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Dysregulation in Youth with Anxiety Disorders: Relationship to Acute and 7- to 19- Year Follow-Up Outcomes of Cognitive-Behavioral Therapy

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Abstract

This study evaluated the impact of dysregulation across cognitive, affective, and behavioral domains on acute and 7- to 19-year follow-up outcomes of cognitive-behavioral therapy (CBT) for anxiety, and explored dysregulation as a predictor of psychopathology and impairment in young adulthood among individuals who received anxiety treatment as youth. Participants ($N=64$; 50% female, 83% non-Hispanic White) from two randomized clinical trials completed a follow-up assessment 7 to 19 years later. Latent profile analysis identified dysregulation based on Anxious/Depressed, Inattention, and Aggressive Behavior scores on the Child Behavior Checklist. Although pretreatment dysregulation was not related to acute or follow-up outcomes for anxiety diagnoses that were the focus of treatment, dysregulation predicted an array of non-targeted psychopathology at follow-up. Among youth with a principal anxiety disorder, the effects of CBT (*Coping Cat*) appear to be robust against broad impairments in self-regulation. However, youth with a pretreatment dysregulation profile likely need follow-up to monitor for the emergence of other disorders.

Keywords

dysregulation; self-regulation; anxiety; treatment; children; adolescents

The acquisition of adaptive self-regulation of emotions and behaviors is an important developmental process in childhood. When self-regulation is not developed, processes related to effortful control may be compromised, contributing to the onset of psychopathology. Affective dysregulation may result in anxiety, depressed mood, or extreme mood fluctuations; behavioral dysregulation may be reflected in impulsivity, agitation, restlessness, and aggression; and cognitive dysregulation may manifest as inattention. The

combination of these difficulties appears to be somewhat heritable and stable over time,² and can be observed by multiple informants. Further, specific neurometabolic, endocrine, temperamental,³ and environmental correlates⁴ of dysregulation across affective, behavioral, and cognitive domains have been identified. Youth who exhibit dysregulation are often described as highly comorbid, mood labile, or explosive.

Dysregulation has been operationally defined as elevated scores on Anxious/Depressed, Attention Problems, and Aggressive Behavior narrow-band scales of the Child Behavior Checklist (CBCL). Some studies have required elevations of at least one standard deviation on all three scales (two standard deviations for severe dysregulation)⁵ or a sum of T-scores 210 across the scales,⁶ while others have used latent class analysis to identify youth with dysregulation.^{7,8} Although CBCL dysregulation was proposed to be an early marker of bipolar disorder,⁹ this conceptualization has been challenged with cross-sectional¹⁰ as well as longitudinal data¹¹ suggesting that CBCL dysregulation is independently associated with a wide range of DSM-IV disorders. At a minimum, this dysregulation profile has been consistently associated with greater symptom severity and functional impairment.¹² Many studies have also documented a link to suicidality.^{13,14}

CBCL dysregulation studies have generally sampled youth diagnosed with or at high risk for DSM-IV disruptive behavior or mood disorders.^{15,16} Relatively few studies have used general samples¹⁷ and one study sampled youth with obsessive-compulsive disorder (OCD). Although emotion regulation deficits in youth with non-OCD anxiety disorders have been reported, the utility of the CBCL dysregulation profile (which cuts across affective, behavioral, and cognitive domains) has not been investigated in youth with anxiety disorders.

A youth who is dysregulated, as captured by the CBCL profile, may be challenging to engage in cognitive-behavioral therapy (CBT) for anxiety, which has generally yielded meaningful symptom reduction in approximately 60% of youth and is associated with benefits identified at follow-up.¹⁸ For example, dysregulation may lead to difficulty monitoring/reporting anxiety symptoms and their triggers, or sustaining attention when anxiety management skills are presented in session. Also, dysregulated youth may resist exposure to anxiety-provoking situations (a critical component of CBT) and experience relatively high levels of associated distress. Further, it has been suggested that self-regulatory capacities are linked to extinction learning, a primary goal of exposure-based treatment. Thus, it is possible that dysregulation impairs the learning that is expected when exposure tasks are completed.

