Journal of Contemporary Psychotherapy (2019) 49:71–77
https://doi.org/10.1007/s10879-018-9393-z

ORIGINAL PAPER

Cognitive Behavioural Therapy for Mild-to-Moderate Transdiagnostic Emotional Dysregulation

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Published online: 10 April 2018

Abstract
Recent research has found that emotional dysregulation is a transdiagnostic feature across a range of common mental health difficulties and within the general population. However, existing treatment for emotional dysregulation is typically long-term, intensive or focused on personality constructs. The aims of this paper are to (1) present a transdiagnostic cognitive model of emotional dysregulation (2) present a short-term cognitive behavioural therapy intervention for mild-to-moderate presentations of emotional dysregulation.

Keywords Cognitive therapy · Cognitive behavioural therapy · Emotional dysregulation · Depression · Anxiety · Continuum

Introduction

Emotional dysregulation, or affective instability, is one of a number of criteria for a diagnosis of borderline personality disorder (BPD; DSM-V; APA 2013). It has been suggested that it is the primary difficulty within BPD (Winsper 2017). However, there is a growing body of evidence suggesting that difficulties with emotional dysregulation operate dimensionally across the population rather than being limited to personality disorders (Kendler et al. 2011; Livesley 2007; Marwaha et al. 2013; Sloan et al. 2017).

Cuthbert and Insel (2013) and the National Institute of Mental Health Research Domain Criteria (RDOC) group have argued for the importance of studying dimensional aspects of distress rather than traditional categorical approaches. In their review of treatments for emotional regulation, Sloan et al. (2017) called for continuing development of adjunctive transdiagnostic treatments to augment the existing evidence base.

Emotion regulation has been defined as the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions (Gross 2013). Conversely, Koenigsberg (2010) has discussed a definition of *emotional dysregulation* to include affective category shifts, disturbances in affect intensity, excessively rapid emotion rises and delayed returns to baseline, excessive reactivity to psychosocial cues and overdramatic affective expression.

Evidence has been found that such emotional experiences are normally distributed across the population. For instance, Marwaha et al. (2013) using the Adult Psychiatric Morbidity Survey (APMS; 2007; N = 7403) found the prevalence of affective instability was 13.9%, indicating that emotional dysregulation was relatively common. The majority of people reporting emotional dysregulation difficulties had no diagnosable psychiatric illness though, controlling for BPD, emotional dysregulation was highly correlated with a wide variety of common mental health difficulties. It was also linked with suicidal ideation and being in treatment for mental health problems. This prevalence was significantly larger than the likely BPD population (generally estimated at 1%; Lenzenweger et al. 2007).

Kendler et al. (2011) found similar support for a normal distribution to emotional dysregulation in a large Norwegian cohort study (n = 44,112) as have other cohort studies in the Netherland, Belgium and Australia (Distel et al. 2007, 2009).

Emotional dysregulation has been identified as a clinically relevant issue in patients with a wide number of clinical disorders including: eating disorders (Harrison et al. 2009; Ruscitti et al. 2016), generalized anxiety disorder (GAD; Mennin et al. 2015), substance use disorder (Dvorak

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et al. 2014) unipolar and bipolar depression (Ehring et al. 2010; Liu and Thompson 2017) as well as ADHD (Shaw et al. 2014).

These data, among others, suggest that emotional dysregulation exists at different levels of severity within BPD, across a range of common mental health difficulties and within the general population.

Clients whose primary presenting problem is mild-to-moderate emotional dysregulation fall between diagnostic and therapeutic categories. Although often very distressed, psychological assessments indicate that they do not have "disordered" personality structures. Nor do they meet classic presentations for mood or anxiety disorders. As has been noted by others, most clearly they appear to present with emotional dysregulation of medium severity (Krueger and Tackett 2005; Raju et al. 2012). Although, this does not fit with classical "Axis I", "Axis II" divisions, these presentations fit well with emerging epidemiological data discussed above.

The "categorical" difficulty is also seen in choosing interventions, in that personality or schema-based treatments are often too long or too intense for the needs of these patients and classic CBT for depression or anxiety does not address the emotional dysregulation itself.

A wide range of psychological models have discussed emotional dysregulation: for instance schema therapy (Fassbinder et al. 2016), biosocial theory (Carpenter and Trull 2013), object relations theory (Huprich et al. 2017), mentalisation-based treatment (Bateman and Fonagy 2013). Primarily, these models have focused on the expression of emotional dysregulation as seen in BPD.

