



Experiences of Change in Emotion Regulation Group Therapy. A Mixed-Methods Study of Six Patients

Anna Dahlberg^{1*}, Elin Wetterberg^{1*}, Lars-Gunnar Lundh¹, and Hanna Sahlin²

¹Department of Psychology, Lund University, Lund, Sweden

²Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden

*Corresponding authors. Both authors contributed equally

E-mail addresses: anna.dahlberg91@gmail.com; elin.wetterberg@gmail.com

To cite this article:

Dahlberg, A., Wetterberg, E., Lundh, L. G., & Sahlin, H. (2018). Experiences of change in Emotion Regulation Group Therapy. A mixed-methods study of six patients. *Journal for Person-Oriented Research*, 4(1), 15-28. DOI: 10.17505/jpor.2018.02

Abstract

Emotion Regulation Group Therapy (ERGT) is a treatment for non-suicidal self-injury (NSSI) that has recently been implemented in Sweden and evaluated in an open trial with 95 patients in 14 adult outpatient psychiatric clinics (Sahlin et al., 2017). The purpose of the present study was to explore in more detail six of these patients' experiences of change in ERGT by means of a person-oriented mixed-methods design. Reliable change and clinical significance were calculated for each individual on measures of self-harm, depression, anxiety, stress, and emotion regulation. Semi-structured interviews were carried out, transcribed and analysed using thematic analysis. Both the quantitative and qualitative data on change suggested that the most consistent changes occurred on emotion regulation. The treatment sessions that were most appreciated were those that focused on emotion awareness and emotion regulation. The participants also expressed appreciation of what ERGT afforded in terms of belonging and sharing with others, and the sense of equality in the relationship to the therapist. Critical comments were expressed concerning some parts of the treatment, as for example not having access to an individual therapist. Among the limitations of the study are the small convenience sample, which does not allow for any generalizing conclusions, and that the interviews took place a considerable time (2-3 years) after the participation in ERGT.

Keywords: non-suicidal self-injury, deliberate self-harm, emotion regulation group therapy, clinical significance, thematic analysis, qualitative interview, DSHI, DASS-21, DERS

Over the last few decades non-suicidal self-injury (NSSI, also referred to as deliberate self-harm) has come to be recognized as a topic of growing concern and an important mental health problem, which is associated with a low quality of life (Washburn, Potthoff, Juzwin & Styer, 2015), an increased risk of suicide attempts (Guan, Fox, & Prinstein, 2012), and being met with negative attitudes by medical staff (Saunders, Hawton, Fortune, & Farrell, 2012).

In 2009, an inventory of the Swedish inpatient care found that NSSI patients as a group are difficult to provide good care for, and are extensively subjected to involuntary care and coercive measures. This resulted in a government-funded project called the National Self-Injury Project (NSIP), an initiative aiming at decreasing the prevalence of self-injurious behaviour among young persons (Socialdepartementet, 2011). As a part of this project, therapists

were trained in Emotion Regulation Group Therapy (ERGT; Gratz, 2007), and this treatment was subjected to evaluation.

ERGT is a group treatment aimed for patients with NSSI. It is described as an "adjunctive" group treatment, that is, a treatment specifically for patients who are already in individual treatment (Gratz, Tull, & Levy, 2014). ERGT is based on the assumption that NSSI serves an emotion-regulating function, and aims to teach the participants more adaptive ways to respond to and regulate their emotions. The purpose is not that the participants should control or eliminate their emotions, but that they should learn a number of other skills including awareness and acceptance of emotions, impulse control, flexible use of emotion regulation strategies and willingness to experience negative emotions as part of carrying out meaningful activities (Gratz & Roemer, 2004; Gratz, 2010). Treatment elements as described by Gratz and

Tull (2011) are drawn from Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999).

ERGT is a 14-week manual-based treatment (Gratz, 2010), where the first sessions deal with the function of NSSI (week 1) and psychoeducation about emotions (week 2). The following sessions focus on various aspects of emotional functioning: emotional awareness (weeks 3-4), primary versus secondary emotional responses (week 5), clear versus cloudy emotional responses (week 6), emotional avoidance/unwillingness versus emotional acceptance/willingness (weeks 7-8), and identifying emotion regulation strategies that do not involve avoidance of emotion (week 9). The last sessions focus on impulse control (week 10), valued directions in life (week 11-12) and commitment to valued actions (weeks 13-14). Post-measurement is carried out after these 14 sessions, but then there are two additional sessions, which deal with the process of valued direction (week 15) and relapse prevention (week 16).

ERGT has previously shown promising results by leading to reduced NSSI in controlled clinical trials conducted in the US (Gratz & Gunderson, 2006; Gratz & Tull, 2011; Gratz, Tull & Levy, 2014). Supporting the feasibility and transportability of ERGT, Sahlin et al. (2017) recently described a multi-site evaluation of ERGT in an uncontrolled open trial, implemented as part of the NSIP. The results showed significant improvements on NSSI, general psychiatric symptomatology, and on emotion regulation, which were either maintained or further improved at six-months follow-up.

The value of idiographic research with a focus on intra-individual changes within the person, rather than on group comparisons, is increasingly being recognized (Molenaar, 2004), as is also the value of qualitative research as a complement to traditional experimental and correlational research. As argued by Kazdin (2007), for example, qualitative methods can be used to study the process of therapy, and in particular “how the patient and therapist experience that process... Qualitative research can provide a fine-grained analysis by intensively evaluating the richness and details of the process, including who changes and how change unfolds, and who does not change and what might be operative there.” (Kazdin, 2007, p. 20). So far, no study of ERGT using qualitative research methods has been reported in the literature, although Gratz and Gunderson (2006) did report anecdotally about patients’ experiences of participating in ERGT, that “the 6 weeks focusing on emotional willingness and valued directions have generated the most enthusiasm from clients during and after treatment” (p. 33).

Aim of this study

The purpose of the present study was to combine qualitative and quantitative methods to explore in depth patients’ experiences of participating in ERGT treatment, to generate hypotheses for further research. The research questions were the following: (1) In what respects do six patients in ERGT

experience that they have changed or not changed? (2) Which components of ERGT do these patients find most valuable? (3) Do these patients have any ideas about how ERGT might be improved, and in that case what do they suggest?

Method

In some fields of psychology, it is essential that single individuals’ measurements can be interpreted so that inferences can be made about, for instance, individual development. This is in contrast to official statistics where the focus rarely is on interpreting single units’ measurements but rather on providing estimates of population parameters like percentages in different categories, means or correlations. These are the dominant forms of statistical reporting. Nevertheless, the importance of paying more attention to single units’ measurements also in official statistics may be underestimated, see Bergman (2010).

