



The conceptualization of emotion regulation difficulties, and its association with posttraumatic stress symptoms in traumatized refugees



Emma L. Doolan, Richard A. Bryant, Belinda J. Liddell, Angela Nickerson*

School of Psychology, UNSW, Sydney

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ABSTRACT

This study investigated the conceptualization of emotion regulation difficulties in a sample of refugees with varying levels of posttraumatic stress (PTS), and examined whether specific emotion regulation difficulties were associated with PTS severity. Refugees were administered an abbreviated version of the Difficulties in Emotion Regulation Scale, the PTSD Symptom Scale – Interview Version, and the Harvard Trauma Questionnaire. Confirmatory Factor Analysis was used to examine model fit for the 6-factor model originally proposed by the developers of the DERS and the more recently proposed 5-factor model that excludes the awareness subscale. Both models displayed adequate fit. After controlling for age, gender, time in Australia, and trauma exposure, the clarity and strategies subscales were significantly associated with PTS severity. The association between impaired emotional clarity and reduced agency related to accessing regulation strategies and PTS severity in this refugee sample highlights the need for further research to assess interventions that target these disruptions in refugees.

1. Introduction

At present, there are over 65 million refugees and forcibly displaced individuals internationally (UNHCR, 2015). Refugees evidence significantly elevated rates of posttraumatic stress disorder (PTSD) compared to population norms (Fazel, Wheeler, & Danesh, 2005; Lillie, Thambiran, & Laugharne, 2015; Steel et al., 2009). A meta-analysis of 20 studies reported refugees based in western countries were approximately ten times more likely to develop PTSD than an age-matched western population (Fazel et al., 2005). Existing literature highlights the strong association between posttraumatic stress (PTS) and difficulties in emotion regulation (Tull, Barrett, McMillan, & Roemer, 2007). Emotion regulation is the mechanism by which an individual monitors, evaluates, and modulates his/her behavior and/or emotional state in response to a given situation (Gratz & Roemer, 2004; Gross, 1998). Individuals with PTSD evidence an impaired ability to regulate their emotions compared to those without PTSD (Ehring & Quack, 2010; Tull et al., 2007; Weiss et al., 2012). Furthermore, the inability to regulate emotions appropriately in response to a traumatic or stressful life event has been implicated in the development and maintenance of prolonged psychological distress (Bardeen, Kumpula, & Orcutt, 2013). Despite the fact that refugees are typically exposed to multiple types of traumatic events and exhibit high levels of PTSD symptoms, little research has examined emotion regulation in refugee groups.

Refugees may be especially likely to manifest emotion regulation difficulties as research indicates that exposure to multiple traumatic events increases a person's vulnerability to emotion regulation difficulties (Ehring & Quack, 2010; Tull et al., 2007; Weiss et al., 2012). Further, prolonged, human-instigated trauma appears to have a particularly strong impact on emotion regulation difficulties. For example, Walsh, Dilillo, and Scalora (2011) found that victims of interpersonal and repeated traumas, such as childhood sexual abuse, evidenced poorer emotion regulation skills compared to single-trauma survivors. Another study found that emotion regulation difficulties mediated the relationship between childhood abuse experiences and PTS symptoms (Stevens et al., 2013). Accordingly, refugees may be particularly vulnerable to emotion regulation difficulties as they are highly likely to experience prolonged, repeated, and interpersonal trauma in the context of persecution (Silove, 1999). Furthermore, research suggests that PTSD symptoms are potentially exacerbated by stressful pre- and post-migration living difficulties, such as ongoing deprivation, discrimination, uncertain visa-status, distance from loved ones and unemployment, for refugees (Porter & Haslam, 2005; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). The only study examining emotion regulation difficulties in refugees to date found that trauma exposure was associated with emotion regulation difficulties in a community sample of resettled refugees (Nickerson et al., 2015). In particular, difficulties in emotion regulation significantly mediated the

* Corresponding author at: School of Psychology UNSW, Sydney NSW 2052, Australia.
E-mail address: a.nickerson@unsw.edu.au (A. Nickerson).

relationship between trauma exposure and PTSD symptoms (Nickerson et al., 2015). This research provides preliminary evidence that emotion regulation difficulties may be prominent in trauma-exposed refugees and underpin posttraumatic psychopathology, however there is a need for further research elucidating the specific dynamics of this association.

Despite the abovementioned research, the extent to which current conceptualizations of emotion regulation difficulties can be generalized to a refugee sample remains an important empirical question. According to Gratz and Roemer (2004), emotion regulation difficulties span across 6 factors comprising (a) non-acceptance of emotional responses; (b) difficulties engaging in goal directed behavior; (c) impulse control difficulties; (d) lack of emotional awareness; (e) limited access to emotion regulation strategies; and (f) lack of emotional clarity (Gratz & Roemer, 2004). This 6-factor structure of emotion regulation difficulties has shown consistency across various age (e.g., adolescents: Neumann, van Lier, Gratz, & Koot, 2010; Perez, Venta, Garnaat, & Sharp, 2012; Saritaş-Atalar, Gençöz, & Özen, 2015; young adults: Bardeen, Fergus, & Orcutt, 2012; Giromini, Velotti, De Campora, Bonalume, & Cesare Zavattini, 2012; Gratz & Roemer, 2004; Ruganci & Gençöz, 2010; and older adults: Fowler et al., 2014) and language groups (e.g., Italian: Giromini et al., 2012; Dutch: Neumann et al., 2010; and Turkish: Ruganci & Gençöz, 2010; Saritaş-Atalar et al., 2015). While most of this research has been conducted with healthy samples, a study with non-suicidal self-injury adolescent inpatients also supported the aforementioned 6-factor conceptualization of emotion regulation difficulties (Perez et al., 2012). Recently, however, a five-factor conceptualization has been proposed that excludes the lack of awareness factor. In a study conducted by Bardeen et al. (2012), the authors argued that the awareness factor made a significantly lower contribution to the emotion regulation construct compared to the other five factors (Bardeen et al., 2012). Only one study has directly compared the 5- and 6-factor conceptualizations of emotion regulation difficulties in a sample of adults with severe mental illness, including major depressive disorder, anxiety, and substance abuse. Results demonstrated equivalent model fit between the 6- and 5-factor models, leading the authors to conclude that more research is necessary before disregarding the lack of awareness factor (Fowler et al., 2014).

