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Depression and Risky Alcohol Use: An Examination of the Role of Difficulties Regulating Positive Emotions in Trauma-Exposed Individuals

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Abstract

Background: The co-occurrence of depression and risky alcohol use is clinically-relevant given their high rates of comorbidity and reciprocal negative impact on outcomes. Emotion dysregulation is one factor that has been shown to underlie this association. However, literature in this area has been limited in its exclusive focus on emotion dysregulation stemming from negative emotions.

Objectives: The goal of the current study was to extend research by exploring the role of difficulties regulating positive emotions in depression symptom severity, risky alcohol use, and their association.

Methods: Participants were 395 trauma-exposed adults recruited from Amazon's Mechanical Turk (MTurk) platform (56.20% female, $M_{age} = 35.55$) who completed self-report questionnaires.

Results: Zero-order correlations among depression symptom severity, the three subscales of difficulties regulating positive emotions, and risky alcohol use were positive. Two subscales of difficulties regulating positive emotions – nonacceptance of positive emotions and difficulties controlling impulsive behavior when experiencing positive emotions – accounted for the relationship between depression symptom severity and risky alcohol use.

Conclusion: Results suggest the importance of incorporating techniques focused on improving positive emotion regulation skills in interventions for risky alcohol use among individuals with depression.

Keywords

depression; positive emotion dysregulation; difficulties regulating positive emotions; positive emotion dysfunction; risky alcohol use

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Introduction

Among adults, risky alcohol use is the fourth leading preventable cause of death in the United States (1), and therefore represents a significant public health concern (2). In 2015, 86.4% of adults in the United States reported that they drank alcohol at some point in their life. More than half of adults report past-month alcohol consumption (56.0%), and more than 15.1 million adults reporting problematic drinking patterns indicative of an alcohol use disorder (3). High rates of alcohol consumption expose individuals to increased risk for various negative health (4), legal (5), and social (6–8) consequences. A large body of research has found that risky alcohol use commonly co-occurs with depression (9, 10), and that depression may be a contributing factor to the development of alcohol use disorders (11–13). Nearly 41% of those meeting criteria for a major depressive disorder also have a diagnosis of lifetime alcohol use disorder and 22% meet criteria for past-12-month alcohol use disorder (14). This is concerning given that alcohol use among individuals with depression is associated with increased severity and duration of depressive episodes and likelihood of suicidal ideation, as well as decreased ability to cope with social stressors (11, 15, 16). Taken together, the above findings highlight the importance of research that extends our understanding of the co-occurrence of depression and risky alcohol use.

One potential transdiagnostic vulnerability factor that may help to explain the co-occurrence of depression and risky alcohol use is emotion dysregulation. Emotion dysregulation is a multi-faceted construct involving maladaptive responses to emotions, including: 1) a lack of awareness, understanding, and acceptance of emotions, 2) an inability to control behaviors when experiencing emotional distress, 3) a lack of access to situationally appropriate strategies to cope with the duration and intensity of emotions to meet situational demands, and 4) an unwillingness to experience emotional distress when pursuing meaningful activities in life (17, 18). Emotion dysregulation has been identified as a key factor underlying the etiology and treatment of both depression and risky alcohol use (19, 20). Emotion dysregulation has been found to positively relate to increased risk for depression, more severe depression symptoms later in life, and worse treatment outcomes for depression (20, 21). Likewise, emotion dysregulation has been found to be positively linked to alcohol consumption and alcohol-related consequences (22, 23), as well as been shown to predict relapse following treatment for risky alcohol use (19). Though found to be associated independently associated with depression and risky alcohol use, research to date has not examined the role of emotion dysregulation in the depression-alcohol use relation.

Another limitation of the extant research is its almost exclusive focus on negative emotion dysregulation, despite work suggesting that individuals may also experience dysregulation stemming from positive emotions (24, 25) across domains of nonacceptance, goal pursuit, and impulse control. Preliminary theoretical and empirical evidence links these difficulties to both depression and risky alcohol use (26, 27). Depression is characterized by diminished positive affect (e.g., anhedonia) (28, 29). Some theorists have suggested that individuals with depression are unable to experience positive affect (28), perhaps due to lack of contact with reinforcing experiences and/or interfering negative cognitions (30), or an unwillingness to experience positive emotions perceived as aversive. For instance, individuals who experience

