Targeting Emotion Dysregulation in the Treatment of Self-Injury

Kim L. Gratz
Center for Addictions, Personality, and Emotion Research
University of Maryland

Clinically useful definitions of emotion regulation with respect to deliberate self-harm (referred to here as self-injury) focus on adaptive ways of responding to emotional distress rather than on the control of emotions or dampening of emotional arousal. According to one such definition, emotion regulation is a multifaceted construct involving a) the awareness, understanding, and acceptance of emotions; b) ability to engage in goal-directed behaviors, and inhibit impulsive behaviors, when experiencing negative emotions; c) the flexible use of situationally appropriate strategies to modulate the intensity and/or duration of emotional responses rather than to eliminate emotions entirely; and d) willingness to experience negative emotions as part of pursuing meaningful activities in life (Gratz & Roemer, 2004). This article addresses the role of emotion dysregulation in self-injury and discusses two treatments for self-injury that explicitly focus on increasing emotion regulation. These treatments are based on the premise that the reduction of emotion dysregulation will decrease the need for maladaptive behaviors that function to regulate emotions, such as self-injury. A case illustration describing how one of these treatments (an acceptance-based, emotion regulation group therapy) is used to treat self-injury is provided. © 2007 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 1091–1103, 2007.

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Deliberate self-injury (also referred to as *deliberate self-harm*; Chapman, Gratz, & Brown, 2006; Gratz, 2003) is a serious clinical concern. Although this behavior is, by definition, distinguished from suicidal behaviors involving an intent to die, individuals who

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Correspondence concerning this article should be addressed to: Kim L. Gratz, Department of Psychology, University of Maryland, College Park, MD 20742; e-mail: klgratz@aol.com

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engage in self-injury are at heightened risk for suicide attempts, sometimes due to demoralization over an inability to control acts of self-injury (Favazza, 1998). Further, although some of the consequences of self-injury are negatively reinforcing (e.g., the reduction in tension that follows), other consequences may inadvertently increase the emotional pain of the deliberately self-injuring individual. For example, self-injury is associated with a wide range of negative interpersonal and intrapersonal consequences, including shame, guilt, regret, and social isolation (Favazza, 1998; Leibenluft, Gardner, & Cowdry, 1987).

One of the most important factors that both contributes to and maintains self-injury is emotion dysregulation. Linehan (1993) proposes that emotion dysregulation is one of the core features of borderline personality disorder (BPD) and underlies many of the associated behaviors of this disorder, including self-injury (which is thought to serve an emotion-regulating function). Other researchers have likewise conceptualized self-injury as an emotion regulation strategy (Gratz, 2003; Klonsky, 2007).

Given the centrality of emotion dysregulation to self-injury, treatments have been developed for this behavior that explicitly focus on increasing emotion regulation. These treatments (two of which will be discussed in detail below) are based on the premise that the reduction of emotion dysregulation will decrease the need for maladaptive behaviors that function to regulate emotions, such as self-injury. Indeed, evidence for the efficacy of these treatments, combined with research on the relationship between emotion dysregulation and self-injury (Gratz & Chapman, 2007; Gratz & Roemer, 2004), suggests the value of treating self-injury by decreasing emotion dysregulation.

Unfortunately, however, disagreement and confusion regarding the definition of emotion regulation may interfere with the identification of specific treatment targets, making it harder to treat self-injury effectively. Knowing exactly what to focus on when treating self-injury requires an understanding of exactly what emotion regulation means; therefore, I begin by describing the two areas of disagreement that are pertinent to developing a conceptualization of emotion regulation that is relevant to self-injury, and propose a clinically useful definition of emotion regulation for self-injury. Then, I describe two treatments for self-injury that explicitly focus on increasing emotion regulation, and present a case illustration of one of these treatments.