Considering the research conducted to date, there is a need to examine how emotion regulation is conceptualized in a refugee sample. Accordingly, the current study first aimed to examine the factor structure of emotion regulation difficulties in a sample of refugees with varying levels of PTSD. Based on the prior research reviewed above, we hypothesized our study would support a 6-factor structure. The second aim of this study was to examine which aspects of emotion regulation difficulties were associated with PTS symptoms in a refugee sample. Extant literature suggests that several of the DERS subscales in particular would be associated with PTS symptoms (Tull et al., 2007). For instance, alexithymia (i.e., difficulty identifying and labelling experienced emotions, Taylor, Bagby, & Parker, 1991), which is conceptually similar to the lack of emotional clarity DERS subscale, has been shown to be associated with PTS severity (Näätänen et al., 2002; Yehuda et al., 1997). Furthermore, research suggests that an inability to accept negative emotions is also related to PTS severity. In particular, there is evidence that PTS is related to an increased tendency to suppress emotions (Moore, Zoellner, & Mollenholt, 2008), and engage in experiential avoidance (i.e., unwillingness to experience negative emotions; Plumb, Orsillo, & Luterek, 2004). Thus, we expect that the current study will find a significant association between the two DERS subscales, non-acceptance of emotional responses and lack of emotional clarity, and PTS symptoms. As mentioned above, Nickerson et al. (2015) found that difficulties engaging in goal-directed behaviour and lack of emotional clarity to be significantly associated with PTSD symptoms in a refugee sample. Given the similarities between the current population and that of Nickerson et al. (2015), we also predicted that we would find an association between PTS symptoms

and difficulties engaging in goal directed behavior.

Current evidence suggests that those who have experienced a greater number of traumas (Mollica, McInnes, Poole, & Tor, 1998), and spent less amount of time in their resettlement environment are at greater risk of developing PTSD symptoms (Steel et al., 2006). Demographic factors such as older age and female gender have also been associated with increased PTSD symptoms in extant literature (Steel et al., 2006). Therefore, we controlled for participant age, gender, trauma exposure, and time in Australia in relevant analyses.

2. Method

2.1. Participants and procedure

Participants in this study were recruited via either referral from casework and specialist counselling services in Sydney, Australia, or community advertisements. Inclusion criteria for this study required that participants were (a) refugees or asylum-seekers, and (b) over 18 years of age. The final sample size was 147 participants. At the time of recruitment participants were either permanent residents ($n = 36$, 24.5%), Australia citizens ($n = 14$, 9.5%), on a bridging visa ($n = 80$, 54.4%), or another type of visa (including community detention or expired visa; $n = 17$, 11.6%). Participants were from a range of countries of origin including Iraq ($n = 19$, 12.9%), Iran ($n = 65$, 44.2%), Afghanistan ($n = 11$, 7.5%), Sri Lanka ($n = 16$, 10.9%), and other (including Bangladesh, Pakistan, Serbia, Myanmar, Kuwait, Bhutan, Nigeria, and China; $n = 36$, 24.5%).

The study interviews were conducted at an outpatient hospital setting or specialist counselling service in Sydney. Participants first provided informed consent in accordance with approval from the Human Research and Ethics Committees at Northern Sydney Local Health District and Western Sydney Local Health Districts. The measures were administered by a clinical psychologist with masters or doctoral-level qualifications. Where necessary, an accredited interpreter was used ($n = 109$). All interpreters were trained in, and therefore familiar with, working in a health-care setting. The psychologist directed all questions to the participant, regardless of whether an interpreter was present. Participants were reimbursed for costs associated with taking part in the research.

2.2. Measures

2.2.1. Difficulties in emotion regulation

The Difficulties in Emotion Regulation scale (DERS; Gratz & Roemer, 2004) was used to measure participants' difficulties in emotion regulation. The DERS is a 36-item self-report questionnaire that assesses emotion dysregulation across 6 domains: Goals (e.g., *When I'm upset, I have difficulty concentrating*); Non-acceptance (e.g., *When I'm upset, I become embarrassed for feeling that way*); Impulse (e.g., *When I'm upset, I become out of control*); Strategies (e.g., *When I'm upset, I believe that I will remain that way for a long time*); Clarity (e.g., *I have no idea how I am feeling*); and Awareness (e.g., *I pay attention to how I feel*). The DERS has demonstrated excellent internal consistency ($\alpha = 0.93$), adequate test-retest reliability, and construct and predicative validity (Gratz & Roemer, 2004).

The current study used an abbreviated version of the DERS, previously employed by Nickerson et al. (2015). This abbreviated version was implemented to reduce assessment burden on refugee participants, and included 18 of the original DERS items (3 from each subscale; see Table 1). The items chosen for each subscale loaded the highest on each of their respective primary factors as reported in Gratz and Roemer (2004), and demonstrated the largest difference between their primary factor loading and the average of the loadings on their non-primary factors. Response options ranged from 1 (*almost never*, 0–10%) to 5 (*almost always*, 91–100%). A higher score indicated greater emotion regulation difficulties, with the exception of three items within

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