depression may be more likely to experience secondary negative emotional reactions to situations or stimuli that are typically positive. This is consistent with evidence that negative affect interference, the tendency to experience negative emotions in situations that typically elicit positive emotions, predicts hedonic decline and anhedonia (symptoms of depression) (31). Alternatively, individuals with depression may come to fear positive emotions over time, perhaps because they elicit negative emotions or because of concern that they will lose control over their emotions or their behavioral responses to emotions (32). Consistent with the idea that individuals with depression may be nonaccepting of positive emotional experiences, greater depression symptom severity has been shown to relate to increased suppression of positive emotions (33). It is also possible that positive emotions lead to behavioral dyscontrol among individuals with depression. Indeed, depression is also associated with positive urgency, or the tendency to act rashly when experiencing extreme positive emotions (34). Further, individuals with depression show altered reward processing (35), suggestive of impairment in behavioral control in the context of positive emotions.

Increasing research also provides support for the role of difficulties regulating positive emotions in risky alcohol use. Individuals who are nonaccepting of positive emotions may use alcohol to alleviate or distract from positive emotional states, consistent with negative reinforcement models of alcohol use (36). Further, positive emotions may be associated with behavioral dyscontrol, which may take the form of risky alcohol use. For instance, positive emotional states may increase distractibility (37) and lead to less discriminative use of information causing one to drink alcohol (38), heightening the risk for disadvantageous decision-making focused on short-versus long-term goals (39). Regarding empirical findings, only a few studies have examined the role of other facets of difficulties regulating positive emotions in risky alcohol use. Weiss, Forkus, Contractor, and Schick (26) found that nonacceptance of positive emotions and difficulties controlling impulsive behavior and engaging in goals-directed behavior when experiencing positive emotions were associated with risky alcohol use among college students. A second study found that overall difficulties regulating positive emotions moderated the daily relation between positive affect stemming from social stressors and alcohol use to cope with social stressors, such that positive affect stemming from social stressors predicted alcohol use to cope with social stressors among individuals with high (but not low) levels of difficulties regulating positive emotions (27). Finally, a third study found support for three classes of domestic violence-victimized women characterized by difficulties regulating negative and positive emotions, and alcohol misuse was more prevalent among the class defined by higher levels of difficulties regulating both negative and positive emotions (40).

The goal of the current study was to address these above-mentioned gaps in the literature by exploring the relations among depression severity, subscales of difficulties regulating positive emotions, and risky alcohol use. We expected that depression severity, subscales of difficulties regulating positive emotions, and risky alcohol use would be significantly positively correlated. Further, we expected that the subscales of difficulties regulating positive emotions would help to explain the relation between depression symptom severity and risky alcohol use.

Methods

Procedure/Participants

Participants were recruited from Amazon's Mechanical Turk (MTurk) platform. Beyond generating reliable data (41, 42), MTurk's subject pool is diverse (41) and represents the general population in terms of demographics (43) and prevalence of certain mental health problems (42).

Data for the present study were collected as part of a larger study developing a novel measure assessing risky behaviors among individuals with stressful life experiences. Participants 18 years of age and older were screened for the larger study based upon three inclusionary criteria: (1) living in North America; (2) working knowledge of the English language; and (3) experience of a traumatic experience (TE) screened with the Criterion A question of the Primary Care PTSD Screen (44). Participants who met eligibility criteria provided informed consent and completed the survey on Qualtrics. Participants were compensated \$1.25 for study participation. All procedures were approved by the Institutional Review Board at a U.S. university.

Exclusions and Missing Data

Of the obtained 891 responses, duplicate responses were excluded for 18 participants who attempted to answer the questionnaire multiple times (47 responses; remaining $n = 844$). We then excluded 150 participants not meeting one or more inclusionary criteria (remaining $n = 694$), 122 participants (remaining $n = 572$) who failed to pass any of four validity checks interspersed in the study to ensure attentive responding (three items; e.g., participants being asked to rate "I have never brushed my teeth" on a 6-point scale ranging from "strongly disagree" to "strongly agree") and comprehension (one item, asking participants to click on a little blue circle rather than on the scale with items labelled from 1 to 5) (45–47), and 97 participants for missing data on all measures (remaining $n = 475$). Using data obtained from the Life Event Checklist for *DSM-5* (LEC-5) (48), we excluded 11 participants who either did not endorse a TE, or did not identify their index (i.e., most distressing) TE (remaining $n = 464$). Finally, we excluded 69 participants missing more than 30% item-level data on any primary variable of interest (see Measures).

