



Metacognitive mastery moderates the relationship of alexithymia with cluster C personality disorder traits in adults with substance use disorders

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HIGHLIGHTS

- Cluster C personality disorder traits are common in substance use disorders.
- Alexithymia may result in the expression of cluster C traits.
- We tested if metacognition moderated the link of alexithymia with cluster C traits.
- These constructs were assessed in adults with substance abuse.
- More cluster C traits were found in persons with both alexithymia and poor mastery.

ARTICLE INFO

Keywords:

Substance abuse
Personality
Alexithymia
Metacognition
Cluster C personality traits

ABSTRACT

Cluster C personality disorder traits have been observed in substance use disorders and linked with poorer outcome. One potential factor which may cause these disturbances in personality function is alexithymia, or the inability to name and express emotion. There may be other proximate factors which moderate the impact of alexithymia on the expression of cluster C traits, such as metacognitive mastery, which is the ability to use knowledge about mental states of self and others to cope with distress and solve social problems. To examine the possibility that mastery mediated the effects of alexithymia on cluster C traits, we assessed each of these constructs using the Metacognitive Assessment Scale Abbreviated, Toronto Alexithymia Scale and SCID II among 58 adults in an early phase of recovery from substance misuse disorders in a residential setting. Results of a multiple regression revealed that, after controlling for symptom severity and severity of substance misuse history, metacognitive mastery moderated the effect of alexithymia on number of cluster C traits. A median split and subsequent ANCOVA revealed that participants with higher levels of alexithymia and poorer metacognitive mastery had more cluster C traits than the other groups. These findings may have clinical implications, suggesting that patients with substance use disorders may benefit from treatment which addresses metacognitive mastery.

Published by Elsevier Ltd.

1. Introduction

Cluster C personality disorder traits include dependent, avoidant and obsessive compulsive traits and represent anxious and fearful behaviors which include the seeking of excessive support, control, or avoidance (Cox, Clara, Worobec, & Grant, 2012). They have been noted to co-occur with a range of different mental health conditions (De Rick, Vanheule, & Verhaeghe, 2009; Langås, Malt, & Opjordsmoen,

2012; Taylor, Bagby, & Parker, 1997) and are of interest in the area of substance use disorders given their potential as a barrier to recovery.

In order to develop interventions to address cluster C traits, research has sought to understand the factors which promote and sustain these traits. One potential cause of cluster C traits is alexithymia, or difficulties focusing on, identifying and describing feelings (Taylor et al., 1997). Alexithymia has been linked to interpersonal difficulties which closely parallel those seen in cluster C traits (Bekker, Croon, van Balkom, & Verme, 2008; Joyce, Fujiwara, Cristall, Ruddy & Ogrodnick, in press; Taylor et al., 1997; Vanheule, Desmet, Rosseel, Verhaeghe, & Meganck, 2007), and tied to poorer outcomes in substance use disorder including factors which portend risk of relapse (Saladin et al., 2012;

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Thorberg, Young, Sullivan, & Lyvers, 2009; Thorberg et al., 2011; Verrocchio, Conti, & Fulcheri, 2010).

While evidence has provided a direct link between alexithymia and cluster C traits in general clinical and substance abuse samples (De-Rick & Vanheule, 2007; Honkalampi, Hintikka, Antikainen, Lehtonen, & Viinama^{ki}, 2001; Nicolò et al., 2011) contradictory findings have been reported. Alexithymia has not been linked, for instance, to outcomes in personality disorder (Joyce, Fujiwara, Cristall, Ruddy, & Ogrodniczuk, 2013) or alcohol use disorders (de Haan et al., 2012). Honkalampi et al. (2010) reported that alexithymia was not associated with depression, personality disorder traits, or alcohol use disorders.

One possible explanation for these contradictions is that the relationship between alexithymia and cluster C traits in substance use disorders occurs in only some conditions. In other words, the effects of alexithymia on cluster C personality traits may be mediated by other factors. One potential factor that might influence the relationship of alexithymia with cluster C traits is metacognitive dysfunctions. Metacognition refers to a spectrum of activities which involves thinking about thinking and stretches from consideration of discrete psychological phenomenon to the synthesis of discrete perception into an integrated representation of self and others. It has long been considered a problem underlying personality disorders (Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Dimaggio et al., 2007; Semerari, Carcione, Dimaggio, Nicolò, & Procacci, 2007; Semerari et al., 2003). Metacognition shares aspects in common with the construct of mentalization (Fonagy, Bateman, & Bateman, 2011) though the constructs diverge as mentalization is often considered in the context of attachment, while metacognition may be activated by any of a number of interpersonal motives and includes a specific focus on metacognitive mastery. Metacognitive mastery refers to the use of metacognitive knowledge to respond to psychological and social conflicts (Semerari et al., 2003, 2007). Deficits in metacognitive mastery have been observed in persons with cluster C traits (Carcione et al., 2011; Dimaggio, Procacci, et al., 2007) and linked to outcome in a range of mental disorders including psychosis (Lysaker, Glynn, Wilkness, & Silverstein, 2010; Lysaker et al., 2011) and depression (Ladegaard, Larsen, Videbech, & Lysaker, submitted for publication) as well as medical conditions such as HIV (Ringer et al., submitted for publication).