In this paper, the authors discuss a cognitive model of emotional dysregulation separate from BPD and a specific cognitive behavioural therapy (CBT) intervention for mild-to-moderate emotional dysregulation difficulties.

A Cognitive Maintenance Model of Emotional Dysregulation

The proposed model is cognitive in that the underlying cause of distress is understood as negative core beliefs and schema. The primary trigger is a cognitive appraisal of a situation (Fig. 1). The maintaining factors of distress are cognitive and behavioural reactions to emotion. Although it incorporates an attachment perspective (Marganska et al. 2013), it is focused on change in the here-and-now through addressing maintaining factors.

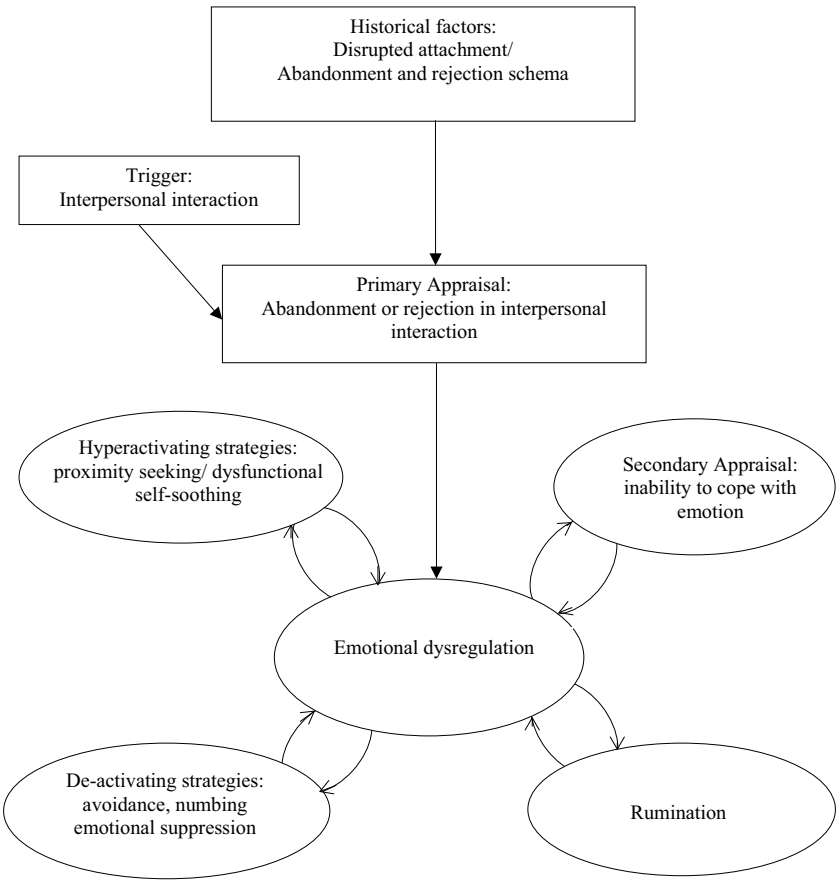

Fig. 1 A cognitive maintenance model of emotional dysregulation

Schema

The proposed model suggests that emotional dysregulation is driven primarily by underlying core beliefs of not being loved or loveable, not being capable, and that others will leave or be rejecting. This is in line with common models of psychopathology and emotional dysregulation (Barrett 2013; Leahy et al. 2011). It is proposed that these core beliefs are formed by early disrupted attachment and early experiences of rejection or partial attachment with care-givers (Mikulincer and Shaver 2012). This leads to a long-term vulnerability to emotional dysregulation in adult life similar to that experienced in early life (Bosmans et al. 2010; Marganska et al. 2013). Insecure attachment has been repeatedly empirically linked to emotional dysregulation (e.g. Brumariu 2015; Scott et al. 2013).

Primary Appraisal

Within the process model of emotional regulation (Gross 2015b), appraisals are understood as a fundamental part of the emotional regulation process. The authors suggest that commonly in emotional dysregulation, interpersonal interactions are appraised as rejecting and trigger negative schemas about the self and others and lead to an increase in dysregulation (Brenning and Braet 2013; Mikulincer and Shaver 2012; Van Dijke and Ford 2015).

