



Anxiety sensitivity and hazardous drinking among persons living with HIV/AIDS: An examination of the role of emotion dysregulation



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HIGHLIGHTS

- Anxiety sensitivity (AS) is associated with hazardous drinking in seronegatives.
- Little is known about anxiety sensitivity among persons living with HIV/AIDS.
- Emotion dysregulation may underlie anxiety sensitivity and hazardous drinking.
- AS was indirectly associated with outcomes via emotion dysregulation.

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ABSTRACT

Hazardous drinking is prevalent among persons living with HIV/AIDS (PLWHA). Anxiety sensitivity is a vulnerability factor that is highly associated with hazardous drinking among seronegatives, but has yet to be tested in PLWHA. Additionally, there is a need to examine potential mechanisms underlying associations of anxiety sensitivity and hazardous drinking. Emotion dysregulation is one potential construct that may explain the association between anxiety sensitivity and hazardous drinking. The current study examined emotion dysregulation as a potential explanatory variable between anxiety sensitivity and four, clinically significant alcohol-related outcomes among PLWHA: hazardous drinking, symptoms of alcohol dependence, number of days consuming alcohol within the past month, and degree of past heavy episodic drinking. The sample included 126 PLWHA ($M_{age} = 48.3$; $SD = 7.5$; 65.9% male). Results indicated significant indirect effects of anxiety sensitivity via emotion dysregulation in all models. Indirect effects (κ^2) were of medium effect size. Alternative models were run reversing the predictor with mediator and, separately, reversing the mediator with the proposed outcome(s); alternative models yielded non-significant indirect effects in all but one case. Together, the current results indicate that anxiety sensitivity is associated emotion dysregulation, which, in turn, is associated with hazardous drinking outcomes. Overall, these findings may provide initial empirical evidence that emotion dysregulation may be a clinical intervention target for hazardous drinking.

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1. Introduction

Hazardous drinking, defined as a pattern of substance use that increases the risk of harmful consequences (World Health Organization [WHO], 2015), is highly common among persons living with HIV/AIDS

(PLWHA; Conigliaro et al., 2006; Schneider, Chersich, Neuman, & Parry, 2012). Hazardous drinkers do not necessarily meet full diagnostic criteria for an alcohol use disorder (AUD), but their drinking volume and patterns increase their risk of health and social problems. Even using conservative standard definitions, hazardous drinking is common among PLWHA (from 37 to 68%; Conigliaro et al., 2006), which is nearly double the rate found in the general population (Dew, Elifson, & Sterk, 2007; Galvan et al., 2002). For example, hazardous drinking has been associated with severe problems, such as HIV medication non-adherence (Kleeberger et al., 2001; Samet, Horton, Traphagen, Lyon, & Freedberg, 2003), risky sexual behavior (Ehrenschein, Horton, & Samet, 2004; Stein et al., 2005), other types of substance use, (Gonzalez, Barinas, &

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O'Leirigh, 2011), smoking (Vidrine, Marks, Arduino, & Gritz, 2012), global psychological and physical health complications (Dew et al., 1997), rapid disease progression (Conigliaro, Gordon, McGinnis, Rabeneck, & Justice, 2003), medication toxicities (Fein, Fletcher, & Di Sclafani, 1998), peripheral neuropathy (Ferrari & Levine, 2010), organ failure, and poor virologic control (Arnsten et al., 2001), and may lead to increased risk of transmission and premature death (Galvan et al., 2002).

Individual differences in psychological factors are an important consideration for better understanding hazardous drinking among PLWHA (for review, see Shuper et al., 2010). Anxiety sensitivity is one individual difference construct that may be particularly relevant to hazardous drinking among PLWHA. Anxiety sensitivity is a cognitive factor that reflects the extent to which an individual experiences physiological arousal as potentially harmful or dangerous (Kushner, Thuras, Abrams, Brekke, & Stritar, 2001; Reiss & McNally, 1985). Anxiety sensitivity is a risk factor for anxiety and depression (Naragon-Gainey, 2010) and it has consistently been related to hazardous drinking among those without HIV (seronegatives; Schmidt, Buckner, & Keough, 2007; Stewart, Peterson, & Pihl, 1995; Stewart, Samoluk, & MacDonald, 1999). Research suggests greater arousal-dampening effects of alcohol for individuals with higher anxiety sensitivity when compared with lower anxiety sensitivity (e.g., Stewart, Zvolensky, & Eifert, 2001; Zack, Poulos, Aramakis, Khamba, & MacLeod, 2007). Individuals with higher anxiety sensitivity also report greater alcohol-related problems, including increased rates of excessive alcohol consumption (Conrod, Stewart, & Pihl, 1997; Stewart et al., 1999), drinking to legal intoxication more frequently (Stewart et al., 1995, 2001), and higher rates of alcohol dependence (Lewis & Vogeltanz-Holm, 2002). Further, longitudinal studies have implicated anxiety sensitivity in the development of alcohol problems. For example, Schmidt et al. (2007) reported that individuals with high anxiety sensitivity were more likely to have developed an alcohol use disorder after 24 months than were individuals with low anxiety sensitivity. However, little is known about relationship between anxiety sensitivity and hazardous drinking among PLWHA. Anxiety sensitivity may be particularly important in PLWHA due to the common physiological arousal/distress associated with symptoms of disease progression and medication side effects (Ammassari et al., 2001).