Design

The study used a mixed qualitative and quantitative multiple case study design to study the experiences of change in six individuals who participated in the Swedish ERGT trial (Sahlin et al., 2017) as part of the NSIP project.

Participants

All six participants were in the age range of 23-31 years. Three of them were employed, one was studying, and two were on sick-leave. They had engaged in NSSI during 2-20 years, and two of them still were engaging in NSSI at the time of the interview. Four of them had psychiatric contact at the time of the interview. Diagnostic data were available for five of them. All met at least three criteria for Borderline Personality Disorder; in addition, the current comorbid diagnoses were represented at the time of treatment: major depression (3), generalized anxiety disorder (3), panic disorder (2), social anxiety disorder (1), bulimia (1), PTSD (1), and antisocial personality disorder (1).

Recruitment of participants. The Swedish ERGT project (Sahlin et al., 2017) included 95 patients at 14 adult outpatient psychiatric clinics across Sweden, of which 3 (with totally six therapists) were situated in the county of Skåne. Because only the latter were at a reasonable travel distance to Lund University, the therapists at these clinics were asked about their willingness to help recruiting participants. Three of these therapists (representing two of the Skåne clinics) expressed interest in contacting their former patients from the ERGT project, briefly informing them that the present study would be conducted, and asking them whether they would be interested in receiving more information about it. As a result, 10 women expressed interest and were contacted by telephone by the two first authors of the present paper, who also sent them written information. After given time to consider their participation, they were contacted a second time via telephone. Of these ten women,

seven passed all inclusion and exclusion criteria (see below), but one of them dropped out after the first phone interview. One of the participants had received ERGT as part of the NSIP, but had dropped out before she completed the treatment; she did however complete the treatment at a later stage, but no diagnostic or quantitative data was available for her.

Exclusion and inclusion criteria. The participants had passed the inclusion and exclusion criteria of the Swedish ERGT study (Sahlin et al., 2017). In addition, to participate in the present interview study, there should be no risk that the interview could interfere with on-going treatment; participants should also be willing to request their questionnaire data from the Swedish ERGT project, and be able to travel to the Department of Psychology in Lund for the interview.

Procedure

Semi-structured interviews were conducted in accordance with an interview guide, where the questions were grouped into six sections; 1) opening questions (including demographic questions); 2) before treatment; 3) experience of treatment; 4) change during treatment; 5) present time; and 6) experience of the interview. Only interview material from the first five sections was included in the analysis.

The interviews took place at the Department of Psychology at Lund University in March and April 2016, 2-3 years after ERGT treatment. The first and second authors were both present during all six interviews; they held three interviews each, and the other acted as observer. The purpose of having an observer was to make all interview material, including non-verbal information, accessible to both the first and the second author. The interviews were between 66 and 106 minutes long. All interviews were recorded with dictaphones and transcribed.

Measures

The quantitative data used in the study consisted of the patients' responses to questionnaires measuring NSSI and psychiatric symptoms before treatment, post-treatment and at six-months post-treatment, as collected for the Swedish ERGT study by Sahlin et al. (2017) by means of the following instruments.

Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) specifies 16 different types of self-harming/injurious acts that result in harm of one's own skin/tissue (e.g., cutting or burning oneself), and in this specific version asked the patients to report the frequency of these during the past 4 months. DSHI exhibits high internal consistency, adequate test-retest reliability, as well as construct, discriminative and convergent validity (Gratz, 2001).

Depression Anxiety Stress scale (DASS-21; Antony, Bieling, Cox, Enns, & Swinson, 1998) contains three subscales, Depression (DASS-D), Anxiety (DASS-A), and Stress (DASS-S), each with seven items, and shows high concurrent validity and internal consistency.

Difficulties in Emotion Regulation Scale (DERS; Gratz

& Roemer, 2004) is a 36-item self-report instrument with good validity and reliability.

Analysis

Reliable change. The reliable change index (RCI) is a standardized score representing the patient's change on a test, defined as the patient's change score divided by the standard error of the difference for that test. The calculation of the standard error of the difference (S_{diff}) requires knowledge about the reliability (r) of the test, and its standard deviation (SD) in the population of interest, in accordance with the following formula:

$$RCI = \frac{(x_{post} - x_{pre})}{S_{diff}} \quad S_{diff} = \sqrt{2S_E^2}$$

$$S_E = SD\sqrt{1-r}$$

If the RCI exceeds 1.96, it is considered likely that the post-treatment score reflects actual change. As recommended by Lambert and Ogles (2009), Cronbach's alpha for each scale was used as the index of reliability. In the present study, we used the alphas from Antony et al. (1998) and the standard deviations from Sahlin et al. (2017) to calculate RCI for the DASS scales; applying the RCI formula, this resulted in the following cut-offs for reliable change: DASS-D ≥ 7 ; DASS-A ≥ 9 ; and DASS-S ≥ 7 . To calculate RCI for the DERS scales, we used alphas from Gratz and Roemer (2004) and SD s from the clinical sample in Gratz et al. (2014); applying the RCI formula, this resulted in a cut-off of ≥ 18 for reliable change. On the DSHI, an individual was considered to be reliably improved if she had a greater than 50% reduction in pre-treatment NSSI frequency (in accordance with Gratz et al., 2014).

Clinical significance. Clinically significance change (Jacobson and Truax, 1991; Lambert & Ogles, 2009) means that a patient shows (a) reliable change and (b) ceases to be part of a pathological population and instead enters a functional one. For DASS-21 we used the norms provided by Lovibond and Lovibond (1995), as described in Table 1.

Table 1. Cut-offs for subscores on the DASS-21 (Lovibond & Lovibond, 1995)

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

For the DERS, we used norms provided for a functional population (Gratz & Roemer, 2004) in combination with the clinical sample data from Gratz et al. (2014), to calculate a cut-off of type C according to Jacobson and Truax (1991). For the DSHI we followed Gratz et al. (2014) by defining normal functioning in terms of an abstinence from NSSI.

Thematic analysis. The interviews were analysed using thematic analysis (TA) as described by Braun & Clarke (2006). In our search for themes, we asked whether the data captured anything vital in relation to the research questions (i.e., change and experience of ERGT). When considering whether something qualified as a theme, we primarily considered prevalence at the level of data items, as for example theme occurrence across interviews; however, if at least two informants clearly opposed what other informants expressed, we disregarded the topic as a theme.