The current study examined CBCL dysregulation in youth who received CBT for anxiety disorders as part of two randomized controlled trials.¹⁹ The primary aim was to evaluate the impact of CBCL dysregulation on acute and 7- to 19-year treatment outcomes (i.e., presence of targeted diagnoses, anxiety severity). A secondary aim was to examine CBCL dysregulation as a predictor of psychopathology (i.e., DSM-IV Axis I disorders, depressive

*This profile has been referred to as the CBCL Dysregulation Profile, the CBCL Juvenile Bipolar Disorder Profile, the CBCL Pediatric Bipolar Profile, the CBCL Mania Proxy, and Deficient Emotional Self-Regulation. Operational definitions have varied irrespective of the profile name used.

symptom severity, suicidality) and functional impairment in young adulthood among individuals who received CBT for anxiety as youth.

Method

Procedure

All study procedures were approved by the Institutional Review Board. Participants ($N = 64$) received treatment for an anxiety disorder during childhood through one of two randomized controlled trials (RCTs) and participated in a follow-up assessment 7 to 19 years later. In both RCTs, participants were randomized to treatment condition and to therapist. Participation occurred at a university-affiliated urban anxiety clinic (see Benjamin et al. for additional information regarding study procedures and recruitment).

Participants

Participant demographics at baseline and treatment outcomes have been reported. At 7- to 19-year follow-up, the mean age of participants ($N=64$) was 27.16 ($SD=3.56$) and they had completed treatment for childhood anxiety, on average, 16.19 years ($SD=3.60$, Range = 6.72–19.17) prior. The sample was 50% female and predominantly non-Hispanic White (83%). Most participants were college educated (M years of education = 5.03, $SD=1.87$). Over half (56%) had never been married and were not living with a partner. Pretreatment principal diagnoses were generalized anxiety disorder (GAD)/overanxious disorder of childhood (56%), social phobia (SoP)/avoidant disorder (27%), and separation anxiety disorder (SAD) (17%). With regard to pretreatment comorbidity, only children who displayed psychotic symptoms were excluded. Following initial study treatment, 61% no longer met diagnostic criteria for their pretreatment principal anxiety disorder.

Recruitment procedures and sample characteristics have been detailed in Benjamin and colleagues. Of the 150 individuals who were eligible to participate in the 7- to 19-year follow-up, 66 were located and participated,[†] 16 were reached and declined participation, and 3 were contacted, agreed to participate, and then could not be reached for an assessment. Additionally, 35 individuals could not be located; contact information was obtained for the remaining 30 individuals but they/their parents could not be reached directly. Follow-up study participants did not differ significantly from nonparticipants in treatment response ($\chi^2(1) = 1.75$, $p = .19$).

Analyses comparing follow-up study participants from the two RCTs showed no significant differences by gender, $\chi^2(1) = 4.10$, $p = .52$, race/ethnicity, $\chi^2(4) = 1.53$, $p = .82$, or age at pretreatment, $F(1, 62) = 3.16$, $p = .08$. However, the groups differed significantly by pretreatment principal diagnosis, $\chi^2(2) = 8.71$, $p = .01$, with a relatively high rate of principal SAD (20%, $n = 11$) among participants treated in the earlier RCT.

[†]In Benjamin et al., $N = 66$ at 7- to 19-year follow-up. For the current analysis, $N = 64$ as a result of dropping 2 participants for whom pretreatment CBCL data were missing.

Measures

Pre- and Post-Treatment Assessment

Anxiety Disorders Interview Schedule, Child and Parent Versions (ADIS-C/P).: The ADIS-C/P is a semi-structured interview that assesses anxiety disorders and comorbid conditions in youth. For each anxiety disorder, diagnosticians provided a clinical severity rating (CSR) on a continuous scale.[‡] The ADIS-C/P has demonstrated favorable psychometric properties, including high inter-rater reliability and retest reliability. Diagnosticians completed supervised practice administrations with actual clients, and met an inter-rater reliability criterion of 0.85 (Cohen's Kappa); random checks during the study indicated that this level of reliability was maintained.

Child Behavior Checklist (CBCL).: The 118-item CBCL, completed by parents, assesses a range of child behavioral problems and social competencies. The CBCL yields a total score and has both broad-band and narrow-band scales; for the current study, the Anxious/Depressed, Attention Problems, and Aggressive Behavior narrow-band scores were used. The psychometric properties of the CBCL are reported in Achenbach and Rescorla.

