Dialectical Behavior Therapy in Emotion Dysregulation - Report of Two Cases

ABSTRACT

Emotion dysregulation is the inability to control and modulate one's affective state, and it might be associated with mental disorders. The development of secure attachment with significant others, in early childhood, has been theorized to be essential to the development of emotional regulation. Disruption of the formation of secure internal representations may, therefore, substantially compromise the acquisition of emotional-regulation capacities in childhood and lead to social maladjustment in later life. It is a pre-post case study design of two adolescents who presented with acts of self-harm and history indicating a provisional diagnosis of personality disorder. However, an in-depth assessment revealed emotional dysregulation. The model of Dialectical Behavior therapy (DBT) recommended for non-clinical populations was delivered in 12-16 sessions, resulting in a positive outcome that sustained for 12-24 months follow-up, improving interpersonal effectiveness. The role of DBT as an early intervention in emotional dysregulation is highlighted, as it enhances social adjustment by altering the attribution style.

Key words: *Dialectical behavior therapy, emotional dysregulation, personality disorders*
Key messages: *Intervention for emotional dysregulation in early years of life might be a preventive measure against mental health issues of adulthood.*

Emotion dysregulation is the inability to control and modulate one's affective state, and it might be associated with mental disorders.[1] The development of a secure attachment with significant others in early childhood has been theorized to be essential to the development of emotional regulation. Disruption in the formation of secure internal representations may therefore substantially compromise the acquisition of emotional-regulation capacities in childhood and lead to social maladjustment in later life.[2] Dialectical Behavior Therapy (DBT) focuses on reducing self-harm and behaviors that interfere with quality of life by keeping an individual engaged in treatment.[3]

CASE #1

S, a 23-year-old unmarried female, pursuing post-graduation and hailing from an urban nuclear family of middle socio-economic status, presented with difficulties in interpersonal relations and feeling unwanted for years. These symptoms were causing significant distress, and for the last two months, she was unable to focus in studies as she felt ignored and rejected. She came for the consultation after reading an article on mental health in a newspaper, which made her think about the unhappiness in her interpersonal relationships.

The assessment revealed that at the age of 9 or 10 years, during family conversations, she discovered she was born out of an unplanned and unwanted pregnancy. Since then, she started thinking that she was unwanted and the family did not love her. This changed her perception towards the actions of others around her. She had friends, but her friendships did not last long. She thought that her friends made plans and usually ignored her or that they wished she did not accompany them in their plan of action. While she was studying in high school, her family members found out about her relationship with a boy from another religion. She got into an altercation with her brother due to this, and consequently, he slapped her in the face. She felt that no one understood her and made multiple superficial cuts on her wrist with a blade, out of anger, the scars being visible during the sessions. She reported that her two romantic relationships were out of boredom and to enjoy the attention, but she felt no emotional connect with either of them. While the therapy was ongoing, the third boy whom she had been dating for the last two months broke up with her, as he found her clingy. She was disturbed because of this, and the cognitions of being unwanted and rejected were reactivated.

The psychiatrist gave no medication, and DBT was planned. Stage one (sessions 1-3) aimed to decrease destabilizing behaviors such as putting cuts on the

forearm with blade and sending multiple messages on social media, by discussing the consequences of such behaviors and other adaptive ways to channelize the impulses such as using cue cards, scribbling on paper, and tearing or cutting paper with scissors. The contact number of suicide prevention helpline was provided for use in emergency. Activity scheduling was assigned to regulate studies and to prevent stalking the ex-boyfriend on social media.

Stage two (sessions 4-8) focused on the resolution of perceived discrimination in the family and feelings of abandonment in childhood that had led to unstable interpersonal relationships. Daily thought record (DTR) identified her inability to say 'no' to others. Out of this fear, so as to avoid rejection, she used to please everyone around. Dysfunctional statements in the DTR were rephrased by externalizing the attribution style. Her erroneous cognitions were challenged and more functional cognitions were generated using devils' court and generating evidence. Also, exposure-based procedures were used to target her negative emotions such as anger and sadness. Her natural action tendencies of withdrawing due to such emotions were replaced by encouraging her to communicate her emotions effectively. Now she understood how, culturally, a male child is given more preference, and regardless of this, she was ultimately taken care of as a child and adequate opportunities were given by her parents. By the 9th session, she developed insight into her cognitions that she lacked the ability to see others' perspective.

The dilemmas related to higher education and jobs were addressed in stage three (Sessions 9-11) by working through decision making. Now, she was not getting offended with remarks/comments of friends. She had developed insight how her core belief of feeling unwanted had impaired her interpersonal relationships. Consequently, her communication skills improved, resulting in enhanced interpersonal effectiveness.

Stage four (session 12-16) aimed to generate capacity for joy and meaning in life by strengthening the skills acquired so far and by assisting her in the generalization of these skills to real-life situations. The exposure based activities had increased her social participation which she earlier avoided due to shame and fear of rejection. Regular practice of mindfulness and of strategies to alter thoughts and emotions were reviewed and evaluated in mutual discussions. Emphasis was made on preventing relapse, stabilizing the emotional reactivity, and regular monitoring of the cognitive patterns through DTR.

On a telephonic follow-up after two years from the date of termination of the therapy, she reported to be teaching in a private school and simultaneously preparing for a scholarship exam to enroll for a doctoral program. She reported the ability to deal with situations (triggers) rationally without acting impulsively, and has been enjoying fulfilling relationships.

