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Anxiety Sensitivity, Distress Tolerance, and Discomfort Intolerance in Relation to Coping and Conformity Motives for Alcohol Use and Alcohol Use Problems among Young Adult Drinkers

Ashley N. Howell, B.S.,
University of Vermont

Teresa M. Leyro, B.A.,
University of Vermont

Julianna Hogan, M.Ed.,
University of Vermont

Julia D. Buckner, Ph.D., and
Louisiana State University

Michael J. Zvolensky, Ph.D.
University of Vermont

Abstract

Anxiety sensitivity, distress tolerance, and discomfort intolerance have been identified as important factors related to alcohol use motives and alcohol-related problems. Yet, these variables are highly correlated and little work has delineated whether these psychological vulnerability factors are differentially related to alcohol use motives and problems. To fill this gap in the existing literature, the present study evaluated whether anxiety sensitivity, distress tolerance, and discomfort intolerance were differentially related to high-risk alcohol use motives (i.e., coping and conformity motives) and alcohol use problems among 224 young adult, current drinkers (52.3% women; $M_{age} = 21.18$, $SD = 7.08$). Results indicated that distress tolerance, but not anxiety sensitivity or discomfort intolerance, was significantly related to coping motives for alcohol use. Additionally, anxiety sensitivity, but not distress tolerance or discomfort intolerance, was significantly related to conformity motives for drinking. For both sets of analyses, the observed significant effects were evident above and beyond the variance accounted for by alcohol consumption level, smoking rate, negative affectivity, and non-criterion alcohol use motives. Additionally, discomfort intolerance and anxiety sensitivity each predicted alcohol use problems; effects were not attributable to negative affectivity, cigarettes smoked per day, or shared variance with distress tolerance. Findings are discussed in relation to the role of emotional sensitivity and intolerance in terms of the motivational bases for alcohol use and alcohol use problems among young adult drinkers.

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Correspondence concerning this article should be addressed to Michael J. Zvolensky, Ph.D. Dr. Zvolensky can be contacted at The University of Vermont, Department of Psychology, 2 Colchester Avenue, John Dewey Hall, Burlington, VT 05405-0134, 802-656-8994 (phone), 802-656-8783 (facsimile). Electronic mail may be sent to Michael.Zvolensky@uvm.edu..

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Anxiety sensitivity is the fear of arousal-related sensations, arising from beliefs that the sensations have adverse consequences such as death, insanity, or social rejection (Reiss, Peterson, Gursky & McNally, 1986). Anxiety sensitivity may play a key role in certain aspects of alcohol use and alcohol use problems. Indeed, higher compared to lower anxiety sensitivity levels are related to weekly drinking rates and excessive drinking episodes, as well as alcohol use disorders (AUD; Schmidt, Buckner, & Keough, 2007; Stewart, Samoluk, & MacDonald, 1999). Extant data also suggest that this factor is a predictor of coping and conformity motives for alcohol use (Conrod, Pihl, & Vassileva, 1998; Stewart & Zeitlin, 1995; Stewart, Zvolensky, & Eifert, 2001). It is as yet unclear whether other emotional sensitivity or tolerance factors account for the association between anxiety sensitivity and alcohol use problems. Additionally, it remains unclear whether the previously documented linkages between anxiety sensitivity and alcohol use motives are accounted for by either (a) higher rates of alcohol use or (b) shared variance between the modeled alcohol use motives.

Together, the present investigation sought to address the role of anxiety sensitivity, in the context of distress tolerance and discomfort intolerance, in regard to alcohol use motives and alcohol use problems among a sample of current young adult drinkers. One prior study, examining the factor-structure of these three sensitivity and tolerance factors, found that anxiety sensitivity and distress tolerance were distinct lower-order factors of a higher-order emotional sensitivity and intolerance construct—relating to criterion variables such as negative mood. Yet, it is currently unclear whether anxiety sensitivity maintains a unique association with (a) alcohol use problems or (b) coping-oriented alcohol use when evaluated in the context of distress tolerance or vice versa (Bernstein, Zvolensky, Vujanovic, & Moos, 2009). It was hypothesized that anxiety sensitivity would be significantly related to coping and conformity-oriented alcohol use motives. It also was hypothesized that anxiety sensitivity would evidence a significant incremental relation to alcohol use problems, relative to distress tolerance and discomfort intolerance, and that this effect would be evident above and beyond daily smoking rate and negative affectivity.