The six phases of thematic analysis as presented by Braun and Clarke (2006) were followed. The interviews were transcribed by one of the interviewers, whereas the other read the transcript while listening to the tape. Both interviewers generated codes, and organized them into themes independently of each other. The two theme structures were then compared and adjusted into one coherent map with regard to the research questions. The themes were also discussed with the third author.

Ethics

The study was approved by the Regional Ethical Review Board in Lund (Dnr 2015/882). The participants were informed that they had the right to end the interview and their participation in the study at any time, without having to state a reason. It was also made clear to them that they could withhold any information they were not comfortable sharing. The participants were asked to sign a pre-printed form requesting their questionnaire data from the Swedish ERGT project in order for it to be analysed in the present study. In the presentation of the results, each informant was assigned a fictitious name (Amanda, Charlotte, Dea, Eowyn, Frida, and Hanna). A summary of the respective interview was sent to each informant so they could check the contents before it was included in the written study. The informants were not compensated for their participation in the study but were compensated for travel expenses.

Results

The results are presented below in accordance with the three research questions. In the first section, the patients' changes on the questionnaire measures are summarized, followed by an analysis of the qualitative data on experiences of change into themes and subthemes. The second section summarizes the patients' reports about which components of ERGT they found most valuable. Finally, the third section contains a summary of the patients' suggestions about how ERGT might be improved. Because the small sample makes analyses at the group level of little interest, these results are presented only in Appendix 1, to inform the reader about differences between the studied sample and the larger sample it was drawn from.

Changes during ERGT

Table 2 shows the individual scores for each measure at pre-treatment, post-treatment and six months follow-up, and the occurrence of reliable change and clinically significant change for each participant. As seen in the table, the most consistent change, both in terms of reliable change and clinically significant change, were on emotion regulation.

The participants were categorized as responders and non-responders to the ERGT on the basis of a combined scrutiny of their quantitative and qualitative data, as follows:

Amanda. Amanda scored consistently low on self-harm. At pre-test, however, she scored above the cut-off for severe depression, and in the range for moderate anxiety and stress. She showed reliable change only on one of the measures, depression, but this did not reach the cut-off for clinical significance. In the interview she reported that she was still engaging in NSSI, and also said that she was more depressed and sadder now than she was prior to treatment. She reported that she seldom uses the emotion regulation strategies taught in ERGT, but instead engages in NSSI to regulate ne-

Table 2.

Individual scores at pre-test, post-test and 6-months follow-up (FU) on self-harm (DSHI), depression (DASS-D), anxiety (DASS-A), Stress (DASS-D) and difficulties in emotion regulation (DERS). Reliable change is indicated by colour, and clinically significant change by asterisks.

Patient	Self-harm			Depression			Anxiety			Stress			DERS		
	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU
Amanda	0	5	0	28	24	16	10	12	4	20	16	16	109	114	95
Charlotte	4	4	0*	22	24	22	22	30	16	26	24	14*	143	122	115
Dea	22	31	2	26	22	10	22	10	12	28	20	16	128	95*	82*
Eowyn	18	0*	0*	30	2*	2*	26	10	4*	24	12	2*	150	53*	49*
Frida	6	56*	17*	32	4*	6*	18	20	12	34	26	20	123	83*	86*

Note. Green indicates a reliable change in a positive direction. Red indicates a reliable change in a negative direction.

* Clinically significant change (green = recovered, red = deteriorated)

gative emotions. On the basis of these combined quantitative and qualitative data she was considered a non-responder to the treatment.

Charlotte. Charlotte's NSSI was considered unchanged after treatment, but showed clinically significant improvement at six months follow-up; in the interview she reported having had only one NSSI episode during the last three years. Before treatment she scored above the cut-off for severe depression, anxiety and stress. At follow-up she showed a reliable and clinically significant decrease in stress, although her scores on depression and anxiety still remained in the severe range. Although she showed no reliable change on depression scores, she said during the interview that she felt happier and experienced more vitality now. Before treatment she scored very high on difficulties in emotion regulation, and although her DERS scores showed reliable change this was far from being clinically significant. During the interview she said that she had continued to work with emotion regulation on her own and in another treatment. She was considered a partial treatment responder.

Dea. Dea's NSSI scores had undergone a reliable reduction at follow-up; but as she still reported some NSSI this change was not classified as clinically significant. During the interview, however, Dea said that she did not engage in NSSI anymore. Her depression scores showed a reliable change from severe to mild; this was consistent with her reporting during the interview that she was happier now than before treatment. Her scores on anxiety and stress also showed a reliable decrease from severe to moderate and mild, respectively. At follow-up Dea showed a clinically significant improvement on emotion regulation, which is consistent with her report during the interview that she had further improved her abilities to identify and handle emotions. She was considered a treatment responder.

Eowyn. On the basis of her quantitative scores Eowyn was considered recovered on all accounts. From reporting high levels of NSSI and scoring at severe levels of depression, anxiety and stress before treatment, she scored in the normal range on all measures at follow-up. During the interview, she reported still being abstinent of NSSI, and said that she was much happier now than before the treatment. Perhaps most remarkable of all, from scoring highest of the informants (and considerably higher than the mean of the clinical group) on difficulties in emotion regulation before treatment, she scored lower than all others at follow-up. During the interview Eowyn described using several adequate emotion regulation strategies. She was considered a clear treatment responder.

Frida. Before treatment Frida scored above the cut-offs for extremely severe depression and stress, and severe anxiety. She showed a clinically significant deterioration with regard to NSSI; and during the interview, she stated that she was still engaging in NSSI, although not as often as before. On the other hand, she showed clinically significant improvements on both depression and stress, as well as on emotion regulation. During the interview Frida said that she

had successfully used several emotion regulation strategies but also that she still had difficulties handling stress. She was considered a mixed treatment responder/ non-responder.

Recurrently the informants said that changes were noticed towards the end of the treatment and that they continued to experience change after finishing ERGT. They found it to be a slow and cumulative process, with episodes of sudden "wow moments". Even though they found their lives different from before ERGT, they described areas that remained unchanged. Informants expressed awareness that the changes they had experienced may not have been caused only by the treatment, but also by other factors.

Themes and subthemes. The participants' reports about changes were analysed into themes and subthemes. An overview of these is presented in Table 3, and illustrated by examples in the text below.

Table 3.
Themes and subthemes in the participants' reports about change during ERGT.