CASE # 2

A, an 18-year-old unmarried female, student, belonging to an urban family of middle socio-economic status, presented with sadness of mood, anger outbursts, self-harm behavior, and a chronic feeling of emptiness for the last one year. The assessment revealed significant interpersonal conflicts between the parents, due to alcohol consumption of father, depression in mother, and financial stressors. Her spinster paternal aunt, who lived in another city, working in a government organization offered to take the patient to her home to support the family. She got admitted in class eighth. She adapted well to studies and the school environment. But the aunt noticed that the patient would easily get irritable on small things, like if food is not of her choice or cold, having any clash with a friend in school, etc. But the aunt kept ignoring these issues until she once noticed some marks on the forearm of the patient. On inquiry, the aunt found out that the patient had been indulging in self-harm as she felt rejected or ignored by the peers in school. Hence she was brought for consultation.

Cognitive behavioral formulation identified childhood experiences leading to schema – *I am unwanted*, causing faulty assumptions and negative thoughts about self, and impairing social and interpersonal functioning. DBT was planned, aiming at erroneous cognition and poor emotional regulation. Sessions 3-10 emphasized on psycho-educating about the formulation, maintaining DTR, and practicing mindfulness. DTR revealed negative cognitions and ruminations that induced negative emotions and to deal with this, she would cut the skin of her forearm with a blade. This thought was cognitively restructured using techniques such as examining the evidence, guided discovery, and Socratic questioning.

She reported improvement in interpersonal relationships and the ability to understand others' perspective without being emotionally overwhelmed by their actions. Her ruminations now lasted for a day, which earlier used to last for two to three days. In order to minimize self-harm behavior, the blade was replaced by marker or pens and she was suggested to write or draw on the forearm. She was able to alter her emotional state and thoughts by the tenth session of therapy. For effectiveness in interpersonal communication, role plays were used in the sessions. Theoretical concept of theory of mind was used while discussing the perspective

Table 1: Pre and post assessment scores on clinical outcome measures

Measures	Case #1		Case # 2	
	Pre-intervention	Post-intervention	Pre-intervention	Post-intervention
DERS				
Awareness	8	7	10	11
Clarity	13	5	8	7
Goals	13	4	12	3
Impulse	11	3	9	3
Nonacceptance	10	3	8	3
Strategies	11	3	11	3
Total	66	25	58	30
GHQ-28				
Somatic symptoms	5	0	5	1
Anxiety/insomnia	8	3	10	4
Social dysfunction	16	2	13	4
Severe depression	13	0	9	2
Total	42	5	41	11

DERS – Difficulties in Emotional Regulation Scale; GHQ – General Health Questionnaire

taking and its role in interpersonal communication. The termination proceeded with monthly booster sessions (11th to 14th). The family members reported significant improvement at home as well as in the behavior with the peers. On visual analog scale (VAS), she and the aunt reported 90-95% improvement at the termination. She had started engaging herself in pleasurable activities such as listening to music, going to walk, and playing table tennis daily than getting affected by negative experiences or negative emotions. Improvement was sustained up to one year of the last therapy session, and she felt adequate pleasure in social relations.

DISCUSSION

Due to the anger outbursts, mood fluctuations and self-harm behaviors, both the cases had initially received a provisional diagnosis of disorders of adult personality and behavior.[4] But later, detailed clinical interview revealed the cases to be non-clinical. This highlights how emotional dysregulation might appear as a personality-related disorder. Both the cases had negative self-schema, which led to erroneous thinking arising from negative emotions, and impaired interpersonal functioning. The common features were interpersonal conflict and the use of self-harm behaviors as a coping mechanism. The intervention helped change the underlying perception of being rejected or unwanted, which resulted in improved interpersonal functioning. In both the cases, the feelings of rejection first experienced within their respective families had been generalized, leading to emotional dysregulation. The same reflected in objective measures; namely, Difficulties in Emotion Regulation Scale (DERS)[5] and General Health Questionnaire (GHQ-28).[6] With the progress in therapy, scores on DERS revealed increased acceptance and clarity to distress, decreased difficulties in concentration on goals and decreased impulse, indicating increased control of one's behavior. There was a decrease in difficulties in using planning strategies in distress, which indicated the use of alternatives and reflected in enhanced social functioning. There was an alleviation of psychological symptoms and social dysfunction on GHQ-28 [Table 1].

Multiple interdependent processes, spanning the biological, psychological, and interpersonal domains, are involved in emotional regulation. A fundamental interplay exists between emotional and cognitive operations where, in both the cases, any event inducing a feeling of rejection activated the memories of the past emotionally-loaded event, the attention being centered around such negative-emotion-inducing events.[7] This further strengthened the patterns of avoidance in interpersonal dealing. These processes operate in such a way that self-harm behaviors are seen to be rewarding, distracting, and minimizing the experience of negative emotions. Bowlby highlighted how the deficits in responsiveness by the significant others in the early years of life might compromise the development of interpersonal communication and interpretation of social cues.[8]

In both the cases, the outcome gains had been maintained even after 24 and 14 months, respectively, of the termination of therapy, as enquired via a telephone call. On reflecting back, it appears that DBT in a non-clinical population might be used to prevent the onset of psychiatric or personality disorders. Also, it was the early intervention that helped in both the cases to modify cognitive and

emotional reaction patterns – in later years, these would have probably caused psychopathology. Besides, with maturing age, these would have become stronger and harder to modify. Whereas, unlike personality issues, a persistent change in adaptive functioning might be achieved from 10-12 sessions and 2-4 booster sessions.

CONCLUSION

DBT might be a good option for a non-clinical population of adolescents and youth having emotional issues as it enhances social adjustment by altering the attribution style. The schemas and attribution might have been internalized from social interaction with primary relations. Intervention improves not only emotion regulation but also interpersonal relationships with significant others, resulting in an increased sense of well-being. It can be the primary intervention preventing the onset of psychopathology in the adulthood.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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