7- to 19-Year Follow-up Assessment

Composite International Diagnostic Interview (CIDI).: The World Mental Health Survey Initiative Version of the World Health Organization (WHO) CIDI is a structured comprehensive lifetime interview for obtaining information on mood disorders, anxiety disorders, substance use disorders, and other relevant conditions. Diagnoses are based on DSM-IV and ICD-10 criteria. Retest reliability is high and CIDI diagnoses are significantly related to independent clinical diagnoses. Interviewers completed a group didactic training session and independently reviewed study materials. CIDI interviewers were blind to initial treatment response.

Beck Anxiety Inventory (BAI).: The BAI is a 21-item, self-report measure of the frequency and severity of anxiety symptoms experienced during the past week. Internal consistency, retest reliability, and convergent and discriminant validity data have been reported.⁻

Beck Depression Inventory (BDI-II).: The BDI-II is a 21-item self-report measure of depressive symptoms experienced during the past two weeks. The BDI-II has demonstrated internal consistency, criterion validity, factorial validity, and convergent and discriminant validity.⁻

Sheehan Disability Scale (SDS).: The SDS is 4-item self-report measure of current impaired functioning across three domains: Social Life/Leisure Activities, Work, Family Life/Home Responsibilities, and Work and Social Disability. The SDS has demonstrated internal consistency, construct validity, and criterion-related validity.⁻

[‡]CSRs for participants in Kendall et al. were based on the 0–4 scale in use at that time. CSRs for participants in Kendall et al. were based on a 0–8 scale. For consistency, the senior author reviewed posttreatment diagnostic reports for participants in Kendall et al. and recoded CSRs using the 0–4 scale.

Analytic Plan

Latent profile analysis (LPA) was conducted to identify distinct groups accounting for the distribution of subjects across three CBCL narrow-band scales: Anxious/Depressed, Attention Problems, and Aggressive Behavior. T-tests compared means across the three scales to confirm groups that emerged from the LPA. Chi-square and *t*-tests examined group differences in demographics at baseline (sex; race/ethnicity), principal diagnosis at baseline, and differences at 7- to 19-year follow-up in marital status and income. Logistic regression evaluated group differences in posttreatment responder status (with response defined as principal diagnosis based on parent report no longer present), controlling for pretreatment severity of the principal disorder. Analysis of covariance compared groups on posttreatment anxiety severity (defined as highest CSR across anxiety disorders), controlling for pretreatment anxiety severity. Chi-square tests examined group differences in the presence of the principal disorder, any targeted anxiety disorder[§] (SAD, GAD, or SoP), and all other specific Axis I diagnoses present during the past 12 months at 7- to 19-year follow-up. For the primary aim, alpha levels were adjusted using a modified Bonferroni procedure. Given that the secondary aim was exploratory, an alpha level of .05 was employed to balance the risk between types I and II errors.

Results

Descriptive Statistics

Descriptive statistics and bivariate correlations are in Table 1. Male participants and participants with a principal diagnosis of GAD had higher CBCL Anxious/Depressed *T* scores. The CBCL dysregulation subscales significantly correlated with one another.

Latent Profile Analysis

Latent profile analysis (LPA) was conducted using Mplus Version 6.0. The Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and the Sample-Size-Adjusted BIC (SSA-BIC) were used to compare fit for a two-group model (AIC = 1340.40, BIC = 1361.99; SSA-BIC = 1330.52) to that of a model with no subgroups (AIC = 1380.97, BIC = 1393.92, SSA-BIC = 1375.04). The two-group model resulted in lower values, indicating that the two-group model had better fit to the data. The entropy value (.87), which indicates how separated the groups are, suggested good classification qualities. Mean posterior probabilities for the two identified groups were .97 and .94. Only 5 participants had probabilities below .80. Due to the sample size and limited number of indicators, the two-group model was not compared to models with increasing numbers of groups.