The final MTurk sample included 395 participants. See Table 1 for demographic data and prevalence rates of index TEs. Average age of participants was 35.55 years ($SD = 11.09$), and 222 were female (56.20%). Approximately one-third of participants reported symptoms consistent with a diagnosis of depression ($n = 130$, 32.9%), based on a cut-off score of 10 or greater (49). Approximately one-quarter of participants reported alcohol consumption consistent with a diagnosis of alcohol use disorder ($n = 96$, 24.3%), based on a cutoff score of 5 or greater (50). The most common index TEs were: transportation accidents (16.8%), natural disasters (13.5%), and sexual assault (12.4%).

Measures

Patient Health Questionnaire-9 (PHQ-9) (51).—The PHQ-9 is a 9-item self-report measure assessing depression symptoms over the past two weeks. The four response options

range from 0 (*not at all*) to 3 (*nearly every day*) (49). Higher scores indicate greater depressive symptom severity. The PHQ-9 has good psychometrics (49). Cronbach's α in the current study was .91 for the PHQ-9.

Difficulties in Emotion Regulation Scale – Positive (DERS-P) (52).—The DERS-P is a 13-item self-report measure that assesses difficulties regulating positive emotions across three subscales: nonacceptance of positive emotions (DERS-P Accept), difficulties engaging in goal-directed behaviors when experiencing positive emotions (DERS-P Goals), and difficulties controlling impulsive behaviors when experiencing positive emotions (DERS-P Impulse). Higher scores on the DERS-P subscales indicate greater difficulties regulating positive emotions. Participants rate each item using a 5-point Likert-type scale (1 = *almost never*, 5 = *almost always*). The dimensions of the DERS-P have good psychometrics (52). Cronbach's α s in the current sample were .93, .88, and .95 for the DERS-P Accept, DERS-P Goals, and DERS-P Impulse, respectively.

Alcohol Use and Disorders Identification Test Alcohol Consumption Questions (AUDIT-C) (50).—The AUDIT-C is a 3-item self-report measure assessing heavy drinking and active alcohol use disorder. Participants rate each item using a 5-point Likert-type scale (Item 1 [frequency]: 0 [*never*] to 4 [*daily or more times a week*]; Item 2 [consumption]: 0 [*1 or 2*] to 4 [*10 or more*]; Item 3 [binge drinking]: 0 [*Never*] to 4 [*daily/ almost daily*]). Higher scores indicate greater alcohol use. The AUDIT-C has good psychometrics (50). Cronbach's α in this study was .74 for the AUDIT-C.

Demographic information.—Information regarding age, gender, ethnicity, race, income, educational level, employment status, ethnicity, and relationship status was obtained.

Data Analysis

Analyses were conducted using IBM SPSS Statistics Version 24.0 (53). In line with recommendations by Tabachnick and Fidell (54), relevant study variables were assessed for assumptions of normality. Next, Pearson product-moment correlations were conducted to evaluate the relations among depression symptom severity (PHQ-9), the three subscales of difficulties regulating positive emotions (DERS-P), and risky alcohol use (AUDIT-C). Finally, to examine whether the subscales of difficulties regulating positive emotions explain the relation between depressive symptom severity and risky alcohol use, we conducted indirect effect analyses (55) with the PROCESS SPSS macro (56). PROCESS uses ordinary least squares regression and bootstrapping methodology, which confers more statistical power than standard approaches and does not rely on distributional assumptions. The bootstrap method was used to estimate the standard errors of parameter estimates and the bias-corrected confidence intervals of the indirect effects (55, 57). The effect is significant if the 95% confidence interval does not contain zero (55). In this study, 5,000 bootstrap samples were used to derive estimates of the indirect effect.

Results

Pearson-product moment correlations among depression symptom severity, subscales of difficulties regulating positive emotions, and risky alcohol use are presented in Table 2. Depression symptom severity was significantly positively associated with each of the subscales of difficulties regulating positive emotions as well as risky alcohol use. Each of the subscales of difficulties regulating positive emotions were significantly positively related to risky alcohol use.