Conceptualizing Emotion Regulation

Control of Emotions Versus Control of Behavior When Experiencing Emotions

First, there is disagreement as to whether emotion regulation refers to the control of negative emotions or the control of behavior when experiencing negative emotions. One approach has been to equate emotion regulation with the control and reduction of negative emotions (e.g., Kopp, 1989), implying that experiencing negative emotions is a sign of emotion dysregulation. Although the assumption that negative emotions are disruptive, problematic, and should be carefully controlled is widespread in psychology, recent research suggests that efforts to control negative emotions may not always be effective or healthy. For example, studies have found that efforts to control, suppress, or avoid unwanted internal experiences (including emotions) may actually have paradoxical effects, increasing the frequency, severity, and accessibility of these experiences (see Salters-Pedneault, Tull, & Roemer, 2004). The classic studies in this area focused on thought suppression (deliberately trying not to think about something), and involved instructing study participants not to think of a white bear (Wegner, Schneider, Carter, & White, 1987). These studies provided the first experimental evidence that attempts to

avoid or suppress internal experiences can have paradoxical effects. Since then, similar results have been found for emotions (see Salters-Pedneault et al., 2004). In general, these findings suggest that conceptualizations of emotion regulation that equate regulation with the control or avoidance of certain emotions may confound processes that undermine regulation with those that promote emotion regulation.

More consistent with the research are conceptualizations of emotion regulation that emphasize the functionality of all emotions (Cole, Michel, & Teti, 1994; Thompson & Calkins, 1996) and view adaptive emotion regulation as the ability to control one's behaviors (e.g., by inhibiting impulsive behaviors and/or engaging in goal-directed behaviors) when experiencing negative emotions, rather than the ability to control one's emotions (Linehan, 1993). Although this means that adaptive regulation could involve efforts to modulate the intensity or duration of an emotion (Thompson & Calkins, 1996), these efforts are in the service of reducing the urgency associated with the emotion in order to control one's behavior (rather than the emotion itself). This approach suggests the utility of behaviors that function to "take the edge off" an emotion or self-soothe when distressed, provided that the individual is not attempting to get rid of the emotion or escape it altogether. As such, this approach is acceptance-based, conceptualizing both positive and negative emotions as functional and encouraging the awareness, understanding, and acceptance of all emotions.

Relationship between Emotion Regulation and Emotional Vulnerability

The second area of disagreement concerns the relationship between emotion regulation and a biologically based or temperamental emotional vulnerability. Some researchers equate emotion regulation with the temperamental characteristic of low emotional intensity/reactivity (e.g., Livesley, Jang, & Vernon, 1998), implying that intense, reactive emotional responses are problematic and inherently dysregulated. Although evidence suggests that individuals who are more emotionally intense and reactive may be at greater risk for emotion dysregulation (Flett, Blankstein, & Obertynski, 1996), this relationship is not direct. Moreover, most research indicates that emotional intensity/reactivity in and of itself is not associated with negative psychological outcomes (Larsen & Diener, 1987). In fact, emotional intensity/reactivity has not been found to be directly associated with risk for self-injury (Gratz, 2006; Gratz & Chapman, 2007). For example, one recent study found that emotional intensity/reactivity increased the risk for self-injury among women only in conjunction with other risk factors (childhood maltreatment and emotional inexpressivity; Gratz, 2006). Further, another study found that emotional intensity/reactivity was *negatively* associated with self-injury frequency among men with a history of this behavior (Gratz & Chapman, 2007).

Alternatively, other researchers define emotion regulation as separate from the quality of the emotional response (Linehan, 1993; Thompson & Calkins, 1996), implying that there is a difference between emotion regulation and one's emotional temperament. According to these definitions, emotional intensity/reactivity does not preclude adaptive regulation; one can be emotionally intense or reactive and not dysregulated. Instead, emotion regulation is seen as any adaptive way of responding to one's emotions, regardless of their intensity or reactivity (distinguishing responses to emotions from the quality of emotions themselves).

Providing some support for the utility and practicality of this approach, an ongoing longitudinal study has found that BPD symptoms associated with a temperamental emotional vulnerability decrease the least over time, whereas symptoms associated with

behavioral dyscontrol (e.g., self-injury) improve the most (Zanarini, Frankenburg, Hennen, & Silk, 2003). These findings suggest that characteristics of an individual's temperament or personality (such as emotional intensity/reactivity) may be both less likely to change and less amenable to treatment. Thus, not only is the desirability of trying to change these aspects of a client's personality unclear (given that they are not directly associated with negative psychological outcomes), so is the clinical utility of doing so. Distinguishing emotion regulation from emotional temperament may arguably direct attention to behaviors that are more amenable to change and directly associated with clinical risk.

