



Affective lability predicts decreased habituation in posttraumatic stress symptom responding during a single laboratory session of imaginal exposure[☆]



Courtney E. Dutton^a, Christal L. Badour^{b,*}, Alyssa C. Jones^b, Emily R. Mischel^a,
Matthew T. Feldner^{a,c}

^a Department of Psychological Science, University of Arkansas, Fayetteville, AR, United States

^b Department of Psychology, University of Kentucky, Lexington, KY, United States

^c Laureate Institute for Brain Research, Tulsa, OK, United States

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ABSTRACT

Affective lability, or the instability of emotional states, is associated with heightened levels of trauma-related emotional responding and posttraumatic stress disorder (PTSD) symptoms. However, the impact of affective lability, specifically on habituation to idiographic trauma cues, has yet to be examined among trauma-exposed individuals. The current study examined differential response trajectories to trauma-related imaginal exposure as a function of affective lability. Specifically, 72 women with a history of sexual victimization participated in a laboratory-based study involving a single session of repeated imaginal exposures to idiographic traumatic event cues. As hypothesized, participants higher in affective lability reported less reduction in trauma-cue elicited posttraumatic stress symptoms across exposure trials. Given these results, it will be important to continue to extend these laboratory findings to better understand how elevated affective lability is related to response to trauma-focused exposure therapy among individuals with PTSD or other trauma-related psychopathology (e.g., borderline personality disorder).

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1. Introduction

Exposure to a *Diagnostic and Statistical Manual – Fourth Edition* (DSM-IV)-defined traumatic event (American Psychological Association [APA], 1994) has been associated with an increase in emotional and physiological responding in the presence of trauma cues, even for those who do not meet full criteria for posttraumatic stress disorder (PTSD; Badour & Feldner, 2013; Badour et al., 2011; McDonagh-Coyle et al., 2001; Orr et al., 1998). Indeed, posttraumatic stress symptom (PTSS) level has been associated with emotion regulation difficulties in response to increased emotional or physiological responding (Badour & Feldner, 2013; Tull, Barrett, McMillan, & Roemer, 2007). PTSS severity has also been associated with affective lability among a sample of individuals with border-

line personality disorder who have experienced a traumatic event (Marshall-Berenz, Morrison, Schumacher, & Coffey, 2011). It is possible that these difficulties in emotion regulation and increased affective lability among individuals with PTSS may result in an interpretation of heightened emotional experiences as uncontrollable and unpredictable (Bouton, Mineka, & Barlow, 2001), and may lead to the avoidance of trauma cues that elicit emotional responding, thus maintaining PTSS (Foa & Kozak, 1986; Tull et al., 2007).

Emotion processing theory posits that fear networks are formed following exposure to a traumatic event. These networks are comprised of information about, behavioral responses to, and interpretations of the meaning of the feared stimulus (Foa & Kozak, 1986). Importantly, following a trauma, this fear structure contains information that implies both danger and a need to escape from or avoid danger, and it is resistant to modification (Foa & Kozak, 1986). Exposure to trauma cues in a safe and planned manner allows for new information to be introduced into the fear network (Foa, Hembree, & Rothbaum, 2007), allowing individuals to experience information that is inconsistent with the maladaptive information included in the trauma-related fear network. Over time, this newly incorporated information results in a change or a reduction of the emotional response to the feared

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* Corresponding author at: Department of Psychology, 106b Kastle Hall, University of Kentucky, Lexington, KY 40506-0044, United States.

E-mail address: Christal.badour@uky.edu (C.L. Badour).

stimulus (Rauch & Foa, 2006). As emotion processing theory highlights the need to both activate and modify the fear network, it is possible that instability in emotional states may impact the success of exposure therapy among those with trauma exposure, including those with PTSD, as the rapid fluctuation between emotional states may not allow for sufficient engagement of the fear network during exposure. Indeed, Rauch and Foa (2006) highlighted that both under-activation and over-activation of the fear structure can hinder the efficacy of exposure therapy for PTSD.

Ample research suggests that people experiencing elevated levels of PTSS evidence greater emotional reactivity in response to the presentation of a traumatic event cue (Badour et al., 2011; Lanius et al., 2003; Liberzon et al., 1999; Orr, Pitman, Lasko, & Herz, 1993; Orr & Roth, 2000; Pitman et al., 1990; Wolfe et al., 2000). Affect lability and emotion regulation are thought of as two separate processes within the emotion system, both of which are important as they have been linked with maladaptive outcomes, including internalizing symptoms (Kim-Spoon, Cicchetti, & Rogosch, 2013). Indeed, Kim-Spoon et al. (2013) found emotion regulation to be a mediator between emotion lability-negativity and internalizing symptomatology among children, with those higher in emotion lability evidencing a decrease in emotion regulation skills in the following year. The authors hypothesize that emotion lability-negativity may serve as a vulnerability factor that may negatively impact the development or use of emotion regulation strategies, and therefore lead to problematic symptomatology (Kim-Spoon et al., 2013). There remains a need to more clearly isolate the components of this emotion response and regulation system as it relates to the presentation of trauma cues.

