuse as a form of coping while others do not. Recent research on the construct of emotion dysregulation might offer some insight.

Gratz and Roemer (2004) have identified several dimensions of emotion dysregulation: nonacceptance of emotions; difficulties engaging in goal-directed behavior; impulse control difficulties; lack of emotional awareness; limited access to emotion regulation strategies; and lack of emotional clarity. It is possible that high levels of emotion dysregulation dimensions in the presence of the considerable distress associated with PTSD lead to alcohol misuse.

Several studies have linked trauma, PTSD, and emotion dysregulation. In a study of community trauma survivors, posttraumatic stress symptom severity was correlated with each dimension of emotion dysregulation (Ehring & Quack, 2010). In a study of college students, posttraumatic stress symptom severity was associated with all dimensions of emotion dysregulation other than lack of emotional awareness. Individuals who scored above a cutoff suggestive of meeting PTSD criteria had significantly higher levels of emotion dysregulation than those below the cutoff (Tull, Barrett, McMillan, & Roemer, 2007). Another study of college students found that those with probable PTSD had higher levels of emotion dysregulation than those without a history of trauma and than those with a trauma history but no PTSD (Weiss et al., 2012). Furthermore, students with a history of trauma but no PTSD showed lower scores than students without a trauma history on the facets of difficulties with impulse control when distressed and limited access to emotion regulation strategies relative to individuals with probable PTSD. Emotion dysregulation has been linked to PTSD in a sample of veterans; Kashdan, Breen, and Julian (2010) examined how daily “strivings” (defined as “an objective you are typically trying to accomplish or attain”) that were related to emotion regulation strategies may have been related to PTSD and other negative outcomes. Veterans with PTSD endorsed more strivings related to emotion regulation, described as those “intended to eliminate, reduce, strategically maintain or increase the experience of any emotional experience” than those without PTSD (Kashdan et al., 2010).

Emotion dysregulation has also been linked to alcohol misuse. In a study comparing individuals who recently began substance use treatment to a group of social drinkers who were not in treatment, those with alcohol dependence had worse emotion regulation skills than the social drinkers. After treatment, improvements in awareness and clarity of emotional experience were made while impulse control difficulties persisted (Fox, Hong, & Sinha, 2008). Another study of

individuals seeking substance abuse treatment used a prospective design and found that lower baseline emotion regulation skills were associated with worse treatment response and that worse emotion regulation skills at the end of treatment predicted post-treatment alcohol use (Berking et al., 2011). A similar line of research found emotion dysregulation to be related to alcohol-related consequences such as fights and police contact (Magar, Phillips, & Hosie, 2008). Poorer emotion regulation skills may affect both the level of alcohol consumption and the manner in which individuals drink.

One prior study has examined PTSD, emotion regulation, and alcohol misuse in a sample of active-duty Iraq war soldiers with and without PTSD (Klemanski, Mennin, Borelli, Morrissey, & Aikins, 2012). This study found that emotion dysregulation significantly partially mediated the relationship between PTSD and outcomes such as depression but not alcohol misuse. It is important to note that this study used a full scale rather than dimensional measure of emotion dysregulation. Klemanski and colleagues also excluded any individuals with current substance abuse or dependence from their study, which may have led to null findings.

Given that PTSD and alcohol misuse commonly co-occur among combat veterans (Jacobson et al., 2008) and that both have been positively associated with emotion dysregulation, the present research examined whether emotion dysregulation mediated the relation between PTSD and alcohol misuse in a sample of combat veterans. We used a multidimensional measure of emotion regulation to investigate different facets of this construct, which is something that has not been done previously. We hypothesized that PTSD symptoms, emotion dysregulation, and alcohol misuse would be positively correlated, and PTSD would indirectly affect alcohol misuse through emotion dysregulation (and each of the six facets).

## 2. Method

### 2.1. Participants and procedure

Data were collected from 139 participants recruited from Veterans Affairs Medical Center (VAMC) sites. The sample was predominantly male ( $n = 124$ ; 89%) and ranged in age from 21 to 66 ( $M = 35.04$ ,  $SD = 9.96$ ). The sample was ethnically diverse, with 46% identifying as African American ( $n = 64$ ), 46% Caucasian ( $n = 64$ ), and the remainder identifying as multiethnic (4%,  $n = 6$ ), Asian (1%;  $n = 1$ ), Hispanic (1%;  $n = 1$ ), Native American (1%;  $n = 1$ ), and 2 (1%) individuals not specifying their ethnicity. The average length of deployment was 18.28 months ( $SD = 12.36$ ). Participants reported being home an average of 3.31 years ( $SD = 2.45$ ) since their last deployment. Participants were provided informed consent to complete the study and then completed a set of questionnaires. The Institutional Review Boards approved all procedures.

### 2.2. Measures

#### 2.2.1. Posttraumatic stress disorder symptoms

The PTSD Checklist–Military (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) was used to assess past month PTSD symptoms. The PCL-M is a brief 17-item measure that screens for PTSD using the DSM-IV criteria (APA, 2000) related to military experience. Items are rated on a scale of 1 to 5, with cumulative scores ranging from 17 to 85 and higher scores indicating more severe PTSD. The PCL has shown excellent internal consistency ( $\alpha = .94$ ) and high convergent validity ( $r = .93$ ) with the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995) in a sample of individuals who experienced a recent trauma (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). The PCL-M has been validated within different veteran populations (i.e. Vietnam, Gulf War) and showed high internal consistency ( $\alpha > .80$ ) and adequate test–retest reliability after 2 to 3 days ( $r > .70$ ). Internal consistency in the current sample was excellent ( $\alpha = .97$ ).

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