Theme	Subtheme
Gaining understanding	Understanding and accepting feelings Identifying and naming feelings Understanding/accepting oneself Sense of control through understanding
Health	Getting worse at first, before getting better Living with anxiety Separating from self-harm Physical health
Attitudes towards life	
Living conditions	Access to and satisfaction with healthcare Occupation
Relations to others	Relationships as motivation to start treatment Relationships as affecting treatment Increased openness towards others Improved quality of relationships Relationships as a source of feedback on change

Gaining understanding. Recurrently, informants mentioned "understanding" and "awareness" when they described their change since the start of treatment. Primary to this was an increased understanding of emotions, which by implication also involved an increased self-understanding, self-acceptance, and sense of control, and was associated

with an improved ability to communicate feelings.

Understanding and accepting feelings. The focus on the ability to accept emotions and tolerate distress was described as positive by several informants. Amanda said she learnt from ERGT that: "it's simply okay to have feelings". Charlotte said:

To be able to accept 'Okay, I feel like shit' and at the same time having the knowledge that 'Okay, I feel like shit now, and the whole world can go to hell right now, but I know it will get better'.

Eowyn added that accepting *positive* emotions made a change in her life: "It was a really big change when I felt that 'But it's alright to feel like this, one's allowed to be happy, there's no problems with that. It's totally okay'".

Identifying and naming feelings. Informants also described that they had become better at recognizing, defining and naming emotions, and some said that this enhanced their communication abilities. Dea said: "I got better at talking, I got much better at expressing myself, when it comes to feelings". She said this improved her relationship with her sister, which was the best thing she got out of the ERGT treatment.

Understanding and accepting oneself. Informants reported that they gained more understanding of themselves and their behaviour. At first, this could be a difficult experience. Dea said "During the time I was in ERGT, it was rather mind-blowing, because I hadn't realized how... how... what a bad condition I was in, so to speak", and Charlotte said that it made her feel "like a stranger to herself" when the leader first suggested that there might be a primary emotion behind her anger. However, after a few days when she had digested the information there was what she called a "wow factor". She thought "wait a little, shit, damn, it's probably right!" and realized that "it's not only anger there all the time, there's something else there". She said that this had great impact on her understanding of herself. Understanding oneself was considered to make it easier to sympathize with, and accept, oneself. Eowyn said: "Okey, this is how I function, and suddenly one wasn't the worst person in the world".

Sense of control through understanding. Several informants described that they felt "lost" before starting ERGT. They said that when they gained understanding and awareness of their emotions, they felt more in control.

Health. Three of the informants described an experience of *getting worse at first, before getting better*. One of them reacted so strongly that she even tried to commit suicide. Eowyn felt worse initially, but she was somewhat prepared because the group leaders had said that it is an expected reaction to initial treatment.

Living with anxiety. The informants were still experiencing anxiety after treatment, but many of them said that their anxiety was not as frightening as before, since they were able to "stay with the feeling". Frida, for example, said that she experiences anxiety on a daily basis and she thinks it will

always be a part of her life, but that she can accept that. Some informants also described a change in the anxiety that was experienced after impulsive behaviour. Amanda said she was now less anxious after engaging in NSSI; her new understanding of the function of NSSI had made her less judgmental towards herself.

Separating from self-harm. At the time of the interview, four informants said they no longer engage in self-harm, and that they had found constructive strategies to abstain. Frida said she still engages in NSSI, but not as often as she used to. Amanda, on the contrary, said that her NSSI has escalated. She also reported that she was inspired by other ERGT participants to engage in new kinds of self-destructive behaviours, and that she interpreted the therapists' attitude towards self-destructive behaviours as accepting.

Even though acts of NSSI had ceased for many informants, thoughts of it still remained. Hanna reported still having NSSI thoughts, but said that it takes longer before they emerge. Eowyn said she is still actively engaging in NSSI "in her mind", but that the strength of her thoughts has decreased. Although informants showed pride and happiness in their ability to abstain from NSSI, this change was not always described as entirely positive. Both Dea and Eowyn expressed a sense of losing a part of themselves and that something was taken away from them. Eowyn described the doubts she had during ERGT: "how shall I be able to separate from this behaviour that I've had so long?"

Physical health. Although the informants' lives had improved in many respects, there were still many issues that had not changed – problems with physical health, eating habits and sick leave. One informant who recently had developed a physical disease said that she had "a better foundation" after treatment, and was glad she did not fall ill prior to ERGT. Another informant reported still having many physical issues, but said that she had more energy than before treatment because she no longer experienced a "chaos inside".

Attitudes towards life. ERGT was described as "life-changing" and many informants said they had gained a will to live. Eowyn said "I have gotten my life back /.../ I wouldn't be alive today, without my partner or without the ERGT, guaranteed". Charlotte said that before ERGT she wondered where she would find "the genuine joy of life everyone is talking about", but today she feels "that life actually has a value". Similar to thoughts of NSSI, suicide thoughts had not disappeared. Eowyn said: "it isn't like I wanna live every day, but I don't wake up every day with the thought 'today I wanna die'".

Living conditions. Some informants said their housing situation had changed for the better. Most frequently mentioned, however, was better *access to and satisfaction with health care and occupation* (several informants had gone from being on sick leave to being employed). As to health care, Charlotte said that for many years, her experience was "just a quick in – quick out to the doctor's, we solve it all with pills". Now she has finally found doctors she likes

and who take the time to understand and help her. Some informants mentioned that they had been helped by receiving neuropsychiatric assessments and diagnosis-related care during or after the time of ERGT-treatment. Two informants had received DBT treatment after ERGT; they both said that ERGT prepared them for and gave them a base to develop further in DBT.

Relations to others. People who were close to the informants or in their immediate surroundings were mentioned as important factors in the complex process of change, both as a *motivation to start treatment*, and as *affecting them during treatment*. Children and partners were mentioned as the reason to stay alive and fight to get better. Supportive partners and friends were also mentioned as helping informants to continue ERGT and practice the skills taught there. Frida, for example, said she had an emotionally intelligent friend she could discuss and interpret situations with. Others said that their ability to focus on the treatment was affected by negative interactions. Hanna, for example, said that "family drama" took much of her thinking capacity during ERGT treatment, and Amanda said that she was still surrounded by "destructive people" during treatment, and that if she really would have adopted ERGT, she should have stopped socializing with them.

Informants also described an *increased openness towards others*. For example, Amanda said that before treatment she used to leave distressing situations without letting anyone know why, and sometimes without knowing why herself. When she experiences a distressing situation today, she will openly say it distresses her before she leaves. Another example came from Eowyn, who said that she is more honest, that she communicates more with her partner, and that she is open about her former self-injurious behaviour with others.

