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Review article

Challenging assumptions from emotion dysregulation psychological treatments

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ABSTRACT

Background: Contemporary treatments assume that the inability to downregulate negative emotional arousal is a key problem in the development and maintenance of psychopathology and that lack of effective regulation efforts and a preference to use maladaptive regulation strategies is a primary mechanism. Though ubiquitous, there is limited empirical evidence to support this assumption. Therefore, the aim of the current study was to examine whether self-reported emotion dysregulation equated to difficulties reducing emotional arousal during a behavioral task and to primary use of maladaptive strategies to manage negative emotions.

Methods: 44 anxious and depressed adults with high emotion dysregulation induced negative distress using autobiographic memory recall. After induction, participants were instructed to downregulate but were not provided any specific instructions in strategies to use. Self-reported emotional arousal was assessed before and after induction and after regulation. Qualitative descriptions of regulation efforts were collected and codedinto effective and maladaptive strategies.

Results: The task was successful in inducing emotional arousal and participants were successful in their efforts to down regulate negative emotions. Additionally, effective regulation strategies were used more frequently than maladaptive strategies.

Limitations: Data collected was exclusively self-report and the sample size was small.

Conclusion: Adults who report high emotion dysregulation may still have effective emotion regulation strategies in their behavioral repertoire and are more likely to engage in these effective strategies when given an unspecific prompt to regulate negative emotional arousal. Despite reporting problems with emotion regulation, adults with anxiety and depression can successfully downregulate distress when prompted to do so.

1. Introduction

Emotions govern much of human behavior. They shape the way people perceive, remember, and respond to their environment; motivate behavior; communicate information to the self and others; and provide direction and meaning (Izard and Buechler, 1979). It is therefore not surprising that the ways adults regulate emotions can profoundly impact multiple domains of functioning. The construct of emotion regulation is defined as the set of processes through which emotions are increased, maintained or decreased, at a conscious or subconscious level (Gross and Thompson, 2007). Emotion dysregulation is therefore defined as either a failure to change an emotional response in the desired way, or as the use of regulation strategies in such a way in which the cost required has detrimental long term effects (Werner and Gross, 2010). Emotion dysregulation may also include use of maladaptive strategies, or deficits and difficulties with the mechanics of applying effective strategies (Kring and Werner, 2004).

Reported difficulties with emotion dysregulation have been conceptually and empirically linked to a range of psychiatric diagnoses including: depressive (Flynn and Rudolph, 2010; Gross and Muñoz, 1995), anxiety (Amstadter, 2008), personality (Kuo and Linehan, 2009), substance use (Axelrod et al., 2011), eating (Harrison et al., 2009, 2010; Safer and Chen, 2011), and autism spectrum (Mazefskyet al, 2014) disorders. Collectively, 85% of disorders recognized by the psychiatric Diagnostic and Statistical Manual of Mental Disorders (*DSM*) include descriptions of problems involving excesses or deficits of emotions, or lack of coherence among emotional components (Kring and Sloan, 2009). Theorists propose that disordered behaviors such as over eating, self-injury, suicide attempts, or impulsive shopping serve as maladaptive strategies for regulating emotions (e.g., Linehan,

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1993; Chapman et al., 2006). Furthermore, experiential avoidance, emotion suppression, and problematic goal setting – all maladaptive strategies for handling emotions– have been linked to a variety of psychological disorders (Kring and Sloan, 2009). Collectively, this research suggests emotion dysregulation is relevant to the development and maintenance of a large number of mental health problems.

1.1. Assumptions underlying psychotherapies targeting emotion regulation

Given this body of research, it is not surprising that emotion dysregulation is a transdiagnostic treatment target of many third wave cognitive behavioral interventions. Current psychotherapies for emotion dysregulation have focused on the fact that emotion dysregulation involves lacking effective skills to regulate emotional arousal. Skills deficits, in turn, lead to problematic behavior. For example, dialectical behavioral therapy (DBT; Linehan, 1993), emotion regulation group therapy (ERGT; Gratz and Gunderson, 2006), emotion regulation therapy (ERT; Mennin, 2006), emotion regulation skills training (Berking et al., 2008), and the unified protocol (UP; Barlow et al., 2010) all target the improvement of emotion regulation via teaching new skills across a variety of clinical populations. Despite the popularity of this view (over 215 publications on this topic in the past 10 years compared to 25 in the 10 years prior) and the success of the listed interventions (Linehan et al., 2006; Gratz et al., 2014; Mennin and Fresco, 2014; Berking et al., 2013; Farchione et al., 2012), the assumption that the best intervention target for emotion dysregulation is teaching new skills needs additional investigation.