A Clinically Useful Definition of Emotion Regulation for Self-Injury

The literature reviewed above suggests that a clinically useful definition of emotion regulation with respect to self-injury will focus on adaptive ways of responding to emotional distress rather than the control of emotions or dampening of emotional arousal in general. According to one such definition, emotion regulation involves the (a) awareness, understanding, and acceptance of emotions; (b) ability to engage in goal-directed behaviors and inhibit impulsive behaviors when experiencing negative emotions; (c) flexible use of situationally appropriate strategies to modulate the intensity and/or duration of emotional responses rather than to eliminate emotions entirely; and (d) willingness to experience negative emotions as part of pursuing meaningful activities in life (Gratz & Roemer, 2004). Conversely, deficits in any of these four areas are considered indicative of emotion dysregulation.

Importantly, there is support for the usefulness of this definition with regard to self-injury, as a growing body of research indicates a relationship between self-injury and emotion dysregulation in general (Gratz & Chapman, 2007; Gratz & Roemer, 2004), as well as some of the individual dimensions of emotion dysregulation. Specifically, studies indicate that self-injury is associated with lower levels of emotional awareness and clarity (Evren & Evren, 2005) and greater use of avoidant emotion-regulation strategies (Gratz, 2004).

Two Emotion Regulation-Based Treatments for Self-Injury

The literature reviewed above indicates the importance of developing treatments for self-injury based on a conceptualization of emotion regulation that does not equate adaptive regulation with the control or avoidance of emotions. Indeed, many individuals who engage in self-injury struggle with their emotions, caught in a vicious cycle of emotional intolerance, followed by attempts to avoid those emotions, followed by the paradoxical consequences of these avoidance attempts (including greater emotional distress and arousal; Chapman et al., 2006). Thus, treatments that focus on teaching deliberately self-injuring individuals ways to avoid or control their emotions may not be useful, and may inadvertently reinforce a nonaccepting and maladaptive stance toward their emotions. Instead, individuals who engage in self-injury are more likely to benefit from learning other, more adaptive, ways of responding to their emotions (such as emotional acceptance and willingness).

Two treatments targeting emotion dysregulation as defined above have been developed to treat self-injury. These treatments are based on the premise that the reduction of emotion dysregulation will decrease the need for maladaptive behaviors that function to regulate emotions, such as self-injury.

Dialectical Behavior Therapy

Based on the theory that emotion dysregulation is the primary mechanism underlying BPD and its related behaviors, Linehan (1993) developed dialectical behavior therapy (DBT) as a comprehensive treatment for BPD among chronically self-injuring and/or suicidal women. DBT combines traditional cognitive–behavioral approaches with acceptance- and mindfulness-based approaches stemming from Eastern philosophies like Zen.

Dialectical behavior therapy includes four treatment components: weekly group skills training, individual psychotherapy, and therapist consultation/supervision meetings, as well as telephone consultation as needed between clients and individual therapists. Four particular sets of skills are taught in the group skills training: emotion regulation, distress tolerance, mindfulness, and interpersonal effectiveness skills. Importantly, it is not just the skills within the emotion-regulation module that may target emotion dysregulation; instead, some of the distress tolerance and mindfulness skills are applicable as well.

With regard to the specific skills within each of these modules that may promote emotion regulation, some emotion-regulation skills seek to increase emotional awareness and understanding, teaching clients to identify and label emotions. Specifically, clients are taught to identify all components of an emotional response (physiological, subjective, and behavioral), as well as the events (and interpretations of these events) that prompt different emotions and the after-effects of emotions on their functioning. For example, a client who was feeling angry would be encouraged to identify the physical sensations associated with her anger (e.g., increased heart-rate, jaw tension), the behavioral urges associated with feeling angry (e.g., raised voice, clenched fists), the environmental precipitants of her anger (e.g., not being given a promotion at work), her interpretations of these environmental events (e.g., "This is unfair! I deserved this promotion!"), and the after-effects of her anger (e.g., increased motivation to approach her supervisor to discuss her job performance, etc.). Further, clients are taught to identify the functions of their emotions, one consequence of which may be increased emotional acceptance.

In addition to these emotion-regulation skills, certain distress tolerance skills may facilitate emotion regulation and a healthier relationship with one's emotions. Distress tolerance skills teach clients to tolerate and accept emotional distress, and emphasize the benefits of accepting one's emotions without trying to change or alter these emotions, and accepting reality for what it is in the moment. Specific skills seek to increase acceptance and willingness (distinguishing between acceptance and approval, and viewing willingness as an active choice), as well as to control behaviors when distressed (e.g., by using distraction and self-soothing techniques, rather than acting impulsively). Other skills emphasize the importance of considering the short- and long-term consequences of one's behaviors (expected to increase contact with the negative long-term consequences of behaviors that function to regulate distress in the short-term, such as self-injury).