Affective lability has been linked to a variety of forms of psychopathology, including PTSD and borderline personality disorder (BPD), where trauma exposure is common (Koenigsberg, 2010; Marshall-Berenz et al., 2011; Scheiderer, Wang, Tomko, Wood, & Trull, 2015). However, PTSD and BPD are highly comorbid disorders (Grant et al., 2008; Pagura et al., 2010), and recent research suggests that affective lability is also associated with heightened levels of PTSS (Carlson & Dalenberg, 2000). Indeed, among individuals with BPD who have experienced a traumatic event (meeting Criterion A for a traumatic event; American Psychiatric Association [APA], 1994), PTSS severity, but not BPD symptom severity, predicted affective lability (Marshall-Berenz et al., 2011). Similarly, Scheiderer et al. (2015) found that individuals diagnosed with both PTSD and BPD reported significantly greater negative affective instability (i.e., fear and sadness) than those diagnosed with only BPD, highlighting the potentially important impact of BPD and PTSD comorbidity on certain emotion regulation difficulties. Importantly, traumatic event exposure has been linked to emotion regulation difficulties even in the absence of PTSD or BPD (New et al., 2009). Indeed, Kashdan, Uswatte, Steger, and Julian (2006) found that Veterans with PTSD, compared to Veterans without a diagnosis of PTSD, reported greater fluctuations in affect, as well as self-esteem.

Research has only recently begun to explore the relation between affective lability and emotional reactivity to trauma-related cues, and no research has examined affective lability in the context of habituation to repeated presentations of idiographic trauma cues among individuals with trauma exposure. Accordingly, the current study provides an initial examination of how affective lability relates to affective responding in a laboratory model of trauma-focused imaginal exposure among sexually assaulted women. Specifically, it was hypothesized that greater affective lability would be associated with less PTSD symptom reduction across one session of repeated imaginal exposures.

2. Method

2.1. Participants

Participants for the present study were 72 community-recruited adult women ($M_{\text{age}} = 31.15, SD = 13.17$) who participated in a larger investigation examining specific emotional responses to sexual assault (Badour & Feldner, 2016). All participants endorsed an index trauma involving sexual victimization that satisfied the definition of a traumatic event as specified in Criterion A of the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision* (DSM-IV-TR; APA, 2000) definition of PTSD. Participants endorsed one or more of the following acts: exposing of sexual organs (22.2%), touching/fondling of sexual organs (50.0%), vaginal intercourse (36.1%), oral intercourse (19.5%), anal intercourse (4.2%), and other sexual acts (8.3%). Participants' relationship to the assailant included relative (38.9%), intimate partner/spouse (8.3%), date (6.9%), acquaintance (11.1%), friend (9.7%), stranger (12.5%), and other (12.5%). Sixty-one individuals (84.7%) reported a history of multiple sexual trauma experiences. The majority of participants (69.4%) reported that their index assault occurred prior to age 18 ($M_{\text{ageofassault}} = 14.00$ years, $SD = 9.20$).

2.2. Measures

2.2.1. Clinician-administered PTSD scale (CAPS; Blake et al., 1995)

The CAPS is a 30-item semi-structured interview designed to assess the frequency and severity of past-month posttraumatic stress symptoms, including 17 symptoms based on DSM-IV PTSD criteria (APA, 1994). The CAPS also allows for a determination of past-month PTSD diagnosis. Respondents rate the frequency and intensity of symptoms on separate 5-point scales. The CAPS has demonstrated excellent psychometric properties, with strong inter-rater reliability (Blake et al., 1990), test-retest reliability (Weathers, Blake, & Litz, 1991; Weathers et al., 1992), and convergent validity with other measures of PTSD (Keane, Caddell, & Taylor, 1988). As such, it is considered the gold standard in PTSD assessment (Weathers, Keane, & Davidson, 2001). The CAPS was used in the present study to record details about traumatic event exposure (e.g., most distressing event, time since exposure), severity of past-month posttraumatic stress symptoms, and past-month diagnosis of PTSD. The Frequency ≥ 1 /Intensity ≥ 2 scoring rule described by Blake et al. (1990) as well as Weathers, Ruscio, and Keane (1999) was used to calculate PTSD. Using this rule, each symptom is considered present when a score of at least 1 is given for frequency and at least 2 for intensity. Participants must meet this criterion for at least one re-experiencing, three avoidance-numbing, and two hyperarousal symptoms. Symptoms need to have persisted for at least one month, and participants must endorse at least moderate distress or interference associated with these symptoms to receive a PTSD diagnosis.

2.2.2. Responses to script-driven imagery scale (RSDI; Hopper, Frewen, Sack, Lanius, & Van der Kolk, 2007)

The RSDI measures symptomatic responses to a script-driven imagery procedure. This measure is comprised of 11 items (e.g., *Did you feel as though the event was reoccurring, like you were reliving it? Were you distressed? Did you avoid experiencing images, sounds, or smells connected to the event?*) and 3 subscales: Re-experiencing, Avoidance, and Dissociation. Respondents rate the degree to which they experienced each symptom on a 7-point scale from 0 (*Not at all*) to 6 (*A great deal*). The RSDI has good psychometric properties, with the subscales demonstrating strong internal consistencies ($\alpha = 0.76\text{--}0.91$) as well as strong convergent and discriminant validity, as compared to physiological and self-report measures of re-experiencing (e.g., CAPS Re-experiencing subscale),

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