



Role of emotion dysregulation in the relationship between childhood abuse and probable PTSD in a sample of substance abusers

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ABSTRACT

This study examined associations among childhood abuse, emotion dysregulation, and probable posttraumatic stress disorder (PTSD) within a sample of 93 substance use disorder (SUD) patients in residential treatment. SUD patients with probable PTSD (vs. non-PTSD) reported (a) greater severity of childhood sexual, physical, and emotional abuse and (b) significantly higher levels of overall emotion dysregulation and the specific dimensions of difficulties engaging in goal-directed behavior when upset, difficulties controlling impulsive behaviors when distressed, limited access to effective emotion regulation strategies, and lack of emotional clarity. Additionally, significant positive associations were found between both childhood physical and emotional (but not sexual) abuse on the one hand and dimensions of emotion dysregulation on the other. Further analyses indicated that difficulties controlling impulsive behaviors when distressed accounted for the associations of both childhood physical and emotional abuse with probable PTSD status. Findings of the present study highlight a potential mechanism underlying the relationships between both childhood emotional and physical abuse and PTSD in SUD patients.

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Posttraumatic stress disorder (PTSD), an anxiety disorder characterized by the development and persistence of re-experiencing, avoidant, emotional numbing, and hyperarousal symptoms following direct or indirect exposure to a potentially traumatic event (American Psychiatric Association, 2000), is a serious clinical concern, associated with considerable functional impairment (Kessler & Frank, 1997) and heightened levels of numerous self-destructive and health-compromising behaviors, including substance abuse (Brady, Back, & Coffey, 2004). Although lifetime rates of PTSD within the general population range from 8 to 14% (e.g., Breslau et al., 1998; Kessler, Sonnega, Bromet, & Hughes, 1995), heightened rates of PTSD have been found in SUD patients with a history of childhood abuse (CA; e.g., 54–63%; Schiff, Levit, & Cohen-Moreno, 2010; Simpson & Miller, 2002). For example, a recent study of heroin dependent women found that 54% of those with a history of CA met criteria for PTSD (Schiff et al., 2010). Furthermore, Epstein, Saunders, Kilpatrick, and Resnick (1998) found that female drinkers with (vs. without) a history of CA reported twice as many lifetime PTSD symptoms, and that PTSD symptom severity mediated the relationship between CA and alcohol-related problems. Notably, SUD patients with (vs. without) a history of CA evidence worse clinical outcomes, including more

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complex treatment needs (Namyniuk, Brems, & Clarson, 1997), poorer treatment outcomes (Easton, Swan, & Sinha, 2000; Westermeyer, Wahmanholm, & Thuras, 2001), greater severity of substance use (Bensley, Spieker, Van Eenwyk, & Schoder, 1999; Dube, Anda, Felitti, Edwards, & Croft, 2002; Easton et al., 2000), and greater co-occurring psychopathology (Brems & Namyniuk, 2002; Brown, Henggeler, Brondino, & Pickrel, 1999; Bulik, Prescott, & Kendler, 2001; Ellason, Ross, Sainton, & Mayran, 1996; Medrano, Hatch, Zule, & Desmond, 2002). Despite the aforementioned findings, however, few studies have examined the factors that may underlie the association between CA and PTSD in SUD patients.

One factor that warrants consideration in this regard is emotion dysregulation, defined here as a multi-faceted construct involving: (a) a lack of awareness, understanding, and acceptance of emotions; (b) the inability to control behaviors when experiencing emotional distress; (c) a lack of access to adaptive strategies for modulating the duration and/or intensity of aversive emotional experiences; and (d) an unwillingness to experience emotional distress in the pursuit of meaningful goals/activities (Gratz & Roemer, 2004). Indeed, theoretical and empirical literature provide support for an association between CA and emotion dysregulation. For example, CA is posited to interfere with the development of adaptive emotion regulation skills (Cicchetti & Howes, 1991) and has been found to lead to difficulties in the recognition (Pollak & Sinha, 2002) and understanding (Shipman, Zeman, Penza, & Champion, 2000) of emotions. Furthermore, significant positive associations have been found between CA (sexual, physical, and emotional) and emotional non-acceptance (Gratz, Bornova, Delany-Brumsey, Nick, & Lejuez, 2007), and between childhood maltreatment (including childhood sexual, physical, and emotional abuse and emotional and physical neglect) and overall emotion dysregulation (Gratz, Tull, Baruch, Bornova, & Lejuez, 2008). Additionally, Soenke, Hahn, Tull, and Gratz (2010) found that childhood emotional abuse (but not childhood sexual or physical abuse) was significantly positively associated with all dimensions of emotion dysregulation, with the exception of lack of emotional awareness. Finally, adults with a history of CA have been found to exhibit more frequent use of emotional suppression and avoidance strategies (Batten, Follette, & Aban, 2001; Sigmon, Greene, Rohan, & Nichols, 1996).