Finally, mindfulness skills (the core skills of DBT) also may facilitate emotion regulation. There are six mindfulness skills within DBT, three of which focus on what to do, and the other three of which focus on how to do it. These "what" skills (observing, describing, and participating) and "how" skills (nonjudgmentally, one-mindfully, and effectively) are designed to be used in conjunction with one another, with the former specifying the behavior to be practiced and the latter specifying the quality of this behavior. Of relevance to the treatment of emotion dysregulation, certain mindfulness skills promote a nonjudgmental awareness of one's internal experiences (including emotions), teaching clients to observe internal experiences as they occur in the moment, and to label these experiences objectively (letting go of evaluations such as "good" or "bad").

Although the efficacy of DBT for the treatment of self-injury in particular and BPD in general is well-established (e.g., Linehan et al., 2006), DBT is a multidimensional treatment developed to treat BPD in its entirety. Thus, it is possible that other aspects of the treatment not related to emotion regulation could also account for the improvements in self-injury. In the absence of research examining the mechanisms of change in DBT and/or the specific treatment components associated with reductions in self-injury, it is unclear exactly what skills are effective in decreasing self-injury.

An Acceptance-based Emotion Regulation Group Therapy

Providing more direct evidence for the usefulness of increasing emotion regulation to treat self-injury, a recent study provided empirical support for a self-injury treatment among women with BPD specifically focused on decreasing emotion dysregulation and emotional avoidance (Gratz & Gunderson, 2006). This 14-week, adjunctive group therapy was designed to treat self-injury by directly targeting the function of this behavior and teaching self-injuring women more adaptive ways of responding to their emotions. Specifically, this emotion regulation group therapy (Gratz & Gunderson, 2006) was developed to systematically address each of the dimensions of emotion regulation described above: emotional awareness, understanding, and acceptance; the ability to control behavior when experiencing negative emotions; the use of non-avoidant emotion-regulation strategies to modulate the intensity and/or duration of emotional responses; and the willingness to experience negative emotions as part of pursuing meaningful activities. This treatment draws heavily from both DBT and another acceptance-based behavioral therapy, acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999).

Table 1 outlines the weekly content of this group therapy. Week 1 focuses on the function of self-injury, providing psychoeducation and assisting clients in identifying the functions of their own self-injury; as such, the first session is expected to target the shame often associated with this behavior. Week 2 focuses on the function of emotions. Clients are taught that emotions are evolutionarily adaptive and provide important information about the environment that can be used to guide their behavior and inform an adaptive course of action. Further, clients are taught that by acting on the information provided by their emotions in this way, they are likely to respond more effectively to their environment. This emphasis on the functionality of emotions is expected to increase emotional acceptance.

Weeks 3–6 focus on increasing emotional awareness and understanding. Clients are assisted in improving their ability to identify, label, and differentiate between emotional

Table 1
Content of Emotion Regulation Group Therapy Modules

Week 1	Function of deliberate self-harm behavior
Week 2	Function of emotions
Weeks 3–4	Emotional awareness
Week 5	Primary vs. secondary emotions
Week 6	Clear vs. cloudy emotions
Weeks 7–8	Emotional avoidance/unwillingness vs. emotional acceptance/willingness
Week 9	Non-avoidant emotion-regulation strategies
Week 10	Impulse control
Weeks 11–12	Valued directions
Weeks 13–14	Commitment to valued actions

states. Similar to the DBT skills described above, clients are taught to identify the cognitive, physiological/bodily, and behavioral components of a variety of emotional responses. For example, clients are taught to ask themselves the following questions to increase their awareness of an emotional response: What thoughts are associated with this emotion? What physical sensations are associated with this emotion? What action tendencies are associated with this emotion? How do I tend to act in response to this emotion? Further, clients are taught to distinguish between primary emotions (initial emotional responses to a situation) and secondary emotions (emotional reactions to these primary emotional responses), as well as to identify the negative beliefs and judgments about emotions that underlie and contribute to secondary emotional responses. Finally, the functionality of primary emotions is emphasized, and clients are encouraged to identify the information provided by their primary emotions, as well as adaptive ways of acting on this information.