The experience of dysregulation includes: physical dysregulation (e.g. hyperarousal, increased agitation, distress, insomnia, "panicky feelings", or numbing) and emotional dysregulation (e.g. anger, anxiety, sadness, guilt, shame increased to a point of significant distress) (Koenigsburg 2010).

Maintaining Factors

It is proposed that the severity and length of the experience of emotional dysregulation is determined by a range of maintaining factors: such as secondary appraisals, hyper-activating attachment strategies, de-activating attachment strategies, rumination.

Secondary Appraisals

Dysregulated emotions are appraised as overwhelming and dangerous. For instance, '*I won't be able to cope with these feelings'*; '*this is too much'; 'this is over-whelming'*. There is evidence that appraisals such as these increase the level of dysregulation further (Mikulincer et al. 2003; Moyal et al. 2013; Selby and Joiner 2009). Other negative appraisals focused on the self, or interpersonal relationships e.g. '*this relationship is over because it is too much; I need to leave my job because it is overwhelming'* are also associated with increased emotional dysregulation (Burr et al. 2017; Sakakibara and Endo 2016).

Hyper-activating attachment strategies include proximity seeking, reassurance-seeking and seeking to be soothed. These behaviours are strongly associated with emotional dysregulation (Malik et al. 2015; Mikulincer and Shaver 2012; Van Dijke and Ford 2015). The authors above argue that hyper-activating strategies manage distress initially but increase levels of distress over time as the strategy becomes less effective or the attachment object pulls away (Huprich et al. 2017), increasing the possibility of further experiences of rejection/abandonment.

De-activating strategies include emotional suppression, avoidance and numbing. Emotional suppression is strongly associated with emotional dysregulation (Aldao et al. 2010; Brenning et al. 2012; Malik et al. 2015). It is argued that suppression causes an emotional rebound effect (Webb et al. 2012) and makes it easy to mis-appraise the cause of the emotion. All-or-nothing behavioural responses such as avoidance or numbing behaviours are also associated with emotional dysregulation (Aldao et al. 2010). Initially, the individual finds these behaviours protective but ultimately leads to increases in emotion (Van Dijke and Ford 2015).

Rumination and worry are highly associated with emotional dysregulation (Aldao et al. 2010; Fresco et al. 2013). Selby and Joiner (2009) place rumination at the centre of their emotional cascade model of emotional dysregulation. They argue that emotional distress induces rumination which in turn increases the intensity of emotional distress until dysregulated behaviours are employed as emotional down regulation. A wide number of interventions have targeted rumination within emotional dysregulation (see Fresco et al. 2013 or; Sloan et al. 2017 for reviews).

CBT Approaches to Emotional Dysregulation

The proposed intervention draws flexibly from first, second and third wave CBT approaches, as well as a number of specific CBT approaches for emotional dysregulation (e.g. Barlow et al. 2004). Our approach is an extension of well-tested CBT techniques to mild-moderate emotional dysregulation presentations.

The therapist stance is collaborative and warm, with a strong working alliance. However, like all CBT interventions, the therapist is not seen as the "healing" factor, rather the therapist's goal is to support a reduction in maintaining behaviours, a re-appraisal of negative appraisals and change in the engagement with the person's context (Mennin et al. 2013).

The first phase of treatment addresses maintaining behaviours. The second phase of treatment addresses the underlying appraisals of abandonment and rejection, and negative

beliefs about coping with emotion. The third phase of treatment addresses co-morbid anxiety and mood disorders.

It is designed as a short-term, 12–20 session intervention for clients presenting with mild-to-moderate emotional dysregulation but not BPD (as people meeting criteria for BPD are likely to need long-term intervention). Self-harm is not a primary presenting difficulty in this population as the presence of self-harm is likely to suggest a diagnosis of BPD and therefore indicate a BPD-focused intervention (such as DBT). Therefore, there is significantly less focus on self-harm and suicidality than in other emotional dysregulation treatment approaches.

The intervention offers initial weekly individual sessions, moving to fortnightly, ultimately moving to monthly. This is approximately after every six sessions. In this way, it is hoped to manage distress, and to reinforce the individual's positive beliefs about their ability to cope. Sessions are structured in a typical CBT manner: agenda, homework, core topics, setting-up homework for the following week. The emphasis is on change outside the session. This is done through typical CBT techniques, such as cognitive restructuring, behavioural experiments, in vivo exposure, and data gathering.