The majority of informants reported an *improved quality of relationships* during treatment, which continued to improve after treatment. Charlotte said that she is a better parent today since she is less "emotionally disabled" and has more "tools" to handle her emotions with. Frida said that she can determine more easily which people are sound for her and which are not.

Relationships also served as a *source of feedback on change*. Several informants had heard from others that they were different today than before treatment; for example, some had been told that they were more pleasant to be around now.

What was most valuable about ERGT?

All informants liked the group-format. The most frequently mentioned positive aspect was that the group provided them with a *sense of belonging and sharing with others*, which helped against feelings of loneliness. Hanna said her problems felt more manageable when she met others who experienced similar suffering, as this "might mean that this isn't the worst thing in the world, because they survive too". The group was described as a forum

where one could share problems, receive help from and help others who had experience of similar situations. Dea said:

It's good to get feedback and it's good to hear others, how others in similar situations think and reflect and what they experience, and to give feedback yourself as well and be of help, because /.../if you are on your own, it's only you and the therapist and that's good in its own way, but in a group then you're also able to /.../ help someone else and that will raise your self-esteem

However, some informants mentioned that there is a risk of sharing things which counteract the treatment, such as ways of self-harming. Eowyn said: "there was some exchanging of ideas and that isn't the smartest thing and it was during the first weeks one did that and then one thought 'right, that's not why we're here'".

Sense of equality in therapist-participant relationship. The majority of the informants talked warmly and enthusiastically about the therapists. When informants were asked to elaborate on what they liked about the therapists, they explained that the relationship "felt equal" and that they managed to create an air of "we are doing this together". The therapists' "open" and self-disclosing attitude was experienced as contributing to a sense of equality. As Hanna formulated it, "it didn't feel like they were like above, and looking down on us and should teach us, but like they were there anyway and on the same level." Eowyn said that her best memory from the treatment was when one of the therapists opened up about her own problems and deficits, because it made her feel more connected to her, and less like an "alone freak".

Nonetheless, the informants mentioned some instances where they had not liked certain aspects of the therapist's behaviours, and when there seemed to be a greater distance between therapists and participants. Eowyn mentioned one instance where she felt that the therapists were "preaching" when they talked about the function of NSSI. She said it was as if they had read about the function in their psychology book but did not understand what it was like, and she found that "disturbing". Amanda disliked that the therapists made statements about what she had understood, without checking: "she often said that, that 'you're on the ball, you're following, even though you weren't here last time, so we can move on'". Such statements made it difficult for her to speak up when there was something she did not fully understand.

Learning about feelings. The informants were asked to indicate on a written list which sessions they found the most useful and which they found less useful. As seen in Table 4, most of the informants found the sessions on emotions highly valuable.

Amanda said that the most valuable part for her was to learn about how thoughts, emotions and actions are inter-linked, and that NSSI fills a function by regulating emotions. Dea liked to learn about clear and cloudy emotions: "what I feel about something doesn't really need to be about that, but

Table 4.
Informants' reports about most and least valued ERGT sessions.

Session number	Session name	Number of informants who said it was among the most useful sessions	Number of informants who said it was among the least useful sessions
1	Function of self-harm behaviour	1	1
2	Facts about emotions	0	0
3-4	Emotional awareness	1	0
5	Primary vs. secondary emotional responses	4	0
6	Clear vs. cloudy emotional responses	4	1
7	Emotional control and avoidance*	3	0
8	Emotional acceptance and willingness*	3	1
9	Identifying non-emotionally avoidant emotion regulation strategies	2	0
10	Impulse control	2	0
11-12	Valued directions	2	2
13-14	Barriers to valued actions and commitment to valued actions	0	0
15	Valued directions, a process*	0	0
16	Relapse prevention*	1	0

*Authors' translation of session names from the Swedish, updated manual. Sessions 7-8 are grouped together as "Emotional avoidance/unwillingness versus emotional acceptance/willingness" in Gratz's (2010) English manual. Sessions 15-16 are not named in Gratz's (2010) English manual.

[could be] something that lingers from earlier on, which it probably usually is"

Charlotte stated that learning about primary and secondary emotional responses had made a difference in her life. She said it made her understand that there could be more emotions present than only constant anger. She also said that the knowledge about primary and secondary emotions made her understand her children better and explore their emotions in a different way. Frida described that the awareness of primary and secondary emotional responses helped her understand which emotions to listen to, and to do something about, and which emotions to accept. This helped her understand and work with feelings of shame.

Suggestions for how ERGT might be improved

All of the informants had suggestions about how ERGT could be improved. These are summarized below.

The setup of the treatment. Half of the informants found the ERGT treatment too short. However, one informant on the contrary found the treatment too long. Among those who wished for the treatment to be longer, one said that from around session 11 it was too compressed. Some suggestions were: dividing each session into two; spending more time on "Valued directions" and "Emotional awareness"; focusing more on relapse prevention; and to include a follow-up session.

Adding interventions from other treatments. Several informants had participated in other forms of treatment and

psychotherapy and integrated the skills practiced there with the ERGT framework. One informant who had received DBT after ERGT said that functional analysis had helped her understand what happened to her between an event and her actions. She suggested that this could be used in ERGT as well, perhaps together with the individual therapist to learn more about feelings on a less generic and more personal level. She also said that she liked practicing the skill of a non-judgmental stance during DBT and thought it would be helpful to include in ERGT as well. Another informant had participated in basic body-awareness therapy and suggested that ERGT could gain from including the body more in therapy.

Individual therapy. Though ERGT is supposed to be combined with individual therapy, some informants reported not having received a proper individual therapy. One informant said she stopped seeing her individual therapist after two sessions as she "did not feel comfortable there". She thought having had an individual therapist would have helped her to handle all the emotions ERGT evoked, and that it could possibly have prevented her suicide attempt. She also proposed that the group therapist should have some form of contact with the individual therapist. Another informant suggested that one could have an individual meeting with one of the group therapists halfway through treatment, to allow for discussing problems from an ERGT perspective but on an individual and specific level.

Valued directions. Although "Valued directions" was

mentioned by two informants as something they had valued the most from ERGT, and also had used frequently, several others made negative comments about the section. For example, it was said to be “a huge pressure” to think about life goals and values. Two informants seemed to have interpreted “valued” as “judgmental” and responded negatively on that account. A third informant found “Valued directions” to be “too much in too little time” and she suggested that more time could be spent on it.

