



## Research report

## Emotion regulation is the essential skill for improving depressive symptoms



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## ABSTRACT

**Background:** For decades, research has shown that various skills (e.g., social skills) are associated with depressive symptoms. In recent years, much work has focused on skills for regulating emotion. Unfortunately, nearly all of these studies have investigated isolated skills. By contrast, the aim of the present study was the combined assessment of multiple skills in order to simultaneously analyze their relevance for depressive symptomatology. The authors wanted to identify skill domains that are essential for improving depressive symptoms.

**Methods:** The sample consisted of  $N=124$  inpatients assessed at admission and discharge. Seven different skills were measured using a structured multidimensional interview. In addition, the severity of depressive symptoms was assessed.

**Results:** Correlations between the improvements in skills and depressive symptoms reached significance for every skill domain ranging from  $r=.21$  to  $r=.54$ . A multiple hierarchical regression analysis was conducted with pre-treatment scores of skills. Compared to other domains, only emotion regulation significantly predicted the improvement of depressive symptomatology. Moreover, emotion regulation at pre-treatment turned out to be a moderator of the association between improvements in skills and the reduction of depressive symptoms.

**Limitations:** Because this study primarily focused on skills, no conclusions can be drawn regarding the relevance of these skills in relation to other predictors of therapy outcome.

**Conclusions:** Even when various skills are tested simultaneously, emotion regulation appears to be the essential skill influencing depressive symptom improvement. Therefore, a targeted enhancement of this skill may help to optimize the outcome regarding the treatment of depressive symptomatology.

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## 1. Introduction

Research on psychotherapy outcome has shown that psychological treatments are effective for numerous disorders (e.g., Nathan and Gorman, 2007; Shadish et al., 2000; Westin and Morrison, 2001). However, some findings also suggest that 20–40% of patients still cannot benefit sufficiently from psychotherapeutic interventions (e.g., Barlow, 2002; Mohr, 1995). Therefore, studying options for optimizing therapy outcome is still an important task for psychotherapy researchers.

Recently, the focus of interest has moved to transdiagnostic, i.e. disorder-unspecific interventions. These approaches assume that certain cognitive and behavioral processes occur across a broad range of different disorders. According to Mansell et al. (2009), the same mechanisms could contribute to the maintenance of various psychiatric diseases. Transdiagnostic interventions target these processes, thus reducing the psychopathology of two or more

disorders. Therefore, transdiagnostic interventions make sense particularly in the case of comorbidity (Stenzel et al., in press). In addition to disorder-specific approaches, transdiagnostic interventions could lead to an increase in the effectiveness of psychotherapy (Barlow et al., 2004). At present, different transdiagnostic processes are discussed. Harvey et al. (2004) give an overview including self-focused attention, rumination, and avoidance, for example.

Furthermore, skills (or rather skill deficits) can be considered relevant transdiagnostic factors. The term “skills” refers to learned or acquired behavior patterns which can be changed and enhanced by practice or experience (see Stenzel et al., in press). Several studies have demonstrated that skill deficits play an important role in the development and maintenance of mental illness (e.g., Aldao et al., 2010; Burt et al., 2008; Segrin, 2000). The relevance of stress management, relaxation, problem solving, and social competence for the prevention of depression and anxiety is highlighted by Dozois et al. (2009).

Current literature confirms Dozois’ view that deficits in skills seem to be associated with depressive symptoms. For example, findings indicate significant correlations with social skill deficits

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(Segrin and Rynes, 2009). A recent meta-analysis across 26 studies calculated a medium effect size for the negative association between depression and problem solving (Aldao et al., 2010). In addition, Hong (2007) demonstrated that the extent of problem solving ability could predict changes in depressive symptomatology over time. Stetter and Kupper (2002) found positive effects of self-relaxation for mild-to-moderate depression and dysthymia. In recent years, more attention has been given to the skills needed to regulate emotions (Gross, 1998; 2009). Some authors consider emotion regulation skills to be important factors concerning vulnerability and resilience to anxiety and mood disorders (see Campbell-Sills and Barlow, 2009). Results of Garnefski et al. (2004) emphasized that maladaptive emotion regulation strategies were related to depressive symptoms.

These findings reveal the importance of considering skills in treatments for improving depressive symptoms. Unfortunately, most research in this field has almost exclusively focused on isolated skills. To date, studies including more than one skill are lacking. This is problematic because no clear statements can be made about the relevance of any particular skill compared to others. The lack of appropriate assessment instruments might be one possible reason for this deficit in research. In fact, until very recently there was no inventory that allowed a combined measurement of multiple treatment-relevant skills. To fill in this gap, the “Operationalized Skills Assessment Inventory” (Stenzel et al., 2010; Stenzel and Rief, 2011) was developed. This structured interview consists of seven scales assessing five skills (problem solving, social competence, stress management, relaxation ability, and emotion regulation) and two self-concepts (self-efficacy and self-esteem). Strictly speaking, the latter two actually do not represent “skills” but were included in the interview because of their relevance for the development and maintenance of mental disorders (Stenzel et al., in press). For reasons of simplification, they were subsumed under the umbrella term “skills” and we will refer to them as skills in the following.