Method

Participants

Participants were 224¹ young adults (52.3% women; $M_{\text{age}} = 21.18$, $SD = 7.08$) who, according to self-report, had consumed alcohol within the past 30 days. They were recruited from the greater Burlington, VT community via flyers and advertisements in local newspapers for a study of emotion. The racial distribution generally reflected that of the state of Vermont (Vermont Department of Health, 2008), with 91.1% of the total sample identifying as Caucasian, 1.9% as African American, 1.5% as Hispanic, 0.7% as Asian, and 4.8% as “other.” Approximately 42.6% of participants reported drinking alcohol at least 2–4 times per month as measured by the Alcohol Use Disorders Identification Test (AUDIT; Babor, de la Fuente, Saunders, & Grant, 1992). Additionally, participants scored a mean of 10.68 ($SD = 5.87$) on the AUDIT, with 63.1% of participants meeting criteria for current alcohol use problems (i.e., scoring 8 or greater on the AUDIT; Babor et al., 1992). With regard to cigarette smoking,

¹Analyses focused on the sensitivity and tolerance factors in regard to the alcohol use motives utilized data from 219, rather than 224, participants due to missing data for a small subset who did not complete some of the relevant measures.

49.6% of the sample were current daily smokers, smoking an average of 5.87 ($SD = 7.98$) cigarettes per day.

Exclusionary criteria for the current study included: (1) limited mental competency or the inability to provide informed, written consent; (2) current suicidal or homicidal ideation; (3) current or past history of psychosis; (4) current (past 6-months) Axis I psychopathology (except for substance abuse); (5) current major medical problems (e.g., heart disease, cancer); (6) current substance dependence (other than nicotine); and (7) self-reported pregnancy.

Measures

The Structured Clinical Interview-Non-Patient Version for DSM-IV (SCID-N/P; First, Spitzer, Gibbon, & Williams, 1995) screening questions were administered by a trained research assistant to rule out psychopathology.

The *Anxiety Sensitivity Index* (ASI; Reiss et al., 1986) is a 16-item measure in which respondents indicate, on a 5-point type scale (0 = “very little” to 4 = “very much”), the degree to which they are concerned about possible negative consequences of anxiety symptoms (e.g., “It scares me when I feel shaky”).

The *Distress Tolerance Scale* (DTS; Simons & Gaher, 2005) is a 14-item self-report measure, in which respondents indicate, on a 5-point Likert scale (1 = “strongly agree” to 5 = “strongly disagree”), the extent to which they can experience and withstand distressing psychological states (Simons & Gaher, 2005). The present study utilized the original 14-item scale; the final, published scale is identical to the one utilized except that it includes a 15th item (Simons & Gaher, 2005).

The *Discomfort Intolerance Scale* (DIS; Schmidt, Richey, & Fitzpatrick, 2006) is a 5-item measure on which participants indicate, on a 7-point Likert-type scale (0 = “not at all like me” to 6 = “extremely like me”), the degree of agreement toward statements that relate to their tolerance of discomfort.

The *Alcohol Use Disorders Identification Test* (AUDIT; Babor et al., 1992) is a 10-item self-report screening measure developed by the World Health Organization to identify individuals with alcohol problems (Babor et al., 1992). The current study utilized (1) the frequency and quantity items to index current alcohol consumption (an average frequency-by-quantity per occasion composite score; Stewart et al., 2001), and (2) the total score to measure alcohol use problems (Babor et al., 1992).

The *Drinking Motives Questionnaire – Revised* (DMQ-R) is a 20-item self-report measure that assesses frequency of drinking for social, enhancement, coping, and conformity motives (Cooper, 1994). Participants estimate relative frequency of drinking for each listed reason over the past 90 days on a six-point scale ranging from 1 (“never”) to 6 (“almost always”).