In addition to examining the direct association of anxiety sensitivity and hazardous alcohol use among PLWHA, there is a need to explicate the processes governing such associations. Indeed, examining underlying factors may help to explicate explanatory mechanisms by which anxiety sensitivity may impact alcohol use in this population. One construct that may provide explanatory value among associations of anxiety sensitivity and hazardous drinking is emotion dysregulation (Chandley, Luebbe, Messman-Moore, & Ward, 2014). Emotion dysregulation has been defined as difficulties engaging a set of abilities wherein one can observe, understand, evaluate, and differentiate one's emotions and subsequently access strategies to regulate emotions and control behavioral responses (Gratz & Roemer, 2004; Tull & Aldao, 2015). Generally, emotion dysregulation is associated with increased alcohol consumption and dependence (Berking et al., 2011), as well as increased alcohol-related problems (Dvorak et al., 2014). Among PLWHA, those meeting criteria for hazardous drinking have greater levels of emotion dysregulation, relative to those not meeting such criteria (Garey et al., 2015).

Theoretically, individuals with greater anxiety sensitivity may respond to physiological sensations (e.g., those associated with anxiety) with less acceptance (i.e., greater emotion dysregulation), resulting in greater subjective distress (Kashdan, Zvolensky, & McLeish, 2008). As a result of such emotion dysregulation, these individuals may use alcohol as a means of regulating negative emotions. Importantly, the theoretical framework derived from other areas of research in substance use (e.g., smoking; Johnson, Farris, Schmidt, & Zvolensky, 2012) indirectly support emotion dysregulation as a factor underlying anxiety sensitivity and hazardous drinking. For example, Johnson et al. (2012)

demonstrated evidence of an indirect effect from anxiety sensitivity to smoking-relevant outcomes via emotion dysregulation. Currently, no such model has been tested examining anxiety sensitivity, emotion dysregulation, and hazardous alcohol use in general or among PLWHA specifically.

Together, the current study tested the hypothesis that anxiety sensitivity would exert an indirect effect on alcohol-related criterion variables via emotion dysregulation (see Fig. 1). Specifically, anxiety sensitivity was expected to positively predict emotion dysregulation, which, in turn, would be associated with the alcohol dependent variables. In the current study, four clinically significant dependent variables identified in past work among PLWHA (e.g., Fiellin, McGinnis, Maisto, Justice, & Bryant, 2013; Surah et al., 2013) were evaluated: 1) hazardous drinking, 2) symptoms of alcohol dependence, 3) number of days consuming alcohol within the past month, and 4) past report of heavy episodic drinking. It was expected that such an effect of anxiety sensitivity via emotion dysregulation would be evident on all criterion measures over and above variance accounted for by the following covariates: gender, sexual orientation, time since HIV diagnosis, and presence of a substance use disorder. These covariates were selected as past work has shown significant associations of each with alcohol consumption (Conen et al., 2009; Marshal et al., 2008; Nolen-Hoeksema, 2004).

2. Method

2.1. Participants

Participants included 129 adults living with HIV/AIDS recruited from AIDS service organizations in Houston, Texas. Flyers were placed in local community health clinics, and doctors' offices as well as in newspaper/magazine advertisements and on webpage announcements (e.g., Craigslist.com). Further advertisement was conducted via public speaking engagements (e.g., Ryan White Foundation Houston, Houston AIDS Foundation) and word-of-mouth. Interested individuals contacted our clinic/research lab to schedule an appointment, completed confidentially (i.e., no identifying information on study materials). Participants were eligible for inclusion if they were at least 18 years old, were previously diagnosed with HIV/AIDS per self-report, and had the cognitive capacity to give written informed consent, as assessed by their ability to read the consent form and explain the study purpose to assessment personnel. Study measures were completed as part of a larger assessment battery. Participants were paid \$20 in gift cards for completing a two-hour baseline assessment consisting of diagnostic interview and questionnaires.

Three participants were missing data on one or more measures of interest and were excluded from analyses yielded 126 individuals for the current study. The majority of participants (65.9%) were male and the mean age was 48.3 years ($SD = 7.5$). In terms of ethnicity, 55.1% of the sample identified as Black, 28.6% as White/Caucasian, 13.4% as Hispanic, and 4.5% identified as "mixed/other" (e.g., Native American). Regarding sexual orientation, 45.2% identified as heterosexual, 38.1% homosexual, 14.3% bisexual, and 2.4% 'other'. Although 85.7% reported completion of high school or further education, 74.3% of participants reported current unemployment and 55.6% reported earning <\$10,000 annually. The average CD4 t-cell count within the sample was 567.3

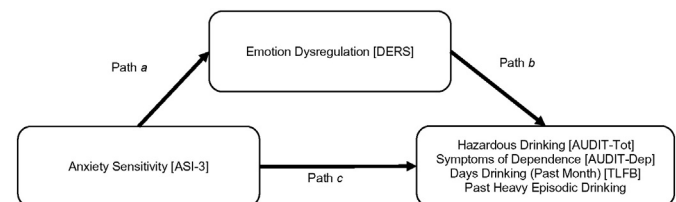


Fig. 1. Proposed model examining the indirect effect of Anxiety Sensitivity on Alcohol Use criterion variables (AUDIT-Tot, AUDIT-Dep, TLFB, and Past Heavy Episodic Drinking) via Difficulties with Emotion Regulation.

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