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Delineating Components of Emotion and its Dysregulation in Anxiety and Mood Psychopathology

Douglas S. Mennin
Yale University
Robert M. Holaway
Temple University
David M. Fresco, Michael T. Moore
Kent State University
Richard G. Heimberg
Temple University

Two studies sought to elucidate the components of emotion and its dysregulation and examine their role in both the overlap and distinctness of the symptoms of 3 highly comorbid anxiety and mood disorders (i.e., generalized anxiety disorder, major depression, and social anxiety disorder). In Study 1, exploratory factor analyses demonstrated that 4 factors—heightened intensity of emotions, poor understanding of emotions, negative reactivity to emotions, and maladaptive management of emotions—best reflected the structure of 4 commonly used measures of emotion function and dysregulation. In Study 2, a separate sample provided support for this 4-factor model of emotion dysregulation. Poor understanding, negative reactivity, and maladaptive management were found to relate to a latent factor of emotion dysregulation. In contrast, heightened intensity of emotions was better characterized separately, suggesting it may relate more strongly to dispositional emotion generation or emotionality. Finally, the 4 components demonstrated both common and specific relationships to self-reported symptoms of generalized anxiety disorder, major depression, and social anxiety disorder.

Address correspondence to Douglas S. Mennin, Ph.D., Department of Psychology, Yale University, P.O. Box 208205, New Haven, CT 06520, USA; e-mail: doug.mennin@yale.edu.

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Approaches to understanding and treating anxiety and mood disorders have advanced considerably since the advent of *DSM-III* (American Psychiatric Association, 1980), at which time the overarching diagnostic syndromes of neuroses were first divided into discrete categories based on symptom content. For generalized anxiety disorder (GAD), major depressive disorder (MDD), and social anxiety disorder (SAD), which are the most impairing disorders outside of substance use (Kessler, Chiu, Demler, Merikangas, & Walters, 2005), the diagnostic movement toward greater specificity provided an opportunity for delineation of core elements of these conditions, including worry in GAD, anhedonia in MDD, and fear of evaluation in SAD. Increased precision in conceptual focus also led to greater success in treatments for these disorders (e.g., Borkovec & Costello, 1993; Heimberg et al., 1998; Jacobson et al., 1996).

Despite these advances, GAD, MDD, and SAD are characterized by high levels of comorbidity, particularly with one another. In fact, the high rate of comorbidity between GAD and MDD has led to calls to combine these disorders in *DSM-V* into a "distress disorder" category (e.g., Watson, 2005). SAD is the next most frequent comorbid condition for both GAD and MDD. Further, SAD can be a difficult differential diagnosis when these other disorders are present given its characteristics of social worry (Mennin, Heimberg, & Jack, 2000) and lack of positive affect (Brown, Chorpita, & Barlow,

1998; Kashdan, 2004), components central to GAD and MDD, respectively. Comorbidity among these disorders has been associated with greater symptom severity and poorer functioning (e.g., Mennin et al., 2000; Stein & Heimberg, 2004). This high level of comorbidity also challenges the notion of these disorders as purely independent entities and suggests that delineation of *both* common and specific factors may provide further explanation of the nature of these conditions.

Studies of the anxiety and mood disorders, utilizing structural modeling, offer evidence for the importance of emotional processes common to these conditions (Brown et al., 1998; Shankman & Klein, 2003; Watson, Clark, & Carey, 1988; Zinbarg & Barlow, 1996). These investigations offer support for the *tripartite model* of emotional disorders, wherein a higher-order factor of negative affect or neuroticism accounted for much of the overlap among anxiety and mood disorders, particularly for the most strongly comorbid disorders, such as GAD and MDD (Mineka, Watson, & Clark, 1998). These findings suggest that emotional factors can aid in understanding the interplay of these disorders. In addition to being an index of commonality, however, affective features can also distinguish GAD, MDD, and SAD. The tripartite model demonstrates that anxious arousal appears to be more specific to fear-based disorders such as SAD and low positive affect appears more relevant for MDD and SAD (Watson, 2005). Also, each of these disorders is associated with a prominent, central, emotional element—fear in SAD, anxiety in GAD, and sadness in MDD—suggesting that although some emotional characteristics may be common to these disorders, others may help distinguish them. Delineating core emotional features may help clarify both the overlap and uniqueness among these disorders.

Emotion Function and Regulation

Contemporary theories define emotion as an adaptive, goal-defining aspect of experience that aids in decision-making, specifically, movement toward or away from particular actions or plans (e.g., Frijda, 1986). Knowledge of how typically functional emotional processes become dysfunctional and, in turn, become associated with psychopathology may improve our understanding of how these conditions interrelate and can be distinguished. Further, a greater understanding of emotion may also provide a broader framework for understanding how cognitive, behavioral, interpersonal, and biological factors are involved in the etiology and successful treatment of these conditions. Indeed, a number of investigators of psychopathology and clinical psychology (e.g., Barlow, 2002; Kring & Werner, 2004) have begun to draw from emotion theory and the contemporary study of emotion (see Davidson, Scherer, & Goldsmith 2003, for an introduction to this field of investigation).

Greater levels of negative emotions (and for MDD and SAD, diminished positive affect as well; cf. Watson, 2005) appear to be central to the symptomatology of GAD, MDD, and SAD. However, characteristic differences in emotionality may only be one way by which these disorders could be integrated and distinguished. In addition, an inability to respond effectively to one's intense emotional experiences may comprise another pathway for emotions to relate to psychopathology. As Frijda (1986) has commented, "people not only have emotions, they also handle them" (p. 401). The field of emotion regulation examines how individuals influence, manage, experience, and express their emotions (Gross, 1998). Regulating emotions to conform adaptively to a given context appears important to well-being (cf. Mayer, Salovey, & Caruso, 2004) and to the promotion of mental health (cf. Kring & Werner, 2004). Subsequently, in addition to emotionality or greater emotional intensity, the dysregulation of emotions may also be important to understanding GAD, MDD, and SAD.

Various factors may contribute to whether emotions are regulated effectively. Individuals who are able to recognize emotional experiences, understand their meaning, utilize their informational value, and manage their experience and expression of emotion in a context-appropriate manner appear most able to respond effectively to life's demands (see Mayer et al., 2004). This set of abilities is often referred to as *emotional intelligence*. Similarly, following the theoretical approaches of Thompson (1990) and Gross (1998), Rottenberg and Gross (2003) caution that, when looking at the relationship between emotion dysregulation and psychopathology, investigators need to recognize that regulation occurs dynamically throughout different points in the emotion generative process. As such, problems in initial generation of emotions, and subsequent difficulties in interpreting and utilizing these emotions, may be just as important to dysregulation as how emotions are managed.

A Model of Emotion and its Dysregulation in Anxiety and Mood Disorders

Given the possibility that dysfunction of emotional processes may occur at points of generation, understanding, reactivity, and regulation, overarching frameworks are necessary to help organize inquiry into the role of emotion factors in psychopathology

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