The *Smoking History Questionnaire* (SHQ; Brown, Lejuez, Kahler, & Strong, 2002) is a self-report measure used to assess smoking history and pattern. The SHQ was used in the current investigation to obtain daily smoking rate.

The *Positive Affect Negative Affect Scale* (PANAS; Watson, Clark, & Tellegen, 1988) is a 20-item measure in which respondents indicate, on a 5-point Likert scale (1 = “very slightly” or not at all to 5 = “extremely”), the extent to which they generally feel different feelings and emotions (e.g., “Hostile”).

Procedure

Interested persons responding to study advertisements were given a detailed description of the study over the phone. After providing verbal consent, the SCID-NP screener was administered by a trained research assistant via the telephone. Those potentially eligible for the study based on their responses were subsequently scheduled to attend a study session in the laboratory. Upon arrival to the study center, participants completed a written informed consent, as well as a battery of questionnaires. Participants were debriefed and compensated \$20.00.

Data Analytic Plan

To test whether anxiety sensitivity was uniquely and significantly related to coping and conformity motives, separate models were conducted for each dependent variable (coping and conformity alcohol use motives). For both models, Step 1 included negative affectivity (PANAS-NA), alcohol consumption, and daily smoking rate. At Step 2, the non-criterion DMQ-R subscales were entered simultaneously. At Step 3, anxiety sensitivity total (ASI), distress tolerance total (DTS), and discomfort intolerance total (DIS) were entered. To test whether anxiety sensitivity was uniquely and significantly related to drinking problems, PANAS-NA and daily cigarette smoking rate were entered into Step 1 of a third hierarchical regression model. At Step 2, ASI, DTS, and DIS were entered. The dependent variable was the continuous index of alcohol use problems (AUDIT total score).²

Results

The ASI and DTS total scores were significantly and negatively related to one another ($r = -.44, p < .001$, sharing 19% of variance; see Table 1). In other words, anxiety sensitivity was significantly, negatively related to distress tolerance. The ASI and DIS total scores were significantly, positively related ($r = .28, p < .001$, sharing 7% of variance). Additionally, the DTS and DIS total scores were significantly, negatively related ($r = -.25, p < .001$, sharing 6% of variance). The ASI total score was significantly and positively correlated with coping ($r = .30, p < .001$) and conformity motives ($r = .32, p < .001$), but no other motives. DTS total scores were similarly significantly, negatively correlated only with coping motives ($r = -.29, p < .001$) and conformity ($r = -.25, p < .001$) motives for alcohol use; no other significant associations were evident with other alcohol use motives. The DIS was significantly, negatively correlated with social ($r = -.26, p < .001$) and enhancement ($r = -.20, p < .001$), but not coping or conformity alcohol use motives. Finally, the DIS total score was significantly, negatively related to the AUDIT total score ($r = -.13, p < .05$), but did not indicate a significant correlation with total scores of the ASI or DTS; neither the ASI total score nor DTS was significantly related to the AUDIT total score (see Table 1).

See Table 2 for a summary of the regression results for alcohol use motives. The total model significantly predicted 37.2% of variance in coping motives ($p < .01$). Step 1 of the model significantly predicted 12.5% of variance in coping motives ($p < .001$), where PANAS-NA ($t = 3.45, \beta = .22, p = .001$) and alcohol consumption ($t = 4.57, \beta = .29, p < .001$) were the only unique, significant Step 1 predictor variables. Step 2 of the model significantly predicted an additional 20.4% of variance in coping motives ($p < .001$). Social ($t = 2.53, \beta = .22, p < .05$) and conformity ($t = 5.97, \beta = .05, p < .001$) motives, but not enhancement motives, were unique and significant Step 2 predictor variables. Finally, Step 3 accounted for an additional 4.3% of

²Neither age nor gender significantly correlated with ASI and DTS totals or DMQ-R coping or conformity motives for drinking. However, a positive and significant correlation did exist between participant age and discomfort intolerance ($r = .23, p < .001$). Age, as expected, but not gender, also negatively and significantly correlated with DMQ-R social ($r = -.24, p < .001$) and enhancement ($r = -.21, p < .05$) motives for drinking. When we added age and gender into Step 1 of the three regression analyses, no significant changes were discovered in the results, except that the DIS total no longer significantly predicted a decrease in alcohol use problems.

variance. Yet contrary to expectation, distress tolerance (not anxiety sensitivity) was the only significant Step 3 predictor.