The majority of participants fell into group 1 ($n = 47$; 73%), labeled the non-dysregulated group because their mean scores fell below the cutoff ($T = 70$) for all three dysregulation scales: Anxious/Depressed ($M = 67.74$, $SD = 8.94$), Attention Problems ($M = 57.06$, $SD = 7.30$), and Aggressive Behavior ($M = 51.38$, $SD = 2.55$). Given that the sample consisted of anxious youth, it makes sense that the mean for group 1 on the Anxious/Depressed scale was

[§]Separation anxiety disorder, generalized anxiety disorder, and social phobia have been conceptualized as sharing an underlying construct, are highly comorbid, and have been studied jointly in the context of treatment.

elevated but not in the clinical range (T scores ranging from 65–69). Participants in group 2 ($n = 17$; 27%), labeled the dysregulated group, scored higher on all three dysregulation scales: Anxious/Depressed ($M = 76.94$, $SD = 7.53$), Attention Problems ($M = 72.29$, $SD = 9.96$), and Aggressive Behavior ($M = 63.18$, $SD = 6.05$). The means for group 2 on the Anxious/Depressed and Attention Problems scales were in the clinical range. Means were significantly higher for participants in the dysregulated group compared to those in the non-dysregulated group on all three scales: Anxious/Depressed ($t(62) = -3.78$, $p < .01$), Attention Problems, ($t(62) = -6.67$, $p < .01$), and Aggressive Behavior, ($t(62) = -11.03$, $p < .01$).

The groups did not vary by sex ($\chi^2(1) = .08$, ns) or race/ethnicity (White, Black, Asian, Hispanic, or other; $\chi^2(4) = 4.99$, ns). These demographic variables were not included in further analyses. There were no significant differences between the dysregulated and non-dysregulated groups on any of the pretreatment principal diagnoses ($\chi^2(1) = 1.26$, ns). Examination of group differences on demographic variables at 7- to 19-year follow-up revealed no differences between the dysregulated and non-dysregulated groups on income ($t(62) = .07$, ns) or marital status ($\chi^2(2) = .53$, ns). At 7- to 19-year follow-up, the groups did not differ on additional treatment obtained since initial study participation (rated on a 0–4 scale by independent raters reviewing the CIDI data, kappa $> .80$), ($t(62) = .18$, ns)^{||}.

Dysregulation and Acute Outcomes of CBT

Controlling for pretreatment severity of the principal diagnosis, dysregulation did not significantly predict responder status (AOR = .53, ns). Dysregulated and non-dysregulated groups did not differ on posttreatment anxiety severity (i.e., highest CSR across anxiety disorders), controlling for pretreatment anxiety severity ($F(1,61) = .02$, ns).

Dysregulation and Outcomes of CBT at 7- to 19-year Follow-up

Chi-square tests did not indicate any differences between dysregulated and non-dysregulated participants on whether one or more of the targeted anxiety disorders (GAD, SoP, or SAD) was present at 7- to 19-year follow-up ($\chi^2(1) = .43$, ns), whether the principal diagnosis was present at 7- to 19-year follow-up ($\chi^2(1) = .10$, ns), or whether a targeted anxiety disorder was present in addition to the principal diagnosis at 7- to 19-year follow-up ($\chi^2(1) = .12$, ns). There were no significant differences between dysregulated and non-dysregulated participants in self-reported anxiety symptoms (BAI total score) at 7- to 19-year follow-up ($t(59) = -1.52$, ns).

Chi-square tests comparing the dysregulated and non-dysregulated groups on the presence of specific disorders are in Table 2. As shown, the dysregulated group had significantly more participants with a diagnosis of posttraumatic stress disorder (PTSD), agoraphobia, panic attacks, and OCD in the past 12 months. Of the same disorders listed in Table 2, the dysregulated group also had significantly more participants with a lifetime diagnosis of PTSD ($\chi^2 = 5.13$, $p < .05$). There were no other significant differences between the dysregulated and non-dysregulated groups on lifetime diagnoses. No participants from either

^{||}See Benjamin et al. for a description of how additional treatment ratings were computed for this sample.

group had diagnoses of mania or bipolar disorder at 7- to 19-year follow-up, although one participant (from the dysregulated group) met criteria for hypomania. Comparison of the two groups on self-report measures revealed significant differences in depressive symptoms (BDI-II total score) at 7- to 19-year follow-up ($t(59) = -2.15, p < .05$). There were no significant differences in functional impairment ($t(59) = -1.25, ns$).

Discussion

This study, the first to examine dysregulation in individuals who received CBT for anxiety in childhood, found that pretreatment CBCL dysregulation was not related to acute or long-term (7- to 19-year follow-up) outcomes for the target anxiety diagnoses (i.e., GAD, SoP, or SAD). That is, dysregulation does not appear to interfere with treatment response among youth with anxiety. However, several significant differences emerged between dysregulated and non-dysregulated participants in rates of non-targeted disorders at 7- to 19-year follow-up.