Recent studies have also provided evidence for a relationship between emotion dysregulation and PTSD. Specifically, PTSD has been found to be positively associated with both overall emotion dysregulation and the specific dimensions of lack of emotional acceptance, difficulties engaging in goal-directed behaviors and controlling impulsive behaviors when upset, limited access to emotion regulation strategies, and lack of emotional clarity (Ehring & Quack, 2010; Tull, Barrett, McMillan, & Roemer, 2007; Weiss, Tull, Davis, et al., 2012). Furthermore, research provides evidence of heightened emotion dysregulation in individuals with (vs. without) PTSD, both in general and within SUD populations in particular (McDermott, Tull, Gratz, Daughters, & Lejuez, 2009; Weiss, Tull, Viana, Anestis, & Gratz, 2012; Weiss, Tull, Anestis, & Gratz, 2013).

The current study sought to extend extant literature by examining the role of emotion dysregulation in the relation between CA (sexual, physical, and emotional) and probable PTSD status within an ethnically-diverse mixed-gender sample of SUD patients. Although previous investigations have found emotion dysregulation to be associated with both CA (e.g., Gratz et al., 2007, 2008) and PTSD (e.g., Tull et al., 2007; Weiss, Tull, Viana, et al., 2012), relatively few studies have examined these relations within SUD patients. However, investigations of the role of emotion dysregulation in PTSD within SUD patients with a history of CA may have particular clinical relevance. Consistent with both self-medication (Brady et al., 2004; Khantzian, 1997) and negative reinforcement (Baker, Piper, McCarthy, Majeskie, & Fiore, 2004) models of substance use, substance use may function to escape or avoid uncomfortable internal experiences (e.g., PTSD symptoms, trauma-related distress) following exposure to a traumatic event (e.g., CA). Whereas the use of substances may reduce distress in the short-term, however, substance use is associated with paradoxical consequences in the long-term, increasing trauma-related distress and the maladaptive use of substances (and other emotional avoidance strategies). In fact, extant literature suggests that SUD patients exhibit heightened levels of both PTSD (see Brady et al., 2004) and emotion dysregulation (e.g., Fox, Axelrod, Paliwal, Sleeper, & Sinha, 2007; Fox, Hong, & Sinha, 2008). Thus, it is possible that co-occurring PTSD-SUD represents one negative long-term outcome associated with the maladaptive regulation of trauma-related distress following CA experiences.

Furthermore, despite evidence suggesting that childhood emotional abuse in particular is associated with PTSD in adulthood (Street & Arias, 2001; Sullivan, Fehon, Andres-Hyman, Lipschitz, & Grilo, 2006), investigations within SUD patient samples have predominantly focused on the associations between PTSD and both childhood sexual and physical abuse (Brady, Killeen, Saladin, & Dansky, 1994; Schiff et al., 2010). Lastly, given that the vast majority of investigations to date have examined these relationships within women, the inclusion of both male and female SUD patients will provide preliminary evidence for the robustness of these associations across gender.

Consistent with previous findings (Gratz et al., 2008; Tull et al., 2007), we hypothesized that participants with (vs. without) probable PTSD would report higher levels of emotion dysregulation and greater severity of childhood sexual, physical, and emotional abuse. Furthermore, given both (a) theoretical literature suggesting that CA interferes with the development of adequate emotion regulation skills (Cicchetti & Howes, 1991) and (b) empirical literature suggesting that emotion dysregulation underlies the relationships between CA and other forms of psychopathology (i.e., borderline personality disorder and generalized anxiety disorder; Gratz et al., 2008; Soenke et al., 2010), we hypothesized that emotion dysregulation would account for the relations between CA (sexual, physical, and emotional) and probable PTSD status. In addition to examining these relations within the overall sample, secondary analyses were conducted to investigate the nature of these relations within male SUD patients in particular.

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