Next, separate models were conducted to examine whether the subscales of difficulties regulating positive emotions accounted for the relation between depression symptom severity and risky alcohol use. The model testing the role of nonacceptance of positive emotions in the relation between depression symptom severity and risky alcohol use is shown in Figure 1. The association between depression symptom severity and nonacceptance of positive emotions was significant, $b = .31$, $SE = .03$, $t = 12.00$, $p < .001$, as was the association between nonacceptance of positive emotions and risky alcohol use, $b = .12$, $SE = .04$, $t = 3.13$, $p = .002$. Furthermore, the indirect effect of depression symptom severity on risky alcohol use through the pathway of nonacceptance of positive emotions was also significant, $b = .04$, $SE = .01$, $p < .05$, 95% CI [.01, .06]. Notably, the direct effect linking depression symptom severity with risky alcohol use was not significant after controlling for nonacceptance of positive emotions, $b = .03$, $SE = .02$, $t = 1.37$, $p = .17$.

The model explicating the role of difficulties engaging in goal-directed behaviors when experiencing positive emotions in the relation between depression symptom severity and risky alcohol use was significant is shown in Figure 2. While the association between depressive symptom severity and difficulties engaging in goal-directed behaviors when experiencing positive emotions was significant, $b = .25$, $SE = .03$, $t = 9.87$, $p < .001$, the association between difficulties engaging in goal-directed behaviors when experiencing positive emotions and risky alcohol use was nonsignificant, $b = .06$, $SE = .04$, $t = 1.39$, $p = .17$. Additionally, the indirect effect of depression symptom severity on risky alcohol use through the pathway of difficulties engaging in goal-directed behaviors when experiencing positive emotions was non-significant, $b = .01$, $SE = .01$, $p < .05$, 95% CI [−.01, .04], and the direct effect linking depression symptom severity with risky alcohol use when controlling for difficulties engaging in goal-directed behaviors when experiencing positive emotions was significant, $b = .06$, $SE = .02$, $t = 2.55$, $p = .01$. These findings suggest that difficulties engaging in goal-directed behaviors when experiencing positive emotions did not fully account for the association between depression symptom severity and risky alcohol use.

Finally, the model explicating the role of difficulties controlling impulsive behaviors when experiencing positive emotions in the relation between depression symptom severity and risky alcohol use is shown in Figure 3. The association between depression symptom severity and difficulties controlling impulsive behaviors when experiencing positive emotions was significant, $b = .33$, $SE = .03$, $t = 10.06$, $p < .001$, as was the association between difficulties controlling impulsive behaviors when experiencing positive emotions and risky alcohol use, $b = .10$, $SE = .03$, $t = 3.25$, $p = .001$. Furthermore, the indirect effect

of depression symptom severity on risky alcohol use through the pathway of difficulties controlling impulsive behaviors when experiencing positive emotions was also significant, $b = .03$, $SE = .01$, $p < .05$, 95% CI [.01, .06]. Notably, the direct effect linking depression symptom severity with risky alcohol use was not significant after controlling for difficulties controlling impulsive behaviors when experiencing positive emotions, $b = .04$, $SE = .02$, $t = 1.72$, $p = .09$.

Discussion

An extensive body of literature has demonstrated the high co-occurrence of depression and risky alcohol use (9, 10). Extending extant work, the goal of the present study was to better understand why depression symptom severity is associated with risky alcohol use. Specifically, we examined the role of difficulties regulating positive emotions in this association. Difficulties regulating positive emotions has been conceptualized as containing three different aspects including nonacceptance of positive emotions, difficulties engaging in goal-directed behavior when experiencing positive emotions, and difficulties controlling impulsive behavior when experiencing positive emotions (25). As expected, depression symptom severity, subscales of difficulties regulating positive emotions, and risky alcohol use were significantly positively correlated at the bivariate level. Further, two subscales of difficulties regulating positive emotions – nonacceptance of positive emotions and difficulties controlling impulsive behaviors when experiencing positive emotions – were found to account for the relation of depression symptom severity to risky alcohol use.

These findings provide support for the relevance of nonacceptance of positive emotions and difficulties controlling impulsive behaviors when experiencing positive emotions in the relation between depression and risky alcohol use. Perhaps nonacceptance of positive emotion increases distress and efforts taken to avoid such emotions (58), in turn, increases risk for engaging in maladaptive emotion regulation strategies (18), including risky alcohol use. On the other hand, difficulties controlling impulsive behaviors when experiencing positive emotions is closely associated with both inhibitory dyscontrol and impulsivity (24), both of which have been linked to risky alcohol use (59, 60). One reason why individuals with depression may be non-accepting of positive emotions is that they may be more likely to experience some secondary negative emotional state in response to stimuli that are typically positive, and therefore may develop a fear of positive emotions over time (32). These individuals may then choose to use alcohol to distract from positive emotions given their increased tendency to suppress these emotional experiences (33).