Existing evidence provides some support for this assumption, but more experimental research is needed. Prior correlational research has shown an association between self-reported use of maladaptive emotion regulation strategies and psychopathology (for a review, see Aldao et al., 2010). In addition, reported use of problematic emotion regulation strategies (e.g., rumination) has been correlated with increased worry, anxiety, and depression among undergraduate students (Golestaneh and Sarvghad, 2013). Similarly, adults classified as vulnerable to depression have been found to spontaneously engage in emotional suppression, a problematic emotion regulation strategy, more frequently than adults who were never depressed (Ehring et al., 2010). Finally, problematic use of cognitive emotion regulation strategies of self-blame, rumination, and catastrophizing were also higher in depressed adults, relative to control subjects (Garnefski and Kraaij, 2006). By contrast, reported use of effective emotion regulation strategies (e.g., reappraisal, self-compassionate writing) have been associated with increased positive affect and decreased negative affect (Odou and Brinker, 2014).

In addition to investigations examining the relationship between specific emotion regulation strategies and clinical dysfunction, there have been numerous studies linking more global self-reported emotion regulation deficits to psychopathology. The majority of these investigations have used the Difficulties with Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) as an index of emotion dysregulation. The DERS is a 36-item self-report measure that assesses six emotion regulation difficulties that may be of relevance to clinical dysfunction: 1) lack of emotional awareness, 2) lack of emotional clarity, 3) non-acceptance of emotional responses 4) limited access to emotion regulation strategies, 5) impulse control difficulties when upset, and 6) difficulties engaging in goal-directed behavior when upset. High scores on the DERS are found in a range of clinical populations, relative to control subjects, including adults who meet diagnostic criteria for post-traumatic stress disorder (e.g., Tull et al., 2007), eating disorders (Whiteside et al., 2007), generalized anxiety disorder (Salters-Pedneault et al., 2006), and depression (Ehring et al., 2008). Collectively, these studies indicate that self-reported problems with emotion regulation are common across various forms of psychopathology.

1.2. Current study

It has been well established that difficulties managing emotions are an important target of mental health treatments. Nevertheless, what exactly about emotion dysregulation is the best target of intervention needs further assessment. In particular, the assumption underlying the majority of contemporary treatments (that addressing emotion regulation skills deficits is needed) could benefit from additional empirical investigation. In order to assess whether continuing to develop and refine skills-based intervention for emotion dysregulation is warranted, it is important to clarify whether high emotion dysregulation reflects a true skills deficit in reducing emotional arousal. As such, the aim of the present study was to begin to explore the following questions using a behavioral experiment: 1) do self-reported difficulties with emotion regulation translate into problems reducing emotional arousal?; 2) do clinical adults with high emotion dysregulation primarily use maladaptive strategies to manage emotions?; and 3) does recovery from emotion dysregulation following psychotherapy lead to reductions in use of maladaptive strategies and increased success in regulating emotions? Specifically, we hypothesized that participants with high emotion dysregulation will not be successful in down-regulating negative emotions in 3 min following a negative mood induction task. Second, we hypothesize that dysregulated participants will use more maladaptive emotion regulation strategies than adaptive strategies. Third, we hypothesized that those who recovered from emotion dysregulation following treatment would be successful at downregulating emotional arousal following a mood induction and would use more adaptive than maladaptive strategies.

2. Methods

2.1. Participants

Participants were 44 men and women with high emotion dysregulation as defined using the Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004), who met criteria for at least one current *DSM-IV-TR* mood or anxiety disorder, and who were interested in group psychotherapy for improving emotion regulation. (See Neacsiu et al., 2014 for more details on target sample and participant flow.) Participants were excluded if they (a) were at high risk for suicide or a life-threatening condition; (b) were in psychotherapy; (c) met diagnostic criteria for BPD, bipolar disorder, or a psychotic disorder; (d) were mandated to mental health treatment; (e) were homeless or sentenced to go to jail; (f) lived outside of commuting distance; (g) had received more than five sessions of outpatient dialectical behavior therapy; (h) could not understand English; (i) were 17 or younger; or (j) had an IQ of less than 70. All study procedures were approved by the University of Washington Human Subjects Division and all included participants provided informed consent.

2.2. Procedure

Interested community adults were screened on the phone or online and if eligible they were invited for an in-person screening. The screening assessment included the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First et al., 1995), the BPD module of the SCID for Axis II Disorders (SCID-II-BPD; First et al.,1997), and a verbal IQ test (PPVT-R; Dunn, 1981). More details about the measures used and their reliability can be found in the parent study (Neacsiu et al., 2014). Participants who met all inclusion criteria at the end of the in-person screening were invited to participate in the study and were randomly assigned to a treatment group. Prior to start of treatment, and right after the completion of treatment, participants returned to the lab for an assessment during which the measures presented in this sub-study were collected.

All participants were assigned to either Dialectical Behavior