



PTSD, emotion dysregulation, and dissociative symptoms in a highly traumatized sample



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ABSTRACT

Exposure to multiple traumas has been shown to result in many negative mental health outcomes, including posttraumatic stress disorder (PTSD). Dissociation, which involves disruptions in memory, identity, and perceptions, may be a component of PTSD, particularly among individuals who have experienced childhood trauma. Emotion regulation difficulties are also strongly associated with childhood trauma and emotion dysregulation may be a particularly important factor to consider in the development and maintenance of dissociative symptoms.

The goal of the present study was to determine whether emotion dysregulation mediated the relationship between PTSD symptoms and dissociation in a sample of 154 (80% female, 97% African-American) adults recruited from a public, urban hospital. PTSD was measured using the Clinician Administered PTSD Scale, emotion dysregulation was measured using the Difficulties in Emotion Regulation Scale, and dissociation was measured using the Multiscale Dissociation Inventory. A linear regression analysis showed that both PTSD and emotion dysregulation were statistically significant predictors of dissociation even after controlling for trauma exposure. Alexithymia and an inability to use emotion regulation strategies in particular were predictive of dissociation above and beyond other predictor variables. Using bootstrapping techniques, we found that overall emotion dysregulation partially mediated the effect of PTSD symptoms on dissociative symptoms. Our results suggest that emotion dysregulation may be important in understanding the relation between PTSD and dissociative symptoms. Treatment approaches may consider a focus on training in emotional understanding and the development of adaptive regulation strategies as a way to address dissociative symptoms in PTSD patients.

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1. Introduction

Dissociation, which involves disruptions in the usually integrated functions of memory, identity, and perception of self and environment, is thought to play an important role in posttraumatic stress disorder for many individuals (PTSD; Stovall-McClough and Cloitre, 2006; Briere et al., 2005; Van der Kolk et al., 1996). Dissociative symptoms that may co-occur with PTSD can interfere with emotional activation and may negatively impact trauma-focused treatment success (Cloitre et al., 2004; Price et al., 2014; Spitzer et al., 2007). Dissociative symptoms have also been shown to contribute to functional impairment in PTSD and may also be

associated with overall severity of PTSD symptoms (Branscomb, 1991; Cloitre et al., 2002; Norman et al., 2007).

The type of dissociation most often studied in relation to PTSD is peritraumatic dissociation, which is the tendency for one to dissociate during or soon after a traumatic event. Numerous studies have shown that peritraumatic dissociation is a significant risk factor for the development of PTSD (Bremner et al., 1992; Kumpula et al., 2011; Marmar et al., 1994; Shalev et al., 1996; Tichenor et al., 1996; Weiss et al., 1995). However, two recent studies (both described in Briere et al., 2005) in trauma-exposed and normative samples demonstrated that persistent dissociation in response to trauma cues was significantly associated with PTSD, and peritraumatic dissociation was no longer related to PTSD when persistent dissociation was included in analyses. Furthermore, the researchers found that generalized dissociation (i.e., dissociative symptoms related to a change in consciousness that is not

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necessarily tied to a trauma cue) remained associated with PTSD independent of peritraumatic or persistent trauma-related dissociation. This dissociative capacity may reflect an effort to tolerate strong and distressing emotional responses.

Emotion dysregulation, more generally, has previously been linked to increased vulnerability for the development and maintenance of PTSD and other trauma-related psychopathology (Bradley et al., 2011; Kring, 2008; McLaughlin et al., 2011). Research on children exposed to childhood maltreatment has shown that traumatized children are more likely to show emotion regulation difficulties, which can then lead to the trauma-related psychopathology (Burns et al., 2010; Herman, 1992; McLaughlin et al., 2011; Van der Kolk et al., 1991). Research also shows that poor emotion regulation is predictive of greater PTSD symptom severity (Tull et al., 2007) and predicts level of overall adaptive functioning in individuals with PTSD (Cloitre et al., 2005), suggesting that emotion dysregulation may be a mechanism that accentuates or perpetuates PTSD symptoms.

