

A multimodal assessment of the relationship between emotion dysregulation and borderline personality disorder among inner-city substance users in residential treatment

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Received 30 August 2006; received in revised form 29 June 2007

Abstract

The concept of emotion dysregulation has been integrated into theory and treatment for borderline personality disorder (BPD), despite limited empirical support. Expanding upon existing research on the relationship between emotion dysregulation and BPD, the present study utilized a multimodal approach to the assessment of emotion dysregulation (including two behavioral measures of the willingness to tolerate emotional distress, and a self-report measure of emotion dysregulation broadly defined) to examine the relationship between emotion dysregulation and BPD among inner-city substance users in residential treatment ($n = 76$, with 25 meeting criteria for BPD). Results provide laboratory-based evidence for heightened emotion dysregulation in BPD, extending extant research on BPD to underserved clinical populations. Specifically, the presence of a BPD diagnosis among a sample of inner-city inpatient substance users was associated with both higher scores on the self-report measure of emotion dysregulation and less willingness to tolerate emotional distress on the behavioral measures of emotion dysregulation. Moreover, both self-report and behavioral measures of emotion dysregulation accounted for unique variance in BPD status, suggesting the importance of utilizing comprehensive assessments of emotion dysregulation within studies of BPD. Findings suggest the need to further explore the role of emotion dysregulation in the development and maintenance of BPD among inner-city substance users in residential treatment.

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Keywords: Borderline personality disorder; Emotion dysregulation; Emotion regulation; Behavioral assessment; Substance users

1. Introduction

Borderline personality disorder (BPD) is a serious mental illness associated with severe emotional, behavioral, cognitive, and interpersonal dysfunction, extensive functional impairment, and heightened levels of self-destructive and health-compromising behaviors, including deliberate

self-harm and suicidal behaviors, drug and alcohol abuse, unsafe sexual behavior, bingeing and purging, and misuse of prescribed medications (American Psychiatric Association, 1994; Gunderson, 2001; Frankenburg and Zanarini, 2004; Links et al., 1995; Skodol et al., 2002, 2005; Trull et al., 2000; Zanarini et al., 1998). Although prominent theoretical accounts of BPD suggest the central role of emotion dysregulation in the pathogenesis of this disorder (Linehan, 1993; Livesley et al., 1998), the specific definition of emotion dysregulation differs across researchers (Putnam and Silk, 2005). Specifically, although some researchers equate emotion dysregulation with the temperamental

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characteristic of emotional intensity/reactivity (Livesley et al., 1998), others define emotion regulation as separate from the quality of the emotional response (Linehan, 1993; Thompson and Calkins, 1996). Consistent with the latter approach, more recent conceptualizations of emotion dysregulation in psychopathology have begun to distinguish emotion dysregulation from a temperamental emotional vulnerability (e.g., Mennin et al., 2005), placing greater emphasis on the ways in which individuals respond to their emotional experience, as opposed to the quality of the emotional experience itself.

The definition used here is consistent with these recent conceptualizations, viewing emotion dysregulation (broadly) as maladaptive ways of responding to emotional distress, including non-accepting responses, difficulties controlling behaviors in the face of emotional distress, and deficits in the functional use of emotions as information (Gratz and Roemer, 2004). Specifically, according to this definition, emotion dysregulation is a multidimensional construct involving: (a) a lack of awareness, understanding, and acceptance of emotions; (b) a lack of access to adaptive strategies for modulating the intensity and/or duration of emotional responses; (c) an unwillingness to experience emotional distress as part of pursuing desired goals; and (d) the inability to control behaviors when experiencing emotional distress (see Gratz and Roemer, 2004, for a review).

Despite the comprehensive and multifaceted nature of emotion dysregulation as defined here, the majority of studies of emotion dysregulation in BPD have examined only the first two aspects of emotion dysregulation, and have utilized only self-report measures (Bijttebier and Vertommen, 1999; Cheavens et al., 2005; Leible and Snell, 2004; Levine et al., 1997; Rosenthal et al., 2005; Yen et al., 2002). However, a recent experimental study of emotion dysregulation in BPD highlighted the particular relevance of one specific aspect of emotion dysregulation: an unwillingness to experience emotional distress (previously unexamined within this population). Specifically, this study provided evidence for less willingness to tolerate emotional distress among outpatients with BPD, compared to outpatients without a personality disorder (Gratz, Rosenthal, et al., 2006). The promising results of this study highlight the utility of incorporating behavioral measures of emotion dysregulation into studies examining the relationship between emotion dysregulation and BPD, and suggest the particular relevance of behavioral measures of the willingness to tolerate emotional distress.

Thus, the present study sought to examine the relationship between emotion dysregulation and BPD utilizing a multimodal approach to the assessment of emotion dysregulation, including the behavioral assessment of the willingness to tolerate emotional distress (as indexed by persistence on two laboratory tasks used in previous work as measures of distress tolerance; Brown et al., 2002; Daughters et al., 2005). A secondary goal of this study was to extend the existing research on emotion dysregula-

tion in BPD to a more diverse, underserved clinical sample; specifically, inner-city substance users in residential treatment. Inner-city substance users represent a population that may be especially vulnerable to the development of BPD (Romero-Daza et al., 2003), given their heightened risk for many of the hypothesized risk factors for BPD, including BPD-relevant personality traits (e.g., impulsivity; Casillas and Clark, 2002; Krueger et al., 2002; Moeller et al., 2002) and environmental adversity (e.g., abuse, neglect, disruptions in attachment, and exposure to violence; see Fleming et al., 1998; Jasinski et al., 2000; Schwartz et al., 2005). Moreover, preliminary findings of a relationship between emotion dysregulation (in the form of an unwillingness to experience emotional distress) and BPD symptom severity among female inner-city substance users in residential treatment (see Lejuez, Wu, et al., 2003) highlight the importance of continuing to examine the relationship between emotion dysregulation and BPD among this underserved clinical population. Therefore, the present study utilized a comprehensive assessment of emotion dysregulation (including two behavioral measures of the willingness to tolerate emotional distress and a self-report measure assessing all four theorized dimensions of emotion dysregulation) to examine the relationship between emotion dysregulation and BPD among inner-city inpatient substance users.

2. Materials and methods

2.1. Participants

Participants were inpatient residents in a drug and alcohol abuse treatment center in Northeast Washington, DC. Typical treatment in the center ranges from 30 to 180 days. The center requires complete abstinence from drugs and alcohol (including any form of pharmacological treatment, such as methadone), with the exception of caffeine and nicotine; regular drug testing is provided and any substance use is grounds for dismissal. When needed, detoxification from an outside source is required prior to entry into the center. Aside from scheduled activities (e.g., group retreats, physician visits), residents are not permitted to leave the center grounds during treatment.

To be included in the study, participants were required to: (1) be current inpatient residents in the aforementioned residential substance use treatment center; (2) have the mental competency and ability to give informed, voluntary, written consent to participate; and (3) have the mental competency and ability to complete the self-report questionnaires and clinical interviews and to participate in the behavioral emotion dysregulation tasks. To enhance generalizability, there were no other inclusion or exclusion criteria.

Based on these criteria, 76 participants were included in the study. Participants ranged in age from 18 to 62, with a mean age of 42.21 (SD = 8.16). Sixty-seven percent ($n = 51$) of the participants were male. Eighty percent of

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