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Self-compassion enhances the efficacy of explicit cognitive reappraisal as an emotion regulation strategy in individuals with major depressive disorder

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ABSTRACT

Cognitive reappraisal has been shown to be an effective strategy to regulate depressed mood in healthy and remitted depressed individuals. However, individuals currently suffering from a clinical depression often experience difficulties in utilizing this strategy. Therefore, the goal of this study was to examine whether the efficacy of explicit cognitive reappraisal in major depressive disorder can be enhanced through the use of self-compassion and emotion-focused acceptance as preparatory strategies. Thereby, explicit cognitive reappraisal refers to purposefully identifying, challenging, and modifying depressiogenic cognitions to reduce depressed mood. To test our hypotheses, we induced depressed mood at four points in time in 54 participants (64.8% female; age $M = 35.59$, $SD = 11.49$ years) meeting criteria for major depressive disorder. After each mood induction, participants were instructed to either wait, or employ self-compassion, acceptance, or reappraisal to regulate their depressed mood. Depressed mood was assessed before and after each mood induction and regulation period on a visual analog scale. Results indicated that participants who had utilized self-compassion as a preparatory strategy experienced a significantly greater reduction of depressed mood during reappraisal than did those who had been instructed to wait prior to reappraisal. Participants who had used acceptance as a preparatory strategy did not experience a significantly greater reduction of depressed mood during subsequent reappraisal than those in the waiting condition. These findings provide preliminary evidence that the efficacy of explicit cognitive reappraisal is moderated by the precursory use of other emotion regulation strategies. In particular, they suggest that depressed individuals might benefit from using self-compassion to facilitate the subsequent use of explicit cognitive reappraisal.

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With a life-time prevalence of 16.6%, major depressive disorder (MDD) constitutes an important health problem (Kessler et al., 2005) that is associated with significant morbidity, mortality, disability, and emotional anguish for patients and their families (Murray & Lopez, 1997). Unfortunately, many patients fail to respond to empirically-based treatments (e.g., DeRubeis et al., 2005; Rush et al., 2006), and even those who do respond, remain impaired due to residual symptoms (Judd et al., 1998; Judd, Akiskal, & Paulus, 1997) or relapse (e.g., Thase et al., 1992; Vittengl, Clark, Dunn, & Jarrett, 2007). Given that deficits in emotion regulation (ER) have lately been discussed as a potentially maintaining factor in depression (Berking, Ebert, Cuijpers, & Hofmann, 2013; Hofmann, Sawyer, Fang, & Asnaani, 2012; Mennin, Holaway, Fresco, Moore, & Heimberg, 2007), the efficacy of current treatments for MDD might be improved by focusing more strongly on teaching patients adaptive ER skills which in turn might facilitate recovery from depression (Mennin & Fresco, 2009).

Adaptive ER refers to a goal-directed and flexible application of ER skills with regard to environmental demands (Aldao, Sheppes, &

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Gross, 2015; Gross, 2014; Sheppes et al., 2014). Consistent with this perspective on ER, the Adaptive Coping with Emotions (ACE) model (Berking & Whitley, 2014) conceptualizes adaptive ER as a situation-dependent interaction between the following ER skills: (1) the ability to be consciously aware of emotions, (2) the ability to identify emotions, (3) the ability to correctly label emotions, (4) the ability to identify what has caused and what maintains one's present emotions, (5) the ability to actively modify emotions, (6) the ability to accept and (7) tolerate undesired emotions when they cannot be changed, (8) the ability to approach situations that are likely to trigger negative emotions if necessary to attain personally relevant goals, and (9) the ability to provide compassionate self-support when working to cope with challenging emotions. The ACE model postulates that when it comes to the *reduction* of mental health problems, the ability to modify undesired emotions is most important among these skills (Berking & Whitley, 2014).