As expected, difficulties engaging in goal-directed behavior when experiencing positive emotions were significantly positively associated with depression symptom severity. Indeed, one symptom of depression is “diminished ability to think or concentrate, or indecisiveness” (61), which may interfere with goal-directed behavior by diminishing one’s ability to maintain focus on engagement in goal-directed behaviors. Additionally, the negative ruminative style characteristic of depression may lead to diminished motivation to pursue one’s goals as a result of reduced expectancies around success (62). This aligns well with behavioral theories of depression, which state that the onset and course of depression stem from a decrease in engagement in goal-directed behaviors or other positively reinforcing

behaviors (63, 64). Further, broadly speaking, the ability to pursue value-consistent, goal-directed behavior would suggest a decreased likelihood of risky alcohol use, as this behavior is generally inconsistent with one's values and long-term goals. However, while associated with depression symptom severity at the bivariate level, difficulties engaging in goal-directed behavior when experiencing positive emotions were not found to explain the association of depression symptom severity to risky alcohol use. Given this unexpected finding, it would be important for future studies to confirm this finding as well as to explore factors that influence the strength and direction (i.e., moderators) of the relations among depression symptom severity, difficulties engaging in goal-directed behavior when experiencing positive emotions, and risky alcohol use. For instance, it may be that alcohol use is consistent with the goals (e.g., social, pleasure) of some individuals with depression, which may explain why this dimension of difficulties regulating positive emotions was not found to account for the depression symptom severity-alcohol use association.

The findings of the current study should be considered within the context of several limitations. First, the cross-sectional and correlational nature of this data precludes our ability to examine the exact nature and direction of the relations of interest; our findings support examining these relations prospectively within a longitudinal framework. Further, these findings are based on self-report measures of depression symptom severity, difficulties regulating positive emotions, and risky alcohol use. It may be that individuals have poor insight into their emotional experiences or that retrospective reports of depression symptom severity and risky alcohol use were over- or under-inflated. In addition, it warrants mention that the conceptualization of emotion regulation underlying the DERS-P (17, 25, 65) differs from other frameworks of emotion regulation, such as those that (a) equate emotion regulation with temperamental characteristics of emotional intensity/reactivity (66), (b) define emotion regulation as control of emotions and reduction in emotional arousal (67), and (c) classify specific emotion regulation strategies as either adaptive or maladaptive (68, 69). Future research would benefit from exploring the various aspects of emotion regulation in relation to depression symptom severity, risky alcohol use, and their relation. Moreover, given that we examined only depression severity as a predictor of risky alcohol use in trauma-exposed individuals, generalizability of results to other populations (e.g., clinical) may be limited, and PTSD symptom severity (which is quite relevant to trauma-exposed individuals) may also be associated with risky alcohol use through difficulties regulating positive emotions. Indeed, one prior study (70) found that PTSD symptoms were indirectly related to risky behavior through positive urgency among trauma-exposed inpatients with substance dependence (83% of whom reported problematic alcohol use). Notably, however, while it is possible that our results may not directly generalize to clinical samples, it is remains important to examine these relations within non-clinical populations, which have important strengths. For instance, non-clinical samples allow researchers to identify vulnerabilities to the initial development of clinical phenomena (71), whereas research using clinical samples may only tap into processes and characteristics that maintain or exacerbate the course of a disorder. Further, non-clinical samples exhibit greater variability in clinical outcomes compared to clinical samples (which are generally more severe) (72), suggesting that non-clinical samples may capture a larger proportion of the target population. It is for these reasons that researchers have argued that the scientific study of incidence,

development, and risk for clinical disorders cannot rely solely on clinical samples (73). Finally, while the MTurk recruitment platform is a notable strength of our study (41–43), collecting data via the internet using an online format has disadvantages that may limit generalizability of results, such as sample biases (because of self-selection) and lack of control over the research environment (e.g., no opportunity to clarify questions, distractions) (74). Thus, future research that integrates other data collection methods (e.g., interviewing, focus groups) is warranted.