These results regarding the target anxiety disorders are consistent with the only other published study examining the impact of CBCL dysregulation on exposure-based treatment. McGuire and colleagues reported that pretreatment dysregulation did not predict a differential response to CBT for pediatric OCD. Dysregulation in that study was associated with treatment discontinuation. It's possible that dysregulated youth are at risk for dropping out of exposure-based treatment but that youth who persevere develop increased regulatory abilities; that is, increased behavioral control over anxiety/OCD symptoms generalizes to other domains. Although we could not examine the impact of CBCL dysregulation on attrition, which was minimal in our sample, this remains an area for future investigation.

Several differences emerged between dysregulated and non-dysregulated participants in rates of *non-targeted disorders* at 7- to 19-year follow-up. The dysregulated group had higher rates of lifetime PTSD diagnosis and 12-month diagnoses of PTSD, agoraphobia, panic attacks, and OCD compared to the non-dysregulated group. These results are consistent with prior studies suggesting that CBCL dysregulation is not a specific marker of bipolar disorder but is a factor that is meaningfully associated with a broad array of psychopathology and potentially a more severe clinical picture.²⁹ Indeed, DSM-5 has attempted to address the need for a unique way to classify dysregulation in youth via the inclusion of a Disruptive Mood Dysregulation Disorder, though the data on this addition are inconclusive at the present time. Also consistent with the interpretation that dysregulated youth are at risk for more severe clinical profiles at follow-up, the dysregulated group in our sample had greater depressive symptoms at follow-up compared to the non-dysregulated group. Interestingly, group differences in depressive disorders did not emerge despite 18.6% of the sample meeting criteria for lifetime major depressive disorder diagnoses in adulthood. It is possible that individuals presenting with depressive symptoms in youth (tapped in the CBCL dysregulation profile) are at relatively high risk for the onset of depressive disorders by adulthood, but that anxiety management skills taught in CBT (e.g., cognitive restructuring; problem solving) and reinforced through exposure tasks generalize to buffer against depression reaching the threshold for a diagnosis.

Among youth presenting for anxiety treatment, there may be anxiety-related explanations for the elevations on all three narrow-band scales that define CBCL dysregulation. For example, the Anxious/Depressed score may be impacted by the frequent comorbidity of anxiety and depression. The Attention Problems score may be elevated due to difficulty concentrating as a result of worry or rumination. An elevated Aggressive Behavior score may reflect behavior that is functional for avoiding anxiety-provoking situations (i.e., negatively reinforced), even among children who do not have broad impairments in self-regulation. Consistent with this possibility, family accommodation of symptoms (e.g., facilitating avoidance of anxiety triggers) has been linked to anxiety severity as well as externalizing problems; among youth with OCD, family accommodation has also been associated with CBCL dysregulation. Research is needed to determine if the CBCL dysregulation profile can sufficiently distinguish individuals who may have elevated scores for reasons related to anxiety from those with a mood-labile phenotype. Also, studies that incorporate direct assessment of emotion regulation to characterize youth with temper outbursts, many of whom meet criteria for anxiety disorders, may inform this issue.

This study is not without limitations. First, dysregulation in our sample was modest relative to other studies examining CBCL dysregulation scores. Although we did not exclude youth with relevant comorbidities (e.g., ADHD), it is possible that youth with severe dysregulation are less likely to be referred for anxiety treatment than for treatment of a mood or disruptive behavior disorder, which may be more salient to adults (e.g., teachers). The sample was predominantly non-Hispanic White, middle to high socioeconomic status, and educated; research with large and diverse samples is needed. There was the absence of a no-treatment comparison group and the assessment tools changed over time to be consistent with the developmental level of participants, a limitation of longitudinal studies of this nature. Finally, CBCL dysregulation was reported by one informant; future studies might use multiple informants.

That CBCL dysregulation did not interfere with treatment response in youth with anxiety is encouraging and supports the robustness of CBT for youth with anxiety who exhibit a range of pretreatment symptom profiles. For clinicians treating youth, this study suggests that a full course of evidence-based CBT is beneficial for youth who have both anxiety and broad dysregulation. Given that dysregulation was related to a more severe overall profile at long-term follow-up, youth with considerable dysregulation may benefit from increased monitoring for the emergence of comorbid disorders and need for adjunctive treatment.

