Emotion Regulation Protects Against Recurrence of Depressive Symptoms Following Inpatient Care for Major Depressive Disorder

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Relapse following response in psychotherapy for major depressive disorder (MDD) is a major concern. Emotion regulation (ER) has been discussed as a putative emerging and maintaining factor for depression. The purpose of the present study was to examine whether ER protects against recurrence of depression over and above residual symptoms of depression following inpatient care for MDD. ER skills (ERSQ-ES) and depression (HEALTH-49) were assessed in 193 patients with MDD (age, M = 47.4, SD = 9.6, 75.1% female, 100% Caucasian) at treatment discontinuation, 3 and 12 months after treatment. Multiple hierarchical regressions were used to examine general and specific ER as predictors of depressive symptoms at follow-ups. Higher general ER predicted lower depression over and beyond residual symptoms of depression at 3-month follow-up among treatment responders but not among treatment nonresponders. With regard to specific ER skills, readiness to confront and acceptance of undesired emotions predicted lower depressive symptoms beyond residual symptoms of depression 12 months, respectively 3 and 12 months after treatment. Findings of the present study indicate that targeting general ER might be more important for remitted and less important for nonremitted patients. Enhancing ER should hence be realized in a sequential treatment design, in which a continuation phase treatment with a specific focus on ER directly follows, once patients sufficiently responded to treatment. Acceptance of undesired emotion and readiness to confront situations that cue these emotions appear to be particularly important for protecting against recurrence of depression. Future research should clarify whether findings can be generalized to outpatient care.

Keywords: depression; psychotherapy; emotion regulation; acceptance; relapse

Major depressive disorder (MDD) is a highly prevalent mental disorder (Donohue & Pincus, 2007). Due to its often recurrent nature and chronic effects, MDD is the leading cause of disability in the world, and it ranks fourth among mental disorders in terms of mortality (Andrews, 2008). Despite ample
Evidence for the efficacy of psychotherapy in treating MDD (Cuijpers et al., 2013), recent meta-analyses show that between 40% to 60% of patients with MDD relapse after initial response to acute phase treatment (Vittengl, Clark, Dunn, & Jarrett, 2007). Therefore, there is a pressing need to identify potential risk factors of relapse as well as potential preventative factors for relapse in depression. Such knowledge could improve depression care, long-term treatment response, and may result in reducing the lifetime disabling effects of depression (Bockting et al., 2011).

Emotion regulation (ER) has been discussed in terms of ER deficits as a putative emerging and maintaining factor for depression (Brockmeyer et al., 2012). ER refers to the set of processes through which people seek to monitor, evaluate, and redirect the spontaneous flow of their emotions to accomplish their needs and goals (Koole, 2009). Based on the assumption that deficits in ER may be accountable for the development, maintenance, and recurrence of numerous mental disorders, Berkling proposed the Adaptive Coping with Emotions (ACE) model (Berkling & Whitley, 2014). The ACE model has been empirically validated (Berkling, Meier, & Wupperman, 2010; Berkling & Znoj, 2008) and serves as the underlying model for the current study. It synthesizes and extends previous models of ER, and it facilitates the utilization of the previously abstract and broad concept of ER in clinical research. The model conceptualizes adaptive ER as a situation-dependent interaction of the skills to (1) be aware of emotions, (2) correctly interpret emotion-related body sensations, (3) identify and label emotions, (4) understand the prompts of emotions, (5) accept aversive emotions, (6) tolerate aversive emotions, (7) provide compassionate self-support in challenging situations, (8) confront and approach situations likely to trigger aversive emotions, and (9) modify aversive emotions to feel better. In the ACE model, the ER skills of acceptance, tolerance, and modification of aversive emotions are assumed to be most significant for mental health, whereas the other skills are assumed to play solely a facilitating role in the successful application of the three aforementioned skills (Berkling & Whitley, 2014).

Empirical evidence for the relevance of the skills included in the ACE model comes from numerous studies. For example, cross-sectional results showed that depressed individuals find difficulty in using ER skills to accept aversive emotions (Ehring, Fischer, Schnu, Bo, & Tuschen-Caffier, 2008), to compassionately support themselves when experiencing negative emotions (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006), and to modify emotions effectively (Brockmeyer et al., 2012). Furthermore, other cross-sectional studies have indicated that depressive symptoms negatively correlate with additional ER strategies that are considered adaptive, such as positive reappraisal and problem solving (Aldao, Nolen-Hoeksema & Schweizer, 2009). Cross-sectional findings have also provided evidence that depressive symptoms positively correlate with ER strategies that are considered to be dysfunctional (Aldao & Nolen-Hoeksema, 2010; Aldao et al., 2009). Furthermore, longitudinal studies suggest that deficits in ER are not only a symptom of depression but may also be a relevant factor for development of depression. For example, prospective studies indicated that self-reported ruminative handling of aversive emotions was a predictor of symptoms and diagnoses of depression (Aldao et al., 2009; Nolen-Hoeksema, 2000). Additionally, in a study including individuals suffering from at least some depressive symptoms, ER skills predicted subsequent depressive symptom severity even after a 5-year period (Berking, Wirtz, Svaldi, & Hofmann, 2014). Recently, Radkovsky, McArdle, Bockting, and Berking (2014) showed that a successful application of ER skills was associated with lower levels of depressive symptoms, and improved successful skill application was associated with a decrease in depressive symptoms over the course of MDD treatment.

Beyond the demonstrated importance of ER for the development and maintenance of depression, we are interested in the significance of ER during the course of depression following treatment. Since predictors for the onset of the first depressive episode and for subsequent episodes may be different (Monroe, Rohde, Seeley, & Lewinsohn, 1999), it is important to investigate whether ER remains a predictor for depression even after treatment of MDD. To the best of our knowledge, there are no studies analyzing whether general ER predicts subsequent depressive symptoms following CBT for MDD at this point. Moreover, there is yet no research on the potentially different relevance of specific ER skills on the course of depression following CBT.

We argue that ER may be especially important for the subsequent course of depression after treatment because of several reasons. First, we assume that processes for the first onset of depression and recurrence or relapse may be similar in the sense that adaptive ER may not only prevent depressive thought patterns from activation but also from reactivation, decreasing the likelihood for MDD relapse (Jarrett et al., 2012). Second, in contrast to the first onset, daily hassles, not serious life events, may present a higher risk for relapse into depression (Bockting et al., 2006a, b). Thus, the ability to successfully deal with negative emotional consequences activated by daily hassles may be of particular importance for persons with a history of depression.
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