Discussion

The purpose of the present study was to explore in more detail the changes experienced by six of the patients who took part in the Swedish ERGT trial (Sahlin et al., 2017), in order to generate hypotheses about the change process in ERGT. The results suggest that the most consistent changes occurred on emotion regulation, and that an improved understanding and acceptance of emotions were among the most important changes. These changes were, in turn, reported to lead to an increased ability to understand and accept oneself, and thereby also to an increased sense of control and well-being, as well as an increased openness to others, and an improved quality of interpersonal relationships.

The thematic analysis in addition pointed to the involvement of a number of other factors. For example, participants reported that relationships to others were important both as motivating them to start the ERGT treatment and to engage in the procedures; conversely, they reported that it was harder to focus on treatment and practice emotion regulation when their relationships were more conflicted. Participants also appreciated the sense of belonging and sharing with others that was afforded by the group format, and the sense of equality in the relationship to the therapists.

Figure 1 shows a map of the results of the thematic analysis, with the filled arrows representing some hypotheses. For example, the results suggest the hypotheses that several factors beyond the ERGT method (e.g., the quality of interpersonal relationships, the therapist’s way of relating, and the sense of belongingness and sharing with others that was afforded by the group format) may be important for a successful outcome.

The findings with regard to the sense of belongingness are consistent with Gratz’ (2010) description that many NSSI patients feel terribly alone, and may therefore find it helpful to see that they are not the only people struggling with similar issues. This suggests that the group format may be preferable not only from an economical perspective, but also from a therapeutic perspective. However, the group in itself may also be a risk factor for deterioration if a participant does not improve during treatment, but instead learns new self-destructive behaviours – as indicated by one of the informants. Social contagion of NSSI in psychiatric settings via modelling and imitation is widely known (Jarvi, Jackson, Swenson & Crawford, 2013), and the ERGT manual prohibits active discussion of NSSI methods during sessions.

Although one participant interpreted the therapist’s behaviour as accepting towards self-destructive behaviour, this is non-adherent to the ERGT model, which takes a non-judgmental stance toward such behaviours while also acknowledging their downsides. No data on adherence and competence were taken in the Swedish ERGT trial, however, so it is not meaningful to discuss the level of adherence among the therapists.

It is interesting to note that some of the informants described ambivalent feelings with regard to their self-harming behaviour. Although acts of NSSI had ceased for many of them, thoughts of it still remained, and one informant said she still engaged in NSSI “in her mind”. Although informants expressed pride and happiness in their ability to abstain from NSSI, some of them also expressed a sense of losing a part of themselves when they stopped it. Even the most successful treatment responder expressed some doubts about her ability “to separate from this behaviour that I’ve had so long.” This suggests that it may be of crucial importance that the individual acquires new skills of emotion regulation before she is ready to give up NSSI.

It may be noted that the results on what was valued most in ERGT are not quite in accordance with Gratz and Gunderson’s (2006) finding that the focus on emotional willingness and valued directions was what generated the most enthusiasm. Although the focus on emotional willingness was widely appreciated in the present interview sample, the sessions on valued directions received more mixed comments. In the case of two participants, this seemed to be associated with an interpretation of “valued” in terms of being “judgmental”, which suggests that they may have misunderstood something about this part of the treatment. One possibility that may deserve further exploration is that the Swedish language may have a role here. In Swedish, the word for “valued” (värderad) and “judgemental” (värderande) are unfortunately similar and might be easier to confuse than in English; this suggests that it may be beneficial to spend more time explaining the concept in a Swedish speaking context.

Many NSSI patients have negative experiences of health care, and research confirms that negative attitudes towards NSSI patients are common (Saunders et al., 2012). This view was largely shared by our informants, who reported having several negative experiences of health care in relation to NSSI. Participation in ERGT, where the relationship to the therapist was experienced as more “equal”, might have been an important corrective experience for participants. The therapist may thereby also function as a role model and help create an environment of sharing in the group. It is recommended in the ERGT manual (Gratz, 2010) that therapists should be self-disclosing, verbalise their feelings and practice acceptance during the sessions. Furthermore, it is emphasized that they should model the humanness of struggles with emotional willingness. To judge from their reports in the interview, the six informants’ therapists seem to have succeeded in adopting this kind of therapeutic stance.