Weeks 7–8 emphasize the experiential benefits and emotion-regulating consequences of emotional acceptance, as well as the potentially paradoxical long-term consequences of emotional avoidance. Clients are also taught that emotional nonacceptance and avoidance may amplify emotions and make the experience of emotions more distressing. A distinction is drawn between emotional pain (which is a necessary part of life) and emotional suffering (which includes secondary emotions and failed attempts at emotional control/avoidance). Clients are also taught that emotional acceptance results in less suffering than emotional avoidance, as it prevents the amplification of emotional arousal (despite not necessarily reducing the primary emotional response). Clients are asked to actively monitor and assess the different experiential consequences of emotional willingness (an active process of being open to emotional experiences as they arise) versus emotional unwillingness.

Weeks 9–10 are the first to emphasize behavioral change, with Week 9 teaching nonavoidant strategies that may be used to modulate the intensity and/or duration of emotions (with a distinction drawn between distraction and avoidance), and Week 10 teaching basic behavioral strategies for impulse control (including consequence modification and behavioral substitution). For example, clients are taught to identify adaptive behaviors that may serve the same functions or meet the same needs as their self-injury, and to replace their self-injury with these more adaptive behaviors that serve the same function.

Finally, Weeks 11–14 focus on identifying and clarifying valued directions (those things in life that matter or are meaningful to the individual) and engaging in actions consistent with these directions. An emphasis is placed on moment-to-moment choices in everyday living and process rather than outcome. As such, valued directions require a present-moment focus and are distinguished from goals, which are future-oriented, static outcomes. For example, a client who values learning would be encouraged to identify a variety of discrete, concrete actions that are consistent with this valued direction and can be performed immediately, in the moment. In this case, the client would be encouraged to identify and engage in a variety of different actions consistent with the valued direction of learning, such as going to the library and reading a book of interest, researching things of interest on the internet, or joining a group for people with similar interests. Commitment to valued actions necessitates emotional willingness, in that it requires clients to remain open to experiencing the negative emotions that arise as part of engaging in these valued actions (rather than to avoid these emotions by not engaging in valued actions).

The group modules are primarily didactic in nature, combining psychoeducation and in-group exercises. The importance of skill generalization and daily practice is emphasized, and regular homework assignments are considered essential. Throughout the group treatment, clients complete daily monitoring forms on the emotional precipitants of their

urges to engage in self-injury, as well as the consequences of their behavioral choice. Additional daily monitoring forms are tailored to the particular group module, and include identifying emotions and the information provided by these emotions, distinguishing between primary and secondary emotions, identifying the consequences of emotional unwillingness versus willingness, and engaging in actions consistent with valued directions.

In order to examine the efficacy of this adjunctive group therapy, female outpatients with BPD and recent, recurrent self-injury were randomly assigned to receive this group in addition to their current outpatient therapy (group therapy plus treatment as usual [TAU]), or to continue with their current outpatient therapy alone for 14 weeks (TAU). These two conditions were then compared on outcome measures of emotion dysregulation, emotional avoidance, self-injury frequency, BPD symptom severity, and severity of depression, anxiety, and stress symptoms (Gratz & Gunderson, 2006). Results indicated significant between-group differences (with large effects sizes) on all outcomes. Further, whereas the TAU condition evidenced no significant changes over time on any measures, the group therapy + TAU condition evidenced significant improvements accompanied by large effect sizes on all measures and reached normative levels of functioning on measures of emotion dysregulation, emotional avoidance, and depression, anxiety, and stress symptoms. Although a single controlled trial is not definitive, the findings suggest that this acceptance-based, emotion regulation group therapy may improve outcomes for BPD clients with self-injury above and beyond standard outpatient therapy alone.

The following case illustration describes how this adjunctive group therapy was used to treat self-injury among one of the clients in this group.

Case Illustration

Client Description

Angela was a 26-year-old college graduate who lived by herself in the city. She worked fulltime for a nonprofit organization and had plans to enter law school in the future. Angela was referred to the group by her individual psychotherapist because of her persistent struggles with self-injury. Angela had been in once-weekly treatment with this therapist for the past year, and was not taking any psychiatric medications. This was her first experience with psychotherapy. Results of a structured diagnostic interview indicated that Angela met criteria for BPD. She also had received a diagnosis of dysthymia from her individual therapist.