One of the most widely studied ER skills aiming at modifying negative emotions is cognitive reappraisal (CR; e.g., Gross, 2002; Gross & John, 2003; McRae, Jacobs, Ray, John, & Gross, 2012). CR has been defined as cognitively "construing a potentially emotion-eliciting situation in a way that changes its emotional impact" (Gross & John, 2003, p. 349). According to cognitive theories of depression, dysfunctional cognitive processes play an important role in the development and maintenance of depression (Beck & Haigh, 2014; Teasdale & Barnard, 1993; for critical reviews, see; Coyne & Gotlib, 1983 or; Haaga, Dyck, & Ernst, 1991). Hence, replacing depressogenic automatic appraisals with alternative evaluations of the situation (i.e., CR) can be assumed to have the potential to reduce negative emotions and associated symptoms in depression (Gotlib & Joormann, 2010). Several forms of CR exist (McRae, Ciesielski, & Gross, 2012). An explicit form of CR that is - among other cognitive strategies - often used in traditional cognitive (behavioral) therapy for depression consists of: (a) becoming aware of the thoughts cueing undesired affective states, (b) reflecting upon/testing the validity/consequences of these thoughts, (c) purposefully developing more valid/helpful thoughts, and (d) using these thoughts to modify one's feelings (e.g., Beck, 2011). This form of CR is not equal to the more complex process of cognitive restructuring, but may contribute to the restructuring of dysfunctional beliefs and thus the reduction of depression in the long-term. Empirical support for the anti-depressive effects of CR comes from studies indicating that CR is negatively associated with depression in non-clinical samples, both concurrently (see e.g. Aldao & Nolen-Hoeksema, 2010; Aldao, Nolen-Hoeksema, & Schweizer, 2010; Garnefski & Kraaij, 2006; Garnefski, Boon, & Kraaij, 2003) and prospectively (e.g., Kraaij, Pruymboom, & Garnefski, 2002). Further evidence originates from studies demonstrating that experimentally induced CR helps healthy and recovered depressed individuals to reduce negative emotions (e.g., Ehring, Tuschen-Caffier, Schnülle, Fischer, & Gross, 2010; Rood, Roelofs, Bögels, & Arntz, 2012) and from studies showing that cognitive (behavioral) therapy is an efficacious treatment for depression (Butler, Chapman, Forman, & Beck, 2006; Cuijpers et al., 2013; Dobson, 1989). However, some empirical findings also indicate that individuals scoring high on indicators of neuroticism (as trait found to be associated with depression; Jylhä & Isometsä, 2006) and depressed individuals themselves have difficulties in reappraising negative emotions (Barnow, Arens, & Balkir, 2011; Ehret, Joormann, & Berking, submitted; Ng & Diener, 2009a, b). CR relies heavily on cognitive executive functions – which are likely to be impaired in depressed individuals (Fossati, Ergis, & Allilaire, 2001; Gotlib & Joormann, 2010). Moreover, accessing more helpful cognitions by reappraising an emotion eliciting situation is a challenging task when these cognitions are incongruent with emotional and somatic states associated with depression (Gotlib & Joormann, 2010; Joormann & Siemer, 2004; Singer & Salovey, 1988). Hence, prior research also shows that depressed individuals do not always benefit from CR (Arditte & Joormann, 2011; Diedrich, Grant, Hofmann, Hiller, & Berking, 2014).

These arguments and the inconsistent findings in the literature about the efficacy of CR raise the question whether factors moderating the efficacy of CR in depressed individuals can be identified. Unfortunately, research on the efficacy of ER strategies has so far neglected the moderating effects of contextual factors (Aldao, 2013; Coifman & Bonanno, 2010). Because of the dynamic nature of the ER process - likely involving the sequential or coactive implementation of multiple ER strategies during a given period of time - the complementary use of other ER strategies appears to be a promising candidate for such a significant contextual factor (Aldao, 2013; Berking, 2007; Berking & Schwarz, 2013; Berking & Whitley, 2014, pp. 19–27). Consistently, the ACE model includes the hypothesis that the efficacy of modification-focused strategies such as CR may be moderated by ER strategies used prior to (or in combination with) CR (Berking & Whitley, 2014). More specifically, Berking and Whitley (2014) assume that compassionate self-support and acceptance of one's current feelings are two ER strategies that may facilitate the utilization of modification-focused strategies such as CR. According to commonly applied definitions, *compassion* refers to the "sympathetic consciousness of others' distress together with a desire to alleviate it" (Merriam-Webster, 2014). Hence, *self-compassion* can be defined as a compassionate response towards one's own suffering (Berking & Whitley, 2014, p. 22; Berking, 2007; Gilbert, 2009; Weissman & Weissman, 1996). The concept of *emotion-focused acceptance* involves the openness to internal affective experiences and the willingness to remain in contact with them even if they are painful (Campbell-Sills, Barlow, Brown, & Hofmann, 2006). Both self-compassion and acceptance have been shown to effectively reduce the intensity of challenging affective states in depression (Diedrich et al., 2014; Liverant, Brown, Barlow, & Roemer, 2008; MacBeth & Gumley, 2012; Singer & Dobson, 2009).

Reasons to assume that self-compassion can also be used to facilitate CR in depressed individuals include the following. First, compassion involves empathy which can be considered a basic affective response (Singer & Lamm, 2009) that is generated in affect generating systems and taxes the resources of these systems (Singer, Seymour, O'Doherty, Kaube, Dolan, & Frith, 2004). As the affect-generating systems have limited processing capacities (Teasdale & Barnard, 1993), eliciting an affective compassionate response (i.e., empathy) towards the self can be assumed to replace affective states that are typically associated with depression (e.g., depressed mood) and that have been shown to interfere with accessing and utilizing positive cognitions (e.g., Joormann & Gotlib, 2007; Koster, De Raedt, Leyman, & De Lissnyder, 2010; Segal et al., 2006). Secondly, the compassionate response includes a supportive attitude towards the suffering self which can be assumed to interfere with depressogenic self-criticism likely to be cued during challenging tasks (such as utilizing CR) in depression-prone individuals (Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Luyten et al., 2007; Mongrain & Leather, 2006). Thirdly, the action tendency associated with compassion is to help the suffering individual (Leiberg, Klimecki, & Singer, 2011). Therefore, self-compassion can be assumed to strengthen the motivation to engage in promising self-help strategies (such as CR) even if they are difficult to initiate and maintain (Berking & Whitley, 2014, p. 22). This effect may be particularly important in depressed individuals likely to suffer from motivational deficits when it comes to active problem solving (McFarland, Shankman, Tenke, Bruder, & Klein, 2006).

Additionally, it has been argued that the positive effects of self-

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