Growing evidence supports a dissociative subtype of PTSD (Lanius et al., 2010, 2012; Wolf et al., 2012) and this has been included in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders, (DSM-5; APA, 2013). In particular, symptoms of depersonalization and/or derealization in the context of PTSD symptoms constitute the dissociative subtype of PTSD. This subtype is supported by fMRI research by Lanius et al. (2010) showing separate neural manifestations of dissociative and hyperarousal subtypes of PTSD. The researchers found that dissociative PTSD patients appear to experience emotional under-engagement in response to traumatic memories evidenced by abnormally high activation in brain regions involved in emotion regulation and prefrontal inhibition of the limbic regions of the brain. Other fMRI research with PTSD participants supports this, showing that participants with dissociative PTSD demonstrated enhanced prefrontal activation during conscious fear processing tasks compared with non-dissociative PTSD patients (Felmingham et al., 2008). Other research on civilian participants with PTSD also found that individuals with high levels of dissociation showed significantly increased early cortical responses to emotional stimuli, suggesting that dissociative symptoms may be associated with greater automatic reactivity to threat stimuli (Klimova et al., 2013). These studies provide support for the idea that dissociation is a form of emotion regulation used to cope with high levels of arousal.

However, we still know little about the complex relationship between dissociative symptoms, PTSD, and overall emotion regulation tendencies. Furthermore, most research has focused on only trauma-related dissociation (i.e., dissociation in the presence of trauma cues or memories). Since it is clear that dissociation may occur more generally in day to day life (whether or not trauma cues are present), there is still a great deal to understand about what impacts general dissociative tendencies. The above evidence points to the possibility of emotion dysregulation mediating the association between PTSD symptoms and dissociative tendencies. The goal of this study was to examine the potential relationship among these variables in a highly-traumatized, economically disadvantaged population. Specifically, the current study explored how PTSD symptoms and emotion dysregulation are related to dissociative symptoms, focusing on the unique effects of PTSD symptoms and emotion dysregulation dimensions to better understand how dissociation may be addressed in a treatment context.

2. Method

2.1. Procedure

Participants were drawn from an NIMH-funded study of risk factors for the development of PTSD in a low socioeconomic,

primarily African American urban population. Participants were recruited from waiting rooms in the gynecology and primary care medical (non-psychiatric) clinics at Grady Memorial Hospital, a publicly funded hospital in Atlanta, Georgia. We did not narrow our recruitment to specific selection criteria, but approached any individual in the waiting room. During the recruitment phase of this study, approximately 58% of individuals that were approached agreed to participate. To be eligible for participation, subjects had to be at least 18 years old, not actively psychotic, and able to give informed consent. After signing the informed consent approved by the Emory Institutional Review Board, an initial interview was administered with questionnaires regarding trauma history, PTSD symptoms, and psychological variables. Trained research assistants administered this interview, which took 45–75 min to complete (duration largely dependent on participant's trauma history and symptoms). Study participants completing the initial interview were invited to participate in a secondary phase of the study in which additional detailed measures of trauma exposure were administered. During this phase of the study, subjects completed additional self-report measures and structured clinical interviews that were conducted by trained research staff. PTSD, emotion dysregulation, and dissociative symptoms were measured during this secondary phase.

2.2. Participants

The sample consisted of 154 individuals, with 80% females. The subjects were all adult (≥ 18 years; median age of 42) and primarily African American (96.8%). The remainder of the racial composition was as follows: White (1.9%), mixed/other (0.6%), and Hispanic or Latino (0.6%). The sample was predominately low income, with 71.9% of individuals unemployed and 77.0% coming from households with a monthly income of less than \$1000. The majority of participants were medical patients (>85%). Other participants were present in the waiting rooms for other reasons, such as waiting for a family member or friend that had an appointment. All participants in the study reported at least one criterion A traumatic event and 88% of participants reported experiencing at least two traumas in their lifetime. A subset of participants reported childhood abuse or neglect. Based on CTQ data, 45.0% reported moderate or severe childhood abuse (20.1% physical abuse, 34.2% sexual abuse, 20.1% emotional abuse, 16.1% emotional neglect and 12.8% physical neglect).

2.3. Measures

2.3.1. Childhood Trauma Questionnaire (CTQ)

The CTQ (Bernstein et al., 2003) is a 25-item, brief, reliable and valid self-report instrument assessing sexual, physical, emotional abuse, and neglect in childhood. Researchers created a continuous variable to account for reported rates of moderate-to-severe emotional, physical, and sexual abuse, as well as emotional and physical neglect. Higher scores on the measure indicated higher levels of reported abuse (mean = 41.88, SD = 17.20, range = 25–105).

2.3.2. Traumatic Events Inventory (TEI)

The TEI is a 14-item screening instrument for lifetime history of traumatic events. It was administered to detail frequency and type of trauma(s) experienced; consistent with prior research (Gillespie et al., 2009; Schwartz et al., 2005), total level of trauma exposure was measured by a sum score reflecting the total number of different types of trauma (e.g., car accident, sexual assault, and natural disaster) to which a participant had been exposed over the course of their life. For this study, the TEI was used to measure trauma exposure in adulthood alone (mean = 4.19, SD = 2.40, range = 1–11).

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