Treatment Structure

Assessment

The psychological assessment examines current difficulties, current social supports/stressors, long-term social and personal history, alcohol and substance use, family interactions, underlying cognitions and maintaining behaviours. This session is used to develop an individualised formulation of the difficulty and to communicate this collaboratively with the client.

Psychoeducation

Psychoeducation is focused on normalising emotion, its role in normal living, its importance and the impossibility of getting rid of emotion. The goal of therapy is to reduce the extremes of emotion but that happiness, sadness etc., will still be experienced and expressed. Psychoeducation is used to discuss the concept of emotional dysregulation and the differences between this and depression or anxiety for instance. We generally chart out normal emotional regulation and emotional dysregulation. Emotions in general are discussed and normalised (Oatley et al. 2006). The therapist and client discuss how emotional "variation is the norm". However, others might not recognise this variation. This allows the client and therapist to discuss the client's emotional experience and the emotional expression within the client's social group or family without the use of blaming language (Meyer et al. 2014).

Regulating Behaviour

Aldao et al. (2010), Liu and Thompson (2017) and Sloan et al. (2017) each found support for reducing avoidance in treating emotional regulation. In order to reduce de-activating behaviour, the therapist and client focus on an adaptation of Activity Scheduling (Beck et al. 1979). This focuses on regulating behaviour by organising the client's week over 21 periods (7 days; morning, afternoon and evening). The therapist guides the client towards a balanced week including physical exercise (at whatever level is appropriate for the client), social contact/individual time, sleep/rest, pleasure/mastery tasks.

"What Works"

Selby and Joiner (2009) and Linehan (1993) have both emphasised the role of behaviour in regulating emotion. Rather than learning new techniques, initially the therapist identifies techniques that the client has used successfully in the past but which they may not be using regularly. This is called "What Works". This covers basic emotional regulation strategies such as exercise, yoga, TV, music, reading, relaxing environments, self-soothing behaviours, conversation, and texting. These are then integrated into an Activity Schedule so that they occur regularly across the week. Busy or stressful points in the week are identified and balanced with emotional regulation strategies before or after.

Examining Triggers for Distress

Although emotional dysregulation can feel random, the proposed model suggests that triggers are generally interpersonal in nature emanating from feelings of abandonment and rejection (Bosmans et al. 2010; Marganska et al. 2013; Young et al. 2003). The therapist supports the client to see triggering situations (Raju et al. 2012) by "backwards chaining" a recent event. The therapist and client work together to predict the times and situations that are likely to act as triggers, so that emotional regulation becomes more predictable and controllable. Then the therapist helps the client problem-solve around these situations (Aldao et al. 2010). Sometimes this involves situational changes such as situation selection or situation modification in line with Gross (2015a).

Disengaging from Harmful Relationships

In order to reduce hyper-activating behaviours, repetitively returning to the damaging relationship is discussed (Malik et al. 2015). Problem solving such solutions such as

disengaging, accommodation, negotiating roles and assertiveness are discussed (Mennin et al. 2013). The emotions associated with such changes, such as guilt, shame or anger are discussed. Incremental changes around these relationships are explored.

Rumination

Rumination is widely associated with emotional dysregulation (Aldao et al. 2010; Selby and Joiner 2009; Sloan et al. 2017). Rumination has a functional goal of managing emotional distress which has the paradoxical outcome of maintaining and exacerbating it (Mennin et al. 2009). We use many of the approaches used within CBT for GAD to help the individual manage and reduce their rumination (Fresco et al. 2013). The goal of this portion of treatment is to reduce the time and space that people give to rumination. Attentional shift is practiced and tasks, activities and the environment are explored to support attentional shifts outside of session. The therapist and client look to cognitively reappraise positive beliefs about rumination (Wells 1995).

Cognitive Re-Appraisal

Cognitive re-appraisal is associated with positive emotional re-regulation (Liu and Thompson 2017; Moyal et al. 2013; Sloan et al. 2017). The authors look at alternative ways of thinking when emotionally distressed. We examine middle way thinking styles, grounding this in a realistic understanding of what can be expected in a situation and responding appropriately.

Sometimes, the therapist works with the client to cognitively reappraise the client's expectations of the situation, in particular, interpersonal expectations. The client and therapist work together on acceptance strategies around the triggering situations (e.g. is this person capable of offering the care/compassion that you want?).