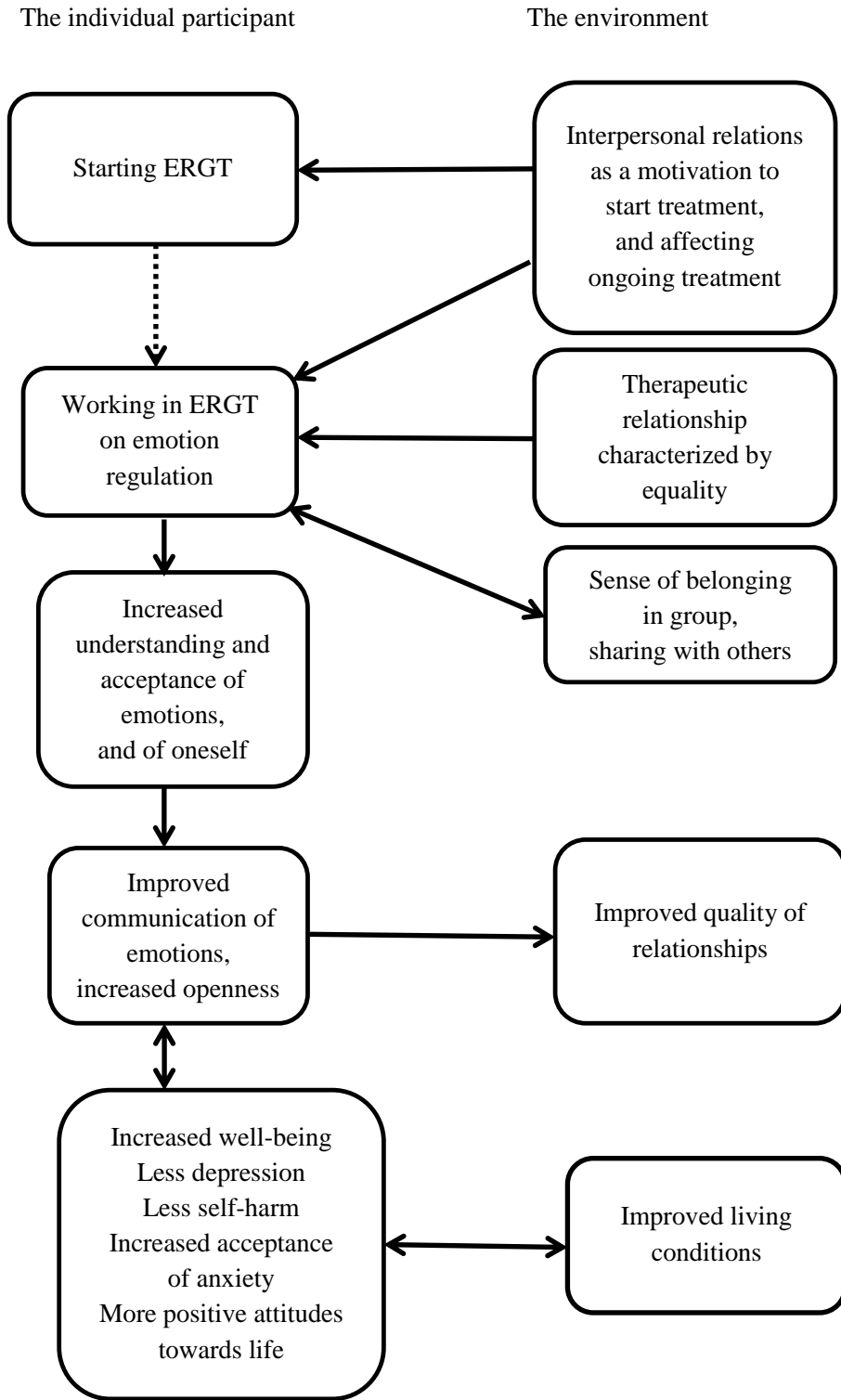


Figure 1. Map of the results of the thematic analysis, with the filled arrows representing hypotheses about change processes.

The informants' suggestions for improvements of ERGT were not as uniform as their opinions on the most valuable components of treatment. They suggested changes in the set-up of the treatment, adding interventions from other treatments, a more consistent involvement of individual therapy, and changes in the sessions on valued directions. Here it is interesting to note that, although ERGT is described as an "adjunctive" treatment for patients who are already undergoing individual therapy, two of the informants in this study reported not having received a proper individual therapy; this raises the question how common this is more generally, and the possible implications of this for the outcome of treatment. In this context it may be noted that 43% of the participants in Gratz et al.'s (2014) study actually had ERGT as their primary treatment, while meeting with their individual clinicians only 1-2 times per month, apparently without detracting from the overall positive treatment effects.

Previous research on ERGT has had little to say about when change might take place in ERGT. Our informants generally reported that the positive changes occurred at the end of the treatment; at least this is when they noticed it. In some cases, the changes were evident only in retrospect. This question may be focused on in more detail in future research.

Limitations

The present research suffers from a number of limitations. First, one limitation is the small convenience sample, which was not representative of the total patient sample, and does not allow for any generalizing conclusions. On the other hand, this is not so much of a problem in the present context, as the purpose of the study was to generate hypotheses about the change process in ERGT – not to draw general conclusions about these processes. Such hypotheses can then be made into the starting-point for further research. Still, it may be argued that the information basis of the paper could have been better with another sampling procedure – for example, selecting three patients with maximally positive treatment outcomes and three with maximally negative outcomes.

A second limitation is that the interviews took place 2-3 years after the participation in ERGT, which means that the informants might have forgotten things about the treatment. The informants were, however, able to describe both content and autobiographical memories from different sessions. In general, the sessions about emotions seemed to be better remembered by the informants, which may be interpreted in terms of these sessions being more valuable to them. However, it cannot be taken for granted that the most important parts of treatment leave the most retrievable memories; what stays in memory may depend also on other factors. It would be an interesting study in itself to investigate what is remembered of a psychological treatment at various levels of distance in time, and to compare this with other measures of what have been the most active ingredients of treatment. In the absence of such knowledge, it is difficult to know to

what extent recollections after 2-3 years really reflect the most important events in therapy.

A third limitation is the use of an interview guide that was constructed specifically for the purpose of this study, and a method of analysis which relies on interpretation of the material. The two first authors were, however, present during all interviews, and analysed the transcribed material independently of each other, which makes for a certain degree of intersubjectivity in the process. The credibility of the analysis was also supported by member checking (Williams, 2015), in the sense that each informant received a written summary of their respective interviews, and was given the option to correct possible errors and add information if needed.

A fourth limitation is that the authors had a positive attitude to ERGT that may have affected the respondents' answers during the interview, and/or created a bias in the thematic analysis. The openness to critical comments, and the explicit inclusion in the interview of questions about possible ways of improving ERGT, however, encouraged the informants to report negative experiences of the treatment. One informant said that she usually speaks positively about ERGT, and that it was nice to be able to "complain a little" during the interview.

A fifth limitation concerns the calculation of reliable change and clinically significant improvement. The method for computing reliable change is based on classical test theory with its strong assumptions, which are now considered rather obsolete. Further, different kinds of criteria were used on different instruments for the calculation of reliable change and clinically significant change: empirically derived norms for DASS (Lovibond & Lovibond, 1995), a definition of normal functioning in terms of an abstinence from self-harm on the DSHI (Gratz et al., 2014), and Jacobson and Truax's (1991) method to calculate a cut-off on the DERS. This implies a certain arbitrariness in the cut-offs, which makes it difficult to compare clinical significance on different instruments.

Finally, one limitation (which applies to the Swedish ERGT project as a whole) is that there was no measurement of therapist adherence or competence. There is therefore no way of knowing the level and variation of adherence and competence, and to what extent this influenced treatment outcomes and the experience of treatment, nor if it could possibly help explain possible differences in the aspects of ERGT that were experienced as most beneficial by participants in this study vs. the Gratz and Gunderson (2006) study.

Author contributions

This paper is a shortened, and partly expanded, version of a Masters thesis that was written by AD and EW (Dahlberg & Wetterberg, 2016), under the supervision of LGL. HS contributed with data from the larger ERGT project. All authors contributed to the present version of the paper and

approved of the final manuscript.

Declaration of conflicting interests

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The informants' travel expenses in connection with the interviews were funded by a grant from Lundh Research Foundation.