Despite these limitations, results of the current study extend our understanding of the role of difficulties regulating positive emotions in depression symptom severity, risky alcohol use, and their relation, and thus have important implications. First, our findings suggest that models of emotion regulation should incorporate dysfunction of positive emotional experiences, particularly as they relate to clinically-relevant outcomes such as depression and risky alcohol use. Second, results highlight the potential utility of assessing difficulties regulating positive emotions among individuals diagnosed with depression as a means of identifying those at risk for problematic alcohol use. Finally, the findings of our study suggest the potential importance of addressing difficulties regulating positive emotions in interventions aimed at reducing alcohol use among individuals with depression, specifically skills for improving nonacceptance of positive emotions (e.g., mindfulness or acceptance-based skills) and controlling impulsive behaviors in the context of positive emotions (e.g., distress tolerance skills). Overall, assessing and addressing positive emotion-based dysregulation in trauma-exposed samples experiencing concurrent depression and risky alcohol use is warranted in clinical work.

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Indirect Effect: $b = .04$, 95% CI [.01, .06]

Note: $*p < .05$, $**p < .01$, $***p < .001$

Figure 1.

Summary of Analyses Explicating the Role of Nonacceptance of Positive Emotions in the Relation between Depression Symptom Severity and Risky Alcohol Use

Indirect Effect: $b = .01$, 95% CI $[-.01, .04]$

Note: $*p < .05$, $**p < .01$, $***p < .001$

Figure 2.

Summary of Analyses Explicating the Role of Difficulties Engaging in Goal-Directed Behaviors when Experiencing Positive Emotions in the Relation between Depression Symptom Severity and Risky Alcohol Use

Indirect Effect: $b = .03$, 95% CI [.01, .06]

Note: $*p < .05$, $**p < .01$, $***p < .001$

Figure 3.

Summary of Analyses Explicating the Role of Difficulties Controlling Impulsive Behaviors When Experiencing Positive Emotions in the Relation between Depression Symptom Severity and Risky Alcohol Use

Table 1.

Sample Characteristics

	<i>M (SD)</i>	<i>n (%)</i>
<i>Age</i>	35.55 (11.07)	
<i>Gender</i>		
Male		167 (42.3%)
Female		222 (56.2%)
<i>Ethnicity</i>		
Hispanic/Latinx		53 (13.4%)
Not Hispanic/Latinx		336 (85.1%)
<i>Race</i>		
Caucasian/White		303 (76.7%)
African American/Black		39 (9.9%)
Asian		42 (10.6%)
American Indian/Alaskan Native		19 (4.8%)
Native Hawaiian/Pacific Islander		3 (0.8%)
<i>Employment Status</i>		
Full-time		284 (71.9%)
Part-time		62 (15.7%)
Unemployed		29 (7.3%)
Retired		13 (3.3%)
Unemployed Student		7 (1.8%)
<i>Relationship Status</i>		
Not dating		64 (16.2%)
Casually dating		29 (7.3%)
Seriously dating		97 (24.6%)
Married		174 (44.1%)
Divorced		18 (4.6%)
Separated		6 (1.5%)
Widowed		7 (1.8%)
<i>Index Traumatic Events</i>		
Natural disaster		53 (13.5%)
Fire or explosion		20 (5.1%)
Transportation accident		66 (16.8%)
Serious accident at work, home, or during recreational activity		13 (3.3%)
Exposure to toxic substance		2 (0.5%)
Physical assault		33 (8.4%)
Assault with a weapon		11 (2.8%)
Sexual assault		49 (12.4%)
Other unwanted or uncomfortable sexual experience		10 (2.5%)
Combat or exposure to a war-zone		4 (1.0%)
Captivity		2 (0.5%)

	<i>M (SD)</i>	<i>n (%)</i>
Life-threatening illness or injury		30 (7.6%)
Severe human suffering		5 (1.3%)
Sudden violent death		26 (6.6%)
Sudden accidental death		28 (7.1%)
Serious injury, harm, or death you caused to someone else		7 (1.8%)
Any other very stressful event or experience		22 (5.6%)

Table 2.

Descriptive Data and Intercorrelations among Variables of Interest

	1	2	3	4	5	<i>M (SD)</i>
1. Depression	1.00	.52 **	.45 **	.46 **	.18 **	7.72 (6.47)
2. DERS-P Accept		1.00	.79 **	.92 **	.22 **	6.12 (3.82)
3. DERS-P Goals			1.00	.83 **	.14 *	6.52 (3.56)
4. DERS-P Impulse				1.00	.22 **	7.54 (4.58)
5. Risky Alcohol Use					1.00	3.09 (2.56)

Note: DERS-P = Difficulties in Emotion Regulation Scale – Positive.

*
p < .01.

**
p < .001.