For conformity motives, the regression model significantly predicted 30.4% of variance ($p < .001$). Step 1 of the model accounted for 7.9% of variance ($p < .001$), and again, PANAS-NA ($t = 2.72, \beta = .18, p < .01$) and alcohol consumption ($t = 3.37, \beta = .22, p < .01$), but not daily number of cigarettes consumed, were unique and significant Step 1 predictor variables. Step 2 of the model accounted for an additional 18.3% of variance, and social and coping motives, but not enhancement motives, were unique and significant Step 2 predictors. A further 4.1% of variance was explained by Step 3 of the model ($p < .01$). In contrast to the analyses for coping motives, yet consistent with prediction, anxiety sensitivity was the only significant predictor of conformity motives.³

For alcohol use problems, the regression model significantly predicted 5.8% of variance (see Table 3). No significant variance was accounted for by Step 1. At Step 2, anxiety sensitivity ($t = 2.15, \beta = .17, p < .05$) and discomfort intolerance (but not distress tolerance) were significantly related to alcohol-related problems (see Table 3).

Discussion

Contrary to prediction, distress tolerance, but not anxiety sensitivity, was uniquely related to coping motives. This effect represented approximately 4% of unique variance and was apparent after controlling for the significant variance accounted for by alcohol use, daily cigarette smoking, and negative affectivity (Step 1), as well as conformity, enhancement, and social motives for alcohol use (Step 2). The distress tolerance effect also was distinguishable from the shared variance with anxiety sensitivity and discomfort intolerance. Notably, neither anxiety sensitivity and discomfort intolerance maintained a significant incremental relation with coping motives for alcohol use when considered in the context of distress tolerance.

As hypothesized, anxiety sensitivity, but not distress tolerance or discomfort intolerance, was significantly and incrementally related to conformity motives for drinking. This significant effect (4% of unique variance) was evident above and beyond the 8% of variance accounted for by the Step 1 predictors and the 18% of additional variance explained by the other covarying alcohol use motives at Step 2. It is possible that young adult drinkers high in anxiety sensitivity experience elevated fears about the perceived negative effects of publicly observable anxiety symptoms (e.g., sweating) and therefore may be more motivated to use alcohol in public, group-oriented settings to conform with the alcohol-using actions of their peers. This finding is interesting when considered in light of data suggesting that beliefs regarding peer alcohol use frequency and approval are among the strongest correlates of drinking and drinking-related consequences among young adults (Lee, Geisner, Lewis, Neighbors, & Larimer, 2007; Neighbors, Lee, Lewis, Fossos, & Larimer, 2007).

Results also indicated that discomfort intolerance and anxiety sensitivity each significantly predicted alcohol use problems. No such incremental effect was evident for distress tolerance and alcohol use problems. These findings suggest that past work documenting an association between distress tolerance and alcohol use problems (e.g., Simons & Gaher, 2005) may be better explained by the correlations between distress tolerance and discomfort intolerance or anxiety sensitivity. Yet, inspection of our observed effect size estimates indicates that

³Discomfort intolerance was significantly correlated with enhancement and social motives. Hierarchical regression results indicated that lower levels of discomfort intolerance significantly predicted enhancement, but not social, motives for alcohol use. These results can be obtained from Dr. Zvolensky upon request.

discomfort intolerance may have demonstrated the strongest association with alcohol use problems (see Tables 1 and 3).

It is notable that anxiety sensitivity, distress tolerance, and discomfort intolerance were significantly related to one another at the zero-order level. The strongest association was between anxiety sensitivity and distress tolerance (approximately 19% of shared variance). Future work with larger sample sizes is needed to more comprehensively explore the relative predictive power of these constructs in terms of problematic alcohol use behavior.