Given this background, the aim of the present study was the simultaneous assessment of various skills in order to analyze their relevance for the improvement of depressive symptoms as therapy outcome. More specifically, three questions should be answered:

- (1) Does the level of skills predict the improvement of depressive symptoms? We expected that higher levels of skills at the beginning of therapy would predict a better improvement of depressive symptomatology.
- (2) Which skills are particularly relevant predictors of treatment success?
- (3) Which improvements in skills are associated with the improvement of depressive symptoms?

Since this was the first study to examine the relevance of multiple skills in comparison to each other we did not make further predictions concerning the last two questions.

## 2. Methods

### 2.1. Participants

The sample consisted of  $N=124$  inpatients treated in one of three mental-health hospitals in Germany (Schön Klinik Bad Arolsen: 56.5% of participants, Salus Klinik Lindow: 29.8%, St. Franziska-Stift Bad Kreuznach: 13.7%). All hospitals provided complex treatments, including medication, psychotherapy in individual as well as in group settings, sports therapy, ergotherapy, and nutrition counseling, for example. The mean age

of participants was  $M=45.47$  years ( $SD=11.30$ ). Almost 67% of them were female and the most frequent primary diagnosis was affective disorder (67.7%). Exclusion criterion was a primary diagnosis other than affective, anxiety or somatoform disorder. Patients with psychosis or addiction, under 18 years of age, or unable to sufficiently understand German were also excluded. See Table 1 for a detailed overview of sample characteristics.

### 2.2. Assessment instruments

**Structured Clinical Interview for DSM-IV.** Diagnoses were evaluated by trained interviewers using the German version of the Structured Clinical Interview for DSM-IV (SCID; German: Wittchen et al., 1997). Apart from the SCID-I interview, the SCID-II interview was also conducted in order to diagnose comorbid personality disorders. One hospital (Salus Klinik Lindow) used another system called “Clinic Control” and the authors of the present study adopted these diagnoses for the analyses.

**Operationalized Skills Assessment Inventory.** The Operationalized Skills Assessment Inventory (German: “Interview zur Operationalisierten Fertigkeitendiagnostik”, OFD; Stenzel et al., 2010; Stenzel and Rief, 2011) is a structured interview. It assesses problem solving, social competence, stress management, relaxation ability, emotion regulation, self-efficacy, and self-esteem. Although these constructs show some intercorrelations, they are not equivalent. Each of them is assessed on three to five subscales. The trained interviewer orally presents specific situations to the interviewee. The interviewee’s task is to describe how he or she would behave in such a situation. Afterwards, the interviewer rates the skill level of the described behavior using a behaviorally anchored five-point Likert scale. Validation studies with clinical and non-clinical samples showed adequate psychometric properties (Stenzel et al., 2010; Stenzel and Rief, 2011). Reliability was satisfying to good ( $r=.86-.90$ ). Confirmatory factor analyses supported the factorial structure of the interview and correlations with well-established questionnaires indicated convergent validity ( $r=.43-.81$ ). Moreover, results showed a high inter-rater reliability ( $r_{icc}=.86-.98$ ) as well as a high sensitivity to change ( $SRM=.61-1.53$ ).

**Beck Depression Inventory-II.** The Beck Depression Inventory-II (BDI-II; German: Hautzinger et al., 2006) contains 21 items that

**Table 1**  
Overview of sample characteristics ( $N=124$ ).

| Variable                             | Number        | %    |
|--------------------------------------|---------------|------|
| BDI <sub>pre</sub> $M$ ( $SD$ )      | 24.85 (9.58)  |      |
| Length of stay in days, $M$ ( $SD$ ) | 46.59 (12.12) |      |
| Age in years, $M$ ( $SD$ )           | 45.47 (11.30) |      |
| Sex                                  |               |      |
| Male                                 | 41            | 33.1 |
| Female                               | 83            | 66.9 |
| Marital status <sup>a</sup>          |               |      |
| Unmarried                            | 43            | 34.7 |
| Married                              | 64            | 51.6 |
| Divorced                             | 16            | 12.9 |
| Years of education <sup>a</sup>      |               |      |
| 9                                    | 45            | 36.3 |
| 10                                   | 35            | 28.2 |
| 12 and more                          | 43            | 34.7 |
| Primary diagnosis                    |               |      |
| Affective disorder                   | 84            | 67.7 |
| Anxiety disorder                     | 27            | 21.8 |
| Somatoform disorder                  | 13            | 10.5 |
| Number of diagnoses                  |               |      |
| 1                                    | 54            | 43.5 |
| 2 and more                           | 70            | 56.5 |

Note. <sup>a</sup> Some data do not add up to  $N=124$  and accordingly 100% because of missing information.

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