References

- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression anxiety stress scales in clinical groups and a community sample. *Psychological Assessment, 10*(2), 176–181. doi:10.1037/1040-3590.10.2.176
- Bergman, L. R. (2010). The interpretation of single observational units' measurements. In M. Carlson, H. Nyquist, & M. Villani (Eds.), *Official statistics: Methodology and applications in honour of Daniel Thorburn* (pp. 37–49). Stockholm: Stockholm University.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi:10.1191/1478088706qp063oa
- Dahlberg, A., & Wetterberg, E. (2016). *Emotion Regulation Group Therapy for individuals with Non-Suicidal Self-Injury - a pilot study of six patients with combined quantitative and qualitative methods*. (Unpublished masters thesis.) Department of Psychology, Lund University, Lund, Sweden.
- Gratz, K. L. (2001). Measurement of deliberate self-harm: Preliminary data on the deliberate self-harm inventory. *Journal of Psychopathology and Behavioural Assessment, 23*(4), 253-263. Retrieved from: <http://www.springerlink.com/openurl.asp?genre=journal&issn=0882-2689>
- Gratz, K. L. (2007). Targeting emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology: In Session, 63*, 1091-1103. doi:10.1093/clipsy.bpg022
- Gratz, K. L. (2010). *An acceptance-based emotion regulation group therapy for deliberate self-harm*. Unpublished manual.
- Gratz, K. L., & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behaviour Therapy, 37*(1), 25-35. doi:10.1016/j.beth.2005.03.002
- Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology & Behavioural Assessment, 26*(1), 41-54. doi: 10.1023/B%3AJOBA.0000007455.08539.94
- Gratz, K. L., & Tull, M. T. (2011). Extending research on the utility of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality pathology. *Personality Disorders: Theory, Research, and Treatment, 2*(4), 316-326. doi:10.1037/a0022144
- Gratz, K. L., Tull, M. T., & Levy, R. (2014). Randomized controlled trial and uncontrolled 9-month follow-up of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder. *Psychological Medicine, 44*(10), 2099-2112. doi:10.1017/S0033291713002134
- Guan, K., Fox, K. R., & Prinstein, M. J. (2012). Nonsuicidal self-injury as a time-invariant predictor of adolescent suicide ideation and attempts in a diverse community sample. *Journal of Consulting And Clinical Psychology, 80*(5), 842-849. doi:10.1037/a0029429
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: an experiential approach to behaviour change*. New York; London: Guilford Press.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19. doi:10.1037/0022-006X.59.1.12
- Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research, 17*(1), 1-19. doi:10.1080/13811118.2013.748404
- Kazdin, A. (2007) Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1-27.
- Lambert, M. J., & Ogles, B. M. (2009). Using clinical significance in psychotherapy outcome research: The need for a common procedure and validity data. *Psychotherapy Research, 19*(4-5), 493-501. doi:10.1080/10503300902849483
- Linehan, M. M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford Press.
- Lovibond, S. H. & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales*. Sydney: Psychology Foundation.
- Molenaar, P. C. M. (2004). A manifesto on psychology as idiographic science: Bringing the person back into scientific psychology, this time forever. *Measurement, 2*, 201-218. DOI: 10.1207/s15366359mea0204_1
- Sahlin, H., Bjureberg, J., Gratz, K. L., Tull, M.T., Hedman, E., Bjärehed, J., Jokinen, J., Lundh, L. G., Ljótsson, B., & Hellner Gumpert, C. (2017). Emotion Regulation Group Therapy for deliberate self-harm: A multi-site evaluation in routine care using an uncontrolled open trial design. *BMJ Open, e016220*. doi:10.1136/bmjopen-2017-016220.

- Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2012). Review: Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders, 139*(3), 205-216. doi:10.1016/j.jad.2011.08.024
- Socialdepartementet. (2011). *Överenskommelse om ett handlingsprogram för att utveckla kunskapen om och vården av unga med självskadebeteende*. (Dnr: S2011/8975/FS). Retrieved from: <http://www.regeringen.se/overenskommelser-och-avtal/2011/10/s20118975fs/>
- Washburn, J. J., Potthoff, L. M., Juzwin, K. R., & Styer, D. M. (2015). Assessing DSM–5 nonsuicidal self-injury disorder in a clinical sample. *Psychological Assessment, 27*(1), 31-41. doi:10.1037/pas0000021
- Williams, B. (2015). How to evaluate qualitative research. *American Nurse Today, 10*(11), 31-38. Retrieved from: <https://americannursetoday.com/evaluate-qualitative-research/>

Appendix 1

To explore if the interview sample differed from the total sample in terms of problem level and improvement, descriptive data and effect sizes (Cohen's d) were calculated for the interview sample and compared with those of the total sample. Effect sizes for the interview sample on self-harm (DSHI), depression, anxiety and stress (DASS-21) and difficulties in emotion regulation (DERS) at post-test and follow-up were calculated by dividing its change score by the pre-treatment standard deviation of the total sample, as reported by Sahlin et al. (2017). Because the DSHI scores were not normally distributed, the effect sizes on the DSHI were calculated on the basis of logarithmically transformed values (in accordance with Sahlin et al., 2017).

Means (SD) and effect sizes of the interview sample, as compared with the total sample from Sahlin et al. (2017).

	The interview sample		The total sample	
	M (SD)	Cohen's d from pre ¹	M (SD)	Cohen's d from pre ¹
DSHI pre	10.00 (9.49)		53.68 (99.88)	
DSHI post	19.20 (23.95)	-0.23 ¹	37.45 (72.22)	0.52 ¹
DSHI follow-up	3.80 (7.43)	0.06 ¹	28.69 (95.44)	0.99 ¹
DASS-D pre	27.60 (3.85)		25.35 (10.28)	
DASS-D post	15.20 (11.19)	1.21	20.11 (11.80)	0.50
DASS-D follow-up	11.20 (7.95)	1.60	19.95 (11.92)	0.55
DASS-A pre	19.60 (6.07)		17.14 (8.98)	
DASS-A post	16.40 (8.65)	0.36	16.30 (9.97)	0.08
DASS-A follow-up	9.60 (5.37)	1.11	14.54 (9.58)	0.25
DASS-S pre	26.40 (5.18)		25.77 (7.95)	
DASS-S post	21.60 (5.90)	0.60	23.34 (9.21)	0.30
DASS-S follow-up	13.60 (6.84)	1.61	21.19 (10.34)	0.56
DERS pre	130.60 (16.29)		125.98 (19.37)	
DERS post	93.40 (27.32)	1.92	108.17 (27.52)	0.91
DERS follow-up	85.40 (24.01)	2.33	104.66 (27.40)	1.03

¹ Based on log-transformed data.

DSHI = Deliberate Self-Harm Inventory; DASS-D = DASS-Depression; DASS-A= DASS-Anxiety; DASS-S = DASS-Stress
DERS = Difficulties in Emotion Regulation Scale

A comparison in terms of median values on the DSHI shows the following results:

	The interview sample	The total sample
DSHI pre	6	22
DSHI post	5	20
DSHI follow-up	0	4