Summary

This study (1) evaluated the impact of dysregulation across cognitive, affective, and behavioral domains on acute and 7- to 19-year follow-up outcomes of CBT for anxiety, and (2) explored dysregulation as a predictor of psychopathology and functional impairment in young adulthood among individuals who received anxiety treatment as youth. Data were from participants ($N = 64$) from two randomized clinical trials of CBT for childhood anxiety disorders who completed a follow-up assessment 7 to 19 years later. Latent profile analysis identified youth exhibiting dysregulation at pretreatment based on scores on the Anxious/Depressed, Inattention, and Aggressive Behavior scales of the CBCL. Controlling for

pretreatment anxiety severity, dysregulation did not significantly predict posttreatment anxiety severity or treatment response, as rated by clinicians. At 7- to 19-year follow-up, there were no differences between dysregulated and non-dysregulated participants on the presence of one or more of the targeted anxiety disorders (GAD, SoP, or SAD) or the principal anxiety disorder, nor were there significant differences in self-reported anxiety symptoms. Although dysregulation was not related to acute or follow-up outcomes for the anxiety diagnoses that were the focus of treatment, dysregulation predicted *non-targeted* psychopathology at 7- to 19-year follow-up: PTSD, agoraphobia, panic attacks, OCD, and depressive symptoms. Among individuals presenting for anxiety treatment in childhood, CBT (*Coping Cat*) appears robust against broad impairments in self-regulation. However, youth with a pretreatment dysregulation profile would likely benefit from increased follow-up to monitor for the onset of other disorders and the need for adjunctive treatment.

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Table 1

Means, Standard Deviations (SDs), and Correlations among Variables (N = 64)

	M (SD)	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. CBCL Anxious/Depressed	70.19 (.946)	--								
2. CBCL Attention Problems	61.11 (10.49)	.46**	--							
3. CBCL Aggressive Behavior	54.52 (6.45)	.52**	.46**	--						
4. Sum of Dysregulation T-scores	185.81 (21.39)	.82**	.83**	.76**	--					
5. Sex	.50 (.50)	.36**	.09	.15	.25*	--				
6. Principal SAD diagnosis	.17 (.38)	-.02	.02	.07	.02	-.21	--			
7. Principal GAD diagnosis	.56 (.50)	.36**	-.02	.09	.18	.19	-.52**	--		
8. Principal SoP diagnosis	.27 (.45)	-.39**	.00	-.15	-.22	-.035	-.27*	-.68**	--	
9. Targeted diagnosis present at follow-up	.36 (.48)	-.16	.11	-.16	-.07	-.163	.00	.00	-.01	--
10. Principal diagnosis present at follow-up	.27 (.45)	-.17	.19	-.05	.00	-.177	.01	-.11	.12	.80**

Note. Scales for CBCL variables are *T*-scores; Sex is dummy coded 0 for female, 1 for male; principal SAD/GAD/SoP diagnosis = SAD/GAD/SoP was the principal diagnosis at pre-treatment assessment; targeted diagnosis present at follow-up = the presence of one or more targeted anxiety disorders (SAD, GAD, and/or SoP) at 7- to 19-year follow-up; principal diagnosis present at follow-up = the pretreatment principal diagnosis was present at 7- to 19-year follow-up.

Table 2

Chi-Square Tests of Differences between the Dysregulated and Non-Dysregulated Groups on the Presence of Specific Disorders during the Past 12 Months at 7- to 19-Year Follow-up.

Disorder	χ^2 (1)	<i>p</i> -value
Major Depressive Disorder	2.40	.12
Major Depressive Episode	.61	.44
Dysthymic Disorder	.37	.54
Hypomania	2.81	.09
Generalized Anxiety Disorder	.16	.69
Social Phobia	.01	.92
Specific phobia	.02	.90
Obsessive Compulsive Disorder	5.13 *	.02
Panic Attack	4.16 *	.04
Panic Disorder	.16	.69
Agoraphobia	8.70 **	<.01
Posttraumatic Stress Disorder	5.71 *	.02
Alcohol Abuse	.02	.90
Alcohol Dependence	.05	.94

*
 $p < .05$.

**
 $p < .01$.