During the intake, Angela reported a 5-year history of self-injury in the form of cutting and burning, usually occurring once or twice per week. She first began to engage in self-injury following graduation from college, secondary to social isolation and resultant loneliness. Although she had once thought that she could easily stop engaging in self-injury at any time she wished, she was growing concerned that the behavior was taking on a life of its own, as her urges to engage in this behavior were becoming more frequent and occurring in response to smaller stressors.

Angela described her family of origin as achievement-oriented and highly successful, and reported no known family psychiatric history. Her family environment throughout childhood and adolescence was marked by an absence of overt emotional displays and an emphasis on self-control and achievement. Angela reported a lack of closeness and connection among family members. Furthermore, although she had always sought out relationships with peers to compensate for the lack of family closeness, Angela's discomfort around others and fears that she would not fit in or would be rejected made establishing and maintaining friendships a challenge. However, despite these fears, Angela

had always managed to develop at least a couple of close relationships through school, capitalizing on her scholastic abilities and basing her friendships on shared academic interests.

Yet, Angela had never learned how to develop friendships outside of a school setting. When college ended and her friends moved away, Angela was left with an absence of social support and no idea how to go about developing new relationships. Although she found a job shortly after graduation, most of the employees knew one another already and seemed to have strong relationships with each other. Entering this situation, Angela felt like an outsider and did not believe that her coworkers would have any interest in getting to know her. She began to isolate after work, and became increasingly sad and lonely.

During the pretreatment assessment, Angela received a score of 125 on the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), indicative of high levels of emotion dysregulation.

Case Formulation

Angela's family modeled emotional control, teaching Angela that strong emotions interfere with success and should be controlled. As a result, Angela learned that intense emotions are bad and disruptive. Angela learned to judge her emotions, and felt ashamed when she experienced strong emotions. Furthermore, her family's focus on success and achievement taught Angela that "vulnerable" emotions like sadness and loneliness are particularly shameful.

While in school, Angela relied on her perfectionism and strong work ethic to help her avoid contact with her emotions by throwing herself into her schoolwork (a coping mechanism that was quite effective at the time). However, the transition out of college was very difficult for Angela, and she soon became overwhelmed by her feelings of loneliness and sadness (as well as feelings of shame for having these emotions).

Angela's self-injury functioned to provide relief from her emotions, and served a secondary function of punishing herself for having experienced them to begin with. However, this behavior also increased her shame and contributed to her social isolation, further increasing her distress and urges to engage in self-injury.

Course of Treatment

Angela experienced extensive shame about her self-injury. She thought it was a "sick" and "disgusting" behavior, and ran counter to her image of a successful and competent person. In a vicious cycle, her shame about her self-injury exacerbated her emotional suffering, thereby further increasing her urges to engage in this behavior, and intensifying her social isolation (increasing her distress even more). Connecting with the other members of the group and seeing that they also engaged in this behavior helped her feel less alone. In particular, seeing that respected group members also engaged in self-injury taught her that struggling with this behavior did not automatically make someone a terrible or incompetent person. In fact, Angela was quickly able to connect with the important functions that self-injury served for the other members of the group, displaying compassion for her peers and challenging their negative beliefs about themselves for engaging in self-injury. Aided by her understanding of the functions of self-injury for her peers, Angela began to identify the functions of her own self-injury, which led to more compassion for herself (interrupting the vicious cycle of increasing shame and resultant urges to engage in self-injury).

A key treatment component for Angela was increasing emotional acceptance. She had learned for so many years that emotions are disruptive and should be avoided that she experienced shame and fear whenever she had a normal emotional response of sadness or loneliness. During Week 2, Angela was encouraged to identify negative beliefs and judgments she had about emotions, as well as the origins of these beliefs. Angela reported that both implicit and explicit messages from her family contributed to her negative beliefs about emotions and led to a fear that having emotions would make her an incompetent or unlovable person and result in disapproval. Next, Angela was provided with psychoeducation on the functions of emotions, and encouraged to use this information to begin to "take a step back" from her judgments about her emotions when they arose, viewing these negative beliefs as learned reactions rather than "the truth."

During the next few weeks of the group therapy, Angela was asked to identify the information provided by her emotions of sadness and loneliness, as well as ways of acting on and learning from this information. Angela identified that her sadness and loneliness functioned to convey her lack of social support and her desire for relationships. She also noted that she could act on this information by beginning to develop connections with her coworkers (rather than engaging in self-injury to temporarily escape these feelings). Angela began to see her emotions as functional, resulting in an increase in emotional acceptance. Further, the more accepting she became of her emotions, the less shame and fear she experienced in response to their presence.