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Zero-order Correlations and Descriptive Statistics

Table 1

Variable	1	2	3	4	5	6	7	8	9	10	11	Mean (SD)	Observed Range
1. PANAS-NA	1	-.10	-.03	.05	.38**	-.41**	.18**	.19**	.15*	.03	-.00	17.30 (4.76)	10-36
2. AUDIT-Alcohol Consumption		1	.76**	.04	-.04	.11	-.18**	.28**	.18**	.51**	.55**	7.54 (4.59)	1-20
3. AUDIT-Total			1	.08	.09	-.05	-.13*	.38**	.24**	.50**	.51**	10.68 (5.87)	0-33
4. Average # of cigarettes per day				1	-.02	.00	.11	.08	-.08	-.12	-.09	5.87 (7.98)	0-40
5. ASI					1	-.44**	.28**	.29**	.31**	.11	.03	16.17 (8.30)	0-45
6. DTS						1	-.25**	-.29**	-.26**	.06	.08	3.61 (0.76)	1.14-5
7. DIS							1	.04	-.04	-.19**	-.22**	11.82 (4.91)	0-30
8.DMQ-R Coping								1	.46**	.41**	.35**	9.57 (3.82)	4-24
9. DMQ-R Conformity									1	.32**	.21**	7.06 (2.89)	0-17
10. DMQ-R Social										1	.74**	17.29 (5.58)	1-25
11.DMQ-R Enhancement											1	16.07 (5.57)	2-25

Note:

PANAS-NA = Positive Affect Negative Affect Scale–Negative Affectivity subscale (Watson, 2000); AUDIT= AUD Identification Test (Babor et al., 1992); ASI = Anxiety Sensitivity Index (Reiss et al., 1986); DTS = Distress Tolerance Scale (Simons & Gaher, 2005); DIS = Discomfort Intolerance Scale (Schmidt et al., 2006).

*
p < .05

**
p < .001

Table 2
Sensitivity and Tolerance Measures Predicting Alcohol Use Motives and Problems

Variable	F	ΔR^2	t	β	sr^2	p
DMQ-Coping	13.74					<.001
Step 1		.13				
PANAS-NA			3.45	.22	.05	=.001
AUDIT-Alcohol Consumption			4.57	.29	.08	<.001
Avg. # Cigarettes/Day			.45	.03	.00	ns
Step 2		.20				<.001
DMQ-R Conformity			5.99	.36	.11	<.001
DMQ-R Social			2.53	.22	.02	<.05
DMQ-R Enhancement			.59	.05	.00	ns
Step 3		.04				<.01
ASI			1.22	.08	.00	ns
DTS			-2.89	-.19	.03	<.01
DIS			.38	.02	.00	ns
DMQ-Conformity	10.12					<.001
Step 1		.08				<.001
PANAS-NA			2.71	.18	.03	<.01
AUDIT-Alcohol Consumption			3.37	.22	.05	=.001
Avg. # Cigarettes/Day			-1.68	-.11	.01	ns
Step 2		.18				<.001
DMQ-R Coping			5.97	.40	.12	<.001
DMQ-R Social			2.02	.19	.01	<.05
DMQ-R Enhancement			-.83	-.08	.00	ns
Step 3		.04				<.01
ASI			2.51	.17	.02	<.05
DTS			-1.66	-.12	.01	ns
DIS			-1.17	-.07	.00	ns
AUDIT-Total Score	2.68					<.05
Step 1		.01				ns
PANAS-NA			-.40	-.03	.00	ns

Variable	F	ΔR^2	t	β	sr^2	p
Avg. # Cigarettes/Day			1.36	.09	.01	ns
Step 2		.05				
ASI			2.15	.17	.02	<.05
DTS			-.23	-.02	.00	ns
DIS			-2.90	-.20	.04	<.001

Note: PANAS-NA = Positive Affect Negative Affect Scale–Negative Affectivity subscale (Watson, 2000); AUDIT= Alcohol Use Disorders Identification Test (Babor et al., 1992); ASI = Anxiety Sensitivity Index (Reiss et al.,1986); DTS = Distress Tolerance Scale (Simons & Gaher, 2005); DIS = Discomfort Intolerance Scale (Schmidt et al., 2006).