Decentring from Thoughts and Emotions

This section focuses on the basic third wave cognitive behavioural approaches to thoughts and emotions and to addressing negative secondary appraisals about emotion (Roemer et al. 2009; Teasdale et al. 2000). The therapist helps the client to develop imagery that allows them to visualise and picture the transient nature of their thoughts/emotions, seeing these as separate from themselves. The therapist helps the client come to a position of accepting unpleasant sensations and helps them use previously discussed techniques to tolerate them.

Beliefs About Self and Coping

The self-representations associated with poor attachment are theorised to lead emotional dysregulation in adults (Mikulincer and Shaver 2012). At this point in therapy, the therapist and client examine all the positive behaviours the client is already engaged in and the ones that they have put in place over the course of therapy. This evidence is used to reinforce the client's beliefs in their ability to cope independently.

Experiences that reinforce beliefs in the ability to cope are explored as well as positive experiences of coping with negative emotion. Underlying beliefs about self, based on this experience are proposed. Through this process, several positive beliefs about emotion are reinforced. That emotions are normal in given situations; that they are often predictable, that they are not dangerous and do not need to be avoided; that they are not strange but normal reactions to the events and that the client themselves can balance them out by positive behaviour.

Anxiety and Mood

Finally, the therapist shifts focus to address any specific anxiety or mood issues with the appropriate CBT models (e.g. Wells and Clark 1997 for social anxiety; Clark 1989 for panic disorder.), while returning to any emotion dysregulation issues as they crop up. While it is expected that the person might experience periods of emotional distress, the focus remains on using the skills to manage these periods. Each positive example of coping is then used as a way to reinforce positive beliefs about self and the ability to cope with distress.

Discussion

There appears to be a range of clients presenting to services with mild-to-moderate forms of emotional dysregulation (Raju et al. 2012). Although, this does not fit with classical "Axis I", "Axis II" divisions, these presentations fit well with emerging epidemiological data on the continuum of emotional dysregulation within the community and across a range of clinical disorders (Marwaha et al. 2013). In these cases, personality or schema-based treatments are often too long or too intense for the needs of these patients and classic CBT for Depression or Anxiety does not address the emotional dysregulation itself.

For these reasons, the authors have looked to extend the cognitive behavioural model to include emotional dysregulation as a transdiagnostic target for treatment, separate from mood or anxiety disorders. We have focused on hypothesised maintaining factors which clinical experience and primary

research indicate are related to emotional dysregulation. Like all cognitive behavioural models, the focus is not on underlying personality (trait) change but on initial change in emotional states so that the patient can subsequently address any long-term negative beliefs about themselves, the world or others. The techniques used are classic CBT techniques extended specifically for emotional dysregulation. In this way, the model and approach are practical for any CBT-trained clinician or CBT service and do not need specific training.

We believe that this is an important extension of the CBT model for several reasons. (i) within the stepped care model, a wide number of people are being offered short-term psychological interventions at a primary care level. If as epidemiological data suggests, there is a cohort of people with mild-to-moderate emotional dysregulation presenting to these services, it is necessary to have short-term treatments to meet their needs. (ii) with a few notable exceptions (i.e. Fresco et al. 2013), CBT models have not addressed emotional dysregulation as a primary treatment target. People with emotional dysregulation are likely to do poorly within mood or anxiety disorder models, which fail to address the variable aspect of their presentation or the interpersonal nature of the triggers. (iii) specialist personality disorder services have long-waiting lists and stringent acceptance criteria meaning people often fail to be accepted onto these programs. (iv) it is an individual treatment package and so does not need a specialist intervention team such as DBT might advocate. In this way a clinician can use the model to work with a large percentage or a small percentage of their caseload depending on the diagnostic range of the people being referred.

The model challenges assumptions about the long-term nature or personality-based nature emotional dysregulation. Although this might be the case in the most severe of cases (e.g. those meeting criteria for BPD), the model suggests that many presentations of mild-moderate emotional dysregulation are maintained by cognitive and behavioural patterns, from which people can recover well.

Initial pilots have been acceptable to the clients and have shown positive outcomes. However, the model and treatment need rigorous assessment, which we are currently undertaking.

Acknowledgements The authors wish to acknowledge Miriam Fehily for her contribution to this paper.

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