This focus on the utility of emotions paved the way for the discussion of the utility of emotional willingness in Weeks 7–8. Angela was asked to identify the consequences of her typical stance toward her emotions of unwillingness and avoidance. She noted that although self-injury provided momentary relief, her emotions always returned—oftentimes, more intense than before—and were accompanied by shame for having engaged in self-injury and fear that others would reject her if they knew. Angela also noted how she had become more afraid of her emotions over the past few years. Over time, she had lost her tolerance for her emotions, and had grown increasingly distressed by their presence and desperate to escape them. Although Angela initially expressed doubts about the utility of emotional willingness, she agreed to try this new stance toward her emotions. Soon, she began to connect to the positive experiential consequences of emotional willingness, noticing that her emotions eventually lessened in intensity, rather than intensifying like they did when she tried to avoid them. Further, each time Angela experienced the positive consequences that accompanied her new stance of emotional willingness, she became less wary of this approach and more committed to using it.

One of the most helpful aspects of the group for Angela was probably the focus on valued actions during Weeks 11–14. At that time, Angela was asked to identify the things in life that matter most to her, as well as the directions she wanted to move toward in her life. Angela quickly identified that social relationships were an important and yet often neglected area of her life. Angela gradually began to identify specific actions she could take to move forward in her valued directions of being open, genuine, and assertive. These valued actions included asking her coworkers to join her for coffee, asking one of the interns at her organization about her photography interests (which Angela shared), approaching a group of her coworkers at lunchtime about the possibility of joining them for lunch, reconnecting with her friends from college via phone or e-mail, and sharing her experiences during group sessions.

Importantly, it was the emphasis on process rather than outcome that seemed to motivate Angela to engage in these valued actions. By focusing her attention on the process of acting consistent with her values, Angela became less concerned about how her coworkers would respond to her in the moment, and reported being less upset if

someone declined her invitation or suggested a rain-check. Further, because success was defined as having engaged in the valued actions regardless of their outcomes, Angela obtained reinforcement (e.g., pride, joy, self-efficacy) even when her actions did not result in the desired outcome. This new perspective on success seemed to "free her up" to approach new people and to be less hard on herself. Moreover, the more she engaged in valued actions, the better she felt about herself and the more meaningful her life became—both of which resulted in a decrease in emotional suffering and reduced urges to engage in self-injury.

Outcome and Prognosis

By the end of the group therapy, Angela was evidencing a very different relationship with her emotions. She was more accepting of her emotions, was committed to identifying the information provided by these emotions, and reported much less emotional suffering. By connecting with the positive (and emotion-regulating) consequences of emotional willingness, she had learned a new way of approaching her emotions and did not struggle with her emotions as she had before. Moreover, Angela reported an improved quality of life, including the development of new friendships at work and enhanced comfort with and commitment to seeking out new relationships. Rather than isolating at home on weeknights and weekends, Angela now socialized at least twice per week. With regard to her self-injury, Angela stopped engaging in this behavior by the third week of the group, and reported only one episode during the rest of the group. Further, during the posttreatment assessment, she received a score of 82 on the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), within the normal range on this measure.

Several months after the end of the group, Angela's individual therapist reported that she was still engaging in valued actions, and suggested that this was aiding in her increased stability and functionality. Moreover, 6 months after the end of the group, her therapist reported that Angela had engaged in self-injury only once. Thus, at least with regard to short-term follow-up, the group appears to have been successful in treating her self-injury.

Clinical Issues and Summary

When treating emotion dysregulation among deliberately self-injuring clients, a growing body of clinical and empirical literature suggests the value of psychological treatments that emphasize emotional acceptance and promote both adaptive ways of responding to emotional distress and the control of behaviors in the face of emotional distress. This approach to the treatment of emotion dysregulation in self-injury is consistent with the growing body of literature suggesting the utility of acceptance- and mindfulness-based approaches to the treatment of psychopathology in general. Indeed, two treatments targeting both emotion dysregulation and emotional avoidance have been developed to treat self-injury, and results of randomized controlled trials provide support for their efficacy. This literature suggests that teaching clients with self-injury more adaptive ways of responding to their emotions may decrease emotion dysregulation and, consequently, the need for self-injury.

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