To explore these possibilities, this study assessed alexithymia, metacognitive mastery and cluster C traits among a group of adults with substance use disorders. We predicted that alexithymia would be related to severity of cluster C traits, defined by the number of cluster traits, but that this relationship would be moderated by metacognitive mastery. Specifically, we anticipated that higher levels of cluster C traits would be found with participants with higher levels of alexithymia and lower levels of metacognitive mastery. To rule out the possibility that these findings were the result of heightened levels of psychopathology or severity of lifetime substance abuse we included these as covariates.

2. Method

2.1. Participants

Fifty five men and three women with SCID confirmed DSM-IV diagnoses of a substance use disorder were recruited from a residential treatment center associated with VA Medical Center. Seventeen had a primary diagnosis of alcohol dependence, six of alcohol abuse, 31 of polysubstance dependence, two of opiate dependence and two of cocaine dependence. All participants were receiving ongoing treatment and in a post-acute or stable phase of their disorder, defined as no hospitalizations or changes in medication in the last month. All had been abstinent from alcohol and substances for a minimum of one month as confirmed with random drug screens and breathalyzers performed at the residential center. Participants with a SCID confirmed diagnosis of a schizophrenia spectrum disorder were excluded. Participants had a mean age of 43.75 (sd = 10.32), a mean educational level of

13.06 years (sd = 1.99) with a mean of 244 (sd = 130.14) months of lifetime drug or alcohol abuse. Forty three participants were Caucasian, 14 African American, and one Latino.

2.2. Instruments

2.2.1. Indiana Psychiatric Illness Interview

Indiana Psychiatric Illness Interview (IPII; Lysaker, Clements, Plascak-Hallberg, Knipscheer, & Wright, 2002) is a semi-structured interview typically lasting 30 to 60 min. Responses are audio taped and later transcribed. The interview asks participants to describe and discuss: i) the story of their life in general, ii) whether they think they have a mental illness or substance abuse condition and, if so, how that has affected and not affected their life, iii) how this condition controls and is controlled by them; iv) how it affects, and is affected by others and v) what they see in the future. The IPII differs from other psychiatric interviews in that minimal content is introduced and metacognitive capacities appear spontaneously.

2.2.2. Metacognition Assessment Scale Abbreviated

Metacognition Assessment Scale Abbreviated (MAS-A; Semerari et al., 2003) was originally designed to study metacognition within psychotherapy transcripts. It has been abbreviated and adapted for the study of IPII transcripts (Lysaker et al., 2005). For this study we employed the Mastery subscale. Lower Mastery scores reflect difficulties in plausibly describing psychological challenges. Intermediate range scores indicate plausible descriptions of psychological problems with a limited ability to respond to them. Higher scores reflect an ability to respond to psychological challenges effectively on the basis of psychological knowledge. Good interrater reliability was found in this study (intraclass correlation = 0.82). Evidence of the validity of this scale has been presented elsewhere (Lysaker et al., 2011).

2.2.3. The Symptom Checklist-90-R

The Symptom Checklist-90-R (SCL-90-R; Derogatis, 1977) is a 90 item self-report inventory designed to assess psychiatric symptom. In this study we used the general psychopathology called the Global Severity Index.

2.2.4. Toronto Alexithymia Scale

Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994) is a self-report instrument that assesses awareness of emotional states. For this study we utilized the total score which is a summary of the three subscales. This scale has been used successfully in previous studies of alexithymia (Nicolò et al., 2011).

2.3. Procedure

All procedures were approved by the appropriate research review committees. Following informed consent, diagnoses of substance abuse were determined using the Structured Clinical Interview for DSM-IV (SCID). Participants were then administered the SCID II, TAS, SCL-90 and IPII interview. Mastery was later rated on the basis of a transcription of the IPII using the MAS-A.

Table 1
Descriptive statistics of study variables ($n = 58$).

Measures	Mean	sd	Range
SCID II cluster C traits	4.70	3.40	0–14
Avoidant traits	1.48	1.80	0–7
Dependent traits	1.00	1.62	0–6
Obsessive compulsive traits	2.22	1.42	0–5
SCID II total traits	17.56	11.46	1–49
TAS total	51.42	13.81	23–81
MAS-A Mastery	3.97	1.35	2–7
SCL-90 GSI T